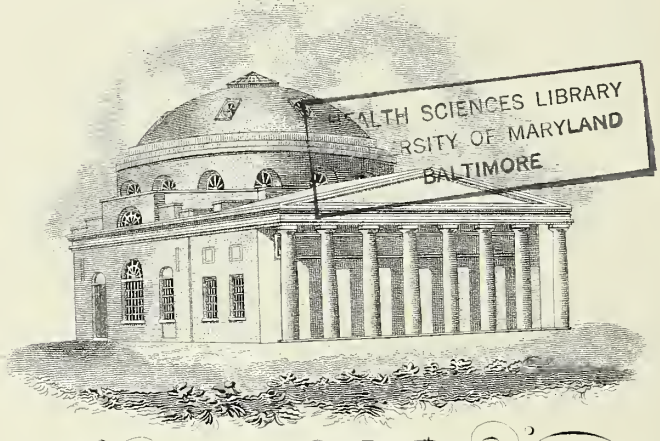
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The Journal

of the

Michigan State Medical Society

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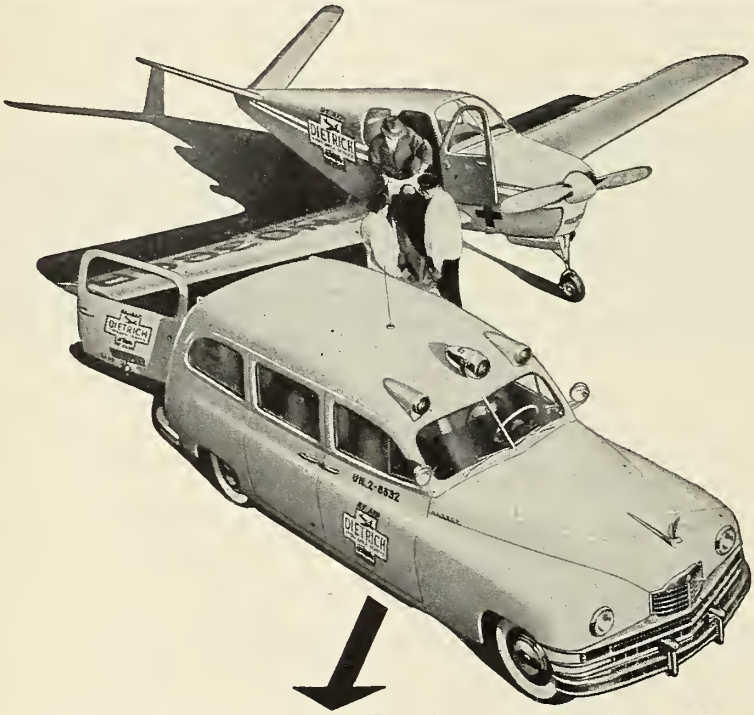
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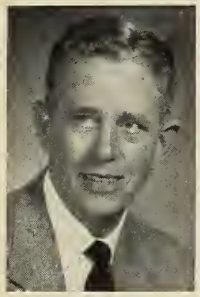
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VOLUME 51 JANUARY, 1952 NUMBER 1

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THOMAS V. HOAGLAND, M.D.



H. C. SALTZSTEIN, M.D.

Have You

Made Plans

and Reservations

for the

Michigan Clinical Institute

March 12-13-14, 1952

Detroit

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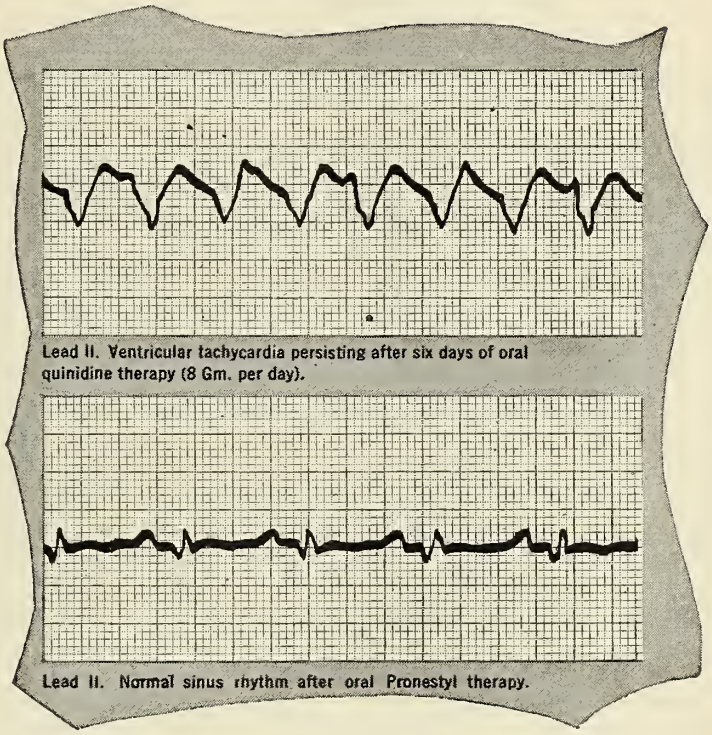
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1952	
Jan. 30	Mt. Carmel Mercy Hospital Clinic Day Detroit
March 12-14	MICHIGAN CLINICAL INSTITUTE Detroit
March 14	Michigan Heart Day (part of M.C.I.) Detroit
Spring	MSMS Postgraduate Extramural Courses State-wide
April 3	Jackson County Medical Society's Clinic Day Jackson
April 9	Genesee County Medical Society's Cancer Day Flint
April	Highland Park Physicians Club Clinic Highland Park
April 24-25	International College of Surgeons (Regional Meeting for Seven States) Detroit
May 1	Ingham County Medical Society's Clinic Day Lansing
May 7	Third Michigan Industrial Health Day Flint
May 14	Wayne University Medical Alumni Clinic Day and Reunion.....Detroit
June 9-13	AMA Annual Session.....Chicago
July	Annual Coller-Penberthy Medical Surgical Conference Traverse City
August	Third Annual Clinic, Central Michigan Committee, ACS Michigan Committee on Trauma, plus Michigan National Guard Medical Personnel, and Michigan Society of North Central Counties Grayling
Sept. 24-26	MICHIGAN STATE MEDICAL SOCIETY ANNUAL SESSION Detroit
Autumn	MSMS Postgraduate Extramural Courses State-wide

Additions to this list of meetings are invited by the Editor of JMSMS, in order to make this monthly announcement complete and accurate.

HIGHLIGHTS OF EXECUTIVE COMMITTEE OF THE COUNCIL

Meeting of November 15, 1951

Ninety-one items were considered by the Executive Committee of The Council at its November 15 meeting in Detroit. Chief in importance were:

- Monthly financial reports were presented and approved. Bills payable were inspected and payment was authorized.
- Motion was adopted that the component county societies of Michigan be allowed to retain, as collection fee, 1 per cent of the Michigan State Medical Society and of the American Medical Association dues collected for the year 1952 (i.e. 1 per cent of $70 or of $45, as collected).
- 606 Townsend. Liability insurance was authorized and also necessary repairs to the garage; purchase of used postage meter machine for executive offices was approved.
- Problems that may be presented to AMA Clinical Session, Los Angeles, were discussed with Michigan's Delegates to the American Medical Association.
- Various resolutions and matters referred to The Council by 1951 MSMS House of Delegates were discussed, including (a) resolution re "Little Hoover" Commission's recommendations on health which instructed that a committee be appointed: the committee selected is composed of J. E. Livesay, M.D., Chairman, Flint, O. J. Johnson, M.D., Bay City, J. G. Molner, M.D., Detroit, H. Marvin Pollard, M.D., Ann Arbor and S. B. Winslow, M.D., Battle Creek; (b) recommendation that a committee of sufficient size be appointed by The Council to act as a Michigan State Medical Society Liaison Committee with Michigan Medical Service. The Committee was appointed as follows: William Bromme, M.D., Detroit, Chairman, John M. Wellman, M.D., Lansing, L. C. Carpenter, M.D., Grand Rapids, B. M. Harris, M.D., Ypsilanti, W. H. Huron, M.D., Iron Mountain, G. W. Slagle, M.D., Battle Creek, and D. B. Wiley, M.D., Utica.
- Committee reports: (a) Committee on Study of Group Malpractice Insurance, at its meeting of November 15, recommended, in view of its findings, that this subject be closed and no action taken; (b) Hospitals-Doctors Conference, October 18: the Executive Committee authorized the creation of a Hospital Relations Committee. The personnel appointed is as follows: L. W. Hull, M.D., Detroit, Chairman, A. H. Kretchmar, M.D., Flint, J. W. Logie, M.D.,

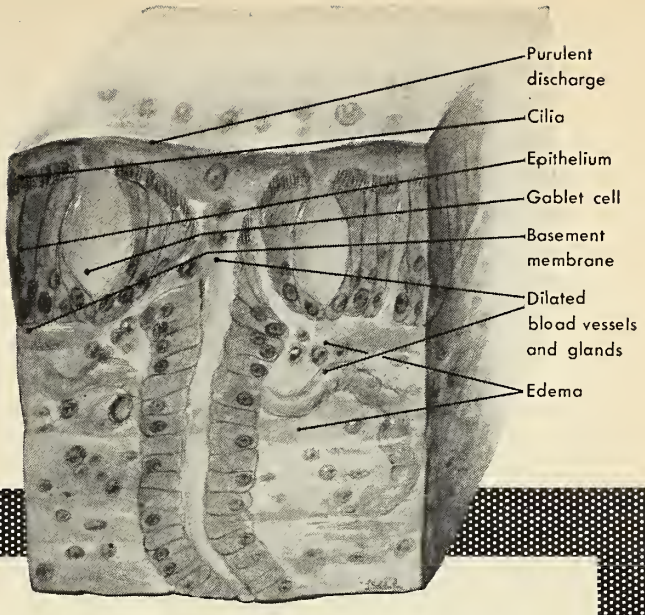
(Continued on Page 10)

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Council on Pharmacy & Chemistry: New and Nonofficial Remedies. 1950, p. 218.



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1. Rehfuss, M. E., Albrecht, F. K., and Price, A. H.: A Course in Practical Therapeutics. Baltimore, Williams & Wilkins Co., 1948, p. 111.
2. Kelley, S. F.: In Cornell Conferences on Therapy. New York, Macmillan Co., 1947, Vol. 2, p. 156.
3. Gold, H.: In Cornell Conferences on Therapy. New York, Macmillan Co., 1947, Vol. 2, p. 151.

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HIGHLIGHTS OF THE COUNCIL

(Continued from Page 8)

Grand Rapids, W. S. Reveno, M.D., Detroit, C. E. Umphrey, M.D., Detroit, Ralph Wadley, M.D., Lansing; (c) Committee on Scientific Work, October 26; (d) Permanent Conference Committee, October 31; (e) Rheumatic Fever Control Committee, October 31; (f) Mental Hygiene Committee, November 1; (g) Cancer Control Committee, November 8; (h) Joint Committee (MSMS-Michigan Health Council) to Study Periodic Health Appraisal, November 7; (i) State Medical Journals Conference, Chicago, November 12-13.

- President Otto O. Beck, M.D., reported on the work toward the restoration of the Beaumont Memorial on Mackinac Island. Finance Chairman W. S. Jones, M.D., recommended $1,000 (from Parke-Davis' recent $5,000 contribution) be transferred to the Beaumont Memorial Trustee Fund to begin the preliminary work on the restoration. This recommendation was approved by the Executive Committee of The Council.
- R. J. Noer, M.D., Detroit, and Wayne Whitaker, Ph.D., Ann Arbor, were appointed to the Cinema Committee (sub-committee of Public Relations Committee).
- A meeting with the Executive Committee of Michigan Medical Service brought up two subjects: (a) progress report on Veterans Administration home-town medical care program in Michigan; and (b) payment for services of chiropodists.
- Legal Counsel J. Joseph Herbert presented opinions on (a) salary stabilization law and how it affects doctors of medicine; and (b) exemption of physicians from jury duty.
- The monthly report of Public Relations Counsel H. W. Brenneman included progress report on the two Michigan television shows and on the new MSMS motion picture "To Save Your Life." Also on the new adult education program, and on the "Formula for Freedom" program.
- Secretary L. Fernald Foster's monthly report included some appointments to committees for the 1952 Michigan Clinical Institute; appointments for the 1952 MSMS Annual Session (including selection of Arch Walls, M.D., Detroit, as General Chairman of Arrangements); and submission of program for 1952 Annual County Secretaries-Public Relations Conference of January 27, 1952.
- John R. Rodger, M.D., Bellaire, was authorized to attend the National Rural Health Conference in February, 1952 as MSMS representative.
- President Otto O. Beck, M.D., Birmingham, has been selected as official representative of the American Medical Association to the inauguration of President Harlan H. Hatcher, University of Michigan, on November 27. Earl I. Carr, M.D., Lansing, Chairman of the MSMS Liaison Committee with University of Michigan President, was selected as MSMS representative.

AMA FELLOWSHIP DUES ELIMINATED FOR 1952

The AMA Board of Trustees recently decided there would be no Fellowship dues for 1952. The dues, the Board felt, are no longer required since AMA members are now paying membership dues. This does not apply to 1951 but becomes effective January 1, 1952.

The AMA Board of Trustees authorized elimination of any charge to AMA members and to student AMA members who make use of the AMA library lending service.

The AMA has initiated correspondence with the U. S. Bureau of Internal Revenue regarding a review of the 1921 ruling which denied deductions to physicians for expenses incurred in taking postgraduate courses. A report to AMA members will be made from time to time as the matter progresses.

LEGAL ASPECTS OF CORPORATE MEDICAL PRACTICE

I. H. Rubenstein, of Chicago, member of the Illinois Bar, asks these questions in *Industrial Medicine and Surgery* for November, 1951: (1) Is it lawful for a corporation to have in its employ licensed physicians and surgeons, (2) does such corporate medical practice constitute a violation of the several medical practice acts; and (3) does it violate the statutes which regulate insurance?

All cases bearing on the second point were reviewed. The general rule is that "it is unlawful for a corporation to engage in the commercial practice of medicine even if conducted through employes who are licensed physicians and surgeons." This ruling represents the overwhelming weight of authority in the United States. Attempts to circumvent this viewpoint that corporate medical practice is unlawful have been made by organizing various insurance corporations to engage in the practice of medicine by means of sales of "medical service insurance policies" operated as stock companies for profit. To obtain benefits holders must accept the services of a physician on an approved

(Continued on Page 12)


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LEGAL ASPECTS OF CORPORATE MEDICAL PRACTICE

(Continued from Page 10)

list. The Supreme court of California held that the activities of the corporation were unlawful and in violation of the state medical practice law. Two states have differed from the majortiy opinion as stated above, Missouri and Nebraska.

There are several recognized exceptions to the general rule. First, industrial corporations which maintain medical departments for their employes. It is well settled that such corporations have the "implied power to incur expense for medical and surgical aid." The second exception includes those benevolent organizations such as fraternal, labor, religious and others of that type which furnish medical services to their members. The third exception is hospitals, sanitariums, and dispensaries, which are unquestionably authorized by law to practice medicine, although of course through the agency of natural persons who are registered as physicians. The fifth exception represents a medical innovation, and the trend in these times embraces the co-operative health membership associations of employes of a city, county or Federal agency to obtain medical care for its members.

The third point for consideration is whether the corporate practice of medicine through the media of limited hospital and medical service plans constitutes the business of transacting insurance, and is therefore subject to regulation by the several insurance statutes. Four outstanding cases were reported holding that the insurance laws did not apply, but a fifth case in Ohio held that the insurance laws do apply (1943, 1944).

"As a result of the increase in the number and various forms of group medical and hospital service plans in this country, especially in the last fifteen years a number of states have enacted statutes recently for their regulation and supervision. The only, but significant, case on the interpretation of such a statute is that of *California Physicians' Service v. Garrison* which was decided by the Supreme Court of California in 1946." "In holding that the California Physicians' Service was neither engaged in the corporate practice of medicine nor in the business of insurance, the California Supreme Court declared: 'It is obvious that the Legislature by enacting (the Health Service Corporation Statute) expressly authorized the organization of corporations such as the California Physicians' Service. By this enactment, the state's social policy in regard to the corporate practice of medicine, to the limited extent specified, has been determined, and the courts are bound thereby."

We have quoted only a small part of the opinion which sets forth a very important legal precedent which other state and local medical societies can follow in establishing low cost prepaid group medical service plans in their own state or community.

Michigan was well advised many years ago and enacted such an enabling law before organizing our hospital and medical service plans.

MORE X-RAY PHYSICIANS SERVING PUBLIC THAN TWENTY YEARS AGO

The American College of Radiology reports that there are more radiologists in practice at the present time than ever before.

Results of a survey, just announced, show that there is now one radiologist to every 42,000 persons, while in 1931 there was one radiologist for every 122,000 persons.

"Considering the growth and expansion of the specialty of radiology during the last twenty years," the report said, "it is safe to assume that more radiological services are being rendered to each of the present 42,000 than were rendered to each of the 122,000 in 1931."

MISSISSIPPI VALLEY MEDICAL SOCIETY 1952 ESSAY CONTEST

The Twelfth Annual Essay Contest of the Mississippi Valley Medical Society will be held in 1952. The Society will offer a cash prize of $200.00, a gold medal, and a certificate of award for the best unpublished essay on any subject of general medical interest (including medical economics and education) and practical value to the general practitioner of medicine. Certificates of merit may also be granted to the physicians whose essays are rated second and third best. Contestants must be members of the American Medical Association and are residents and citizens of the United States. The winner will be invited to present his contribution before the 17th Annual Meeting of the Mississippi Valley Medical Society to be held in St. Louis, Mo., October 1, 2, 3, 1952, the Society reserving the exclusive right to first publish the essay in its official publication—the *Mississippi Valley Medical Journal* (incorporating the *Radiologic Review*). All contributions shall be typewritten in English in manuscript form, submitted in five copies, not to exceed 5,000 words, and must be received not later than May 1, 1952. The winning essays in the 1950 contest appear in the January, 1951 issue of the *Mississippi Valley Medical Journal* (Quincy, Ill.).

Further details may be secured from Harold Swanberg, M.D., Secretary, Mississippi Valley Medical Society, 209-224 W.C.U. Bldg., Quincy, Illinois.

BEAUMONT MEMORIAL RESTORATION APPROVED BY MSMS

WHEREAS, Dr. William Beaumont began his pioneering work in physiology at Mackinac Island, Michigan, in 1822, and

WHEREAS, the first observation of his famous patient, Alexis St. Martin, was made by Dr. Beaumont in the American Fur Company's trading post, now known as the Early House on Mackinac Island, and

WHEREAS, through the generosity of Parke, Davis & Company, Detroit, the Early House was acquired several years ago by the Mackinac Island State Park Commission as the first step in plans to convert this historic building into a permanent shrine to the memory of

(Continued on Page 14)

"particularly useful... for the routine therapy of the menopause"[1]







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1. Perloff, W. M.: Am. J. Obst. & Gynec. *58*:684, 1949.

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BEAUMONT MEMORIAL RESTORATION

(Continued from Page 12)

Beaumont, with maintenance to be assumed by the Park Commission, and

WHEREAS, such a monument to the imperishable research of Beaumont would constantly remind the thousands of people who visit Mackinac Island annually that a free medicine is always a progressive one, eternally endeavoring to improve its science and its service to the public; therefore, be it

RESOLVED: That contributions in this campaign be on a voluntary basis with the names of all donors inscribed permanently in the Beaumont Memorial, and that the work be completed, if at all possible, in 1952 in order to commemorate the 130th anniversary of Beaumont's important discovery.

Resolution adopted unanimously by MSMS House of Delegates, Grand Rapids, September 24-25, 1951.

MEDICAL CIVIL DEFENSE TO BE DISCUSSED MARCH 12, 1952

Norvin C. Kiefer, M.D., Washington, D. C., Director, Health and Special Weapons Defense Division, F.C.D.A. is guest speaker at the Medical Civil Defense meeting of Wednesday evening March 12, 8:30 p.m. in the Grand Ballroom, Sheraton-Cadillac Hotel, Detroit. Doctor Kiefer's address is being sponsored by the Wayne County Medical Society, the Michigan Clinical Institute and the Michigan State Medical Society, and is entitled: "The Physician in Civil Defense."

JOURNAL FEATURES SPECIAL TOPICS IN 1952

THE JOURNAL of the Michigan State Medical Society will be dedicated in 1952 to the following topics:

January—Michigan Clinical Institute
February—Easter Seals
March—Atomic Energy
April—Cancer
May—Michigan's Foremost Family Physician plus Geriartrics
June—Michigan Medical Service
July—Roster
August—Annual Session
September—Arthritis and Rheumatism
October—Diabetes Detection plus Red Feather Campaign
November—Cerebral Palsy plus Michigan Health Council
December—Heart

Paul R. Hawley, M.D., director of the American College of Surgeons and former head of the Veterans Administration, declared that extravagant use of medical manpower by the armed forces leaves the United States unprepared for the heavy casualties that would occur in a full-scale war. Dr. Hawley urged that the nation's entire medical potential—nurses, technicians, and hospital beds as well as doctors—be pooled to serve the armed forces and the civilian population "so that each will be cared for and neither gain a monopoly on medical care." He specifically condemned the practice of retaining military casualties in Army or Navy hospitals, instead of transferring them to VA hospitals staffed partly by civilian doctors. Dr. Hawley further criticized the practice whereby the Army continues to treat cases of advanced pulmonary tuberculosis for a period of years in Army hospitals, and questioned "why the Army should draft doctors to deliver babies, and to treat, often, uncles and aunts and cousins of military personnel."—Conference on prolonged illness, Chicago, October 30, 1951.

A unique industry-wide health and welfare program has been proposed to employers by the International Association of Machinists (AFL). The plan would permit union members to cross state lines in nine Midwest states and move from job to job without losing coverage. Workers securing jobs with non-participating employers would be able to retain benefits up to a period of four months by paying insurance premiums. The cost of the plan is $7 a month for each employe, plus $5 monthly for family coverage. Benefits include a $2,500 life insurance policy, $30 a week payable 26 weeks for disability, and certain hospital and surgical expense coverage.

Federal family insurance payments increased nationally by about 140 per cent one year after the enactment of the amended Social Security Act on August 28, 1950. This is due to the: (1) increase in level of payments to beneficiaries from an average of $26 to $48; (2) doubling of minimum payments of $10; (3) increase in maximum payments from $45 to $68.50 (maximum payment to the family of an insured wage earner is now $150 a month); and (4) increase in the number of persons made eligible for insurance benefits under provision of the new law. For the month of August, 1951, about 4,150,000 persons were receiving payments as against 2,967,055 for August, 1950. Monthly payments in 1951 averaged about $147,175,000, as compared with $61,641,000 in 1950.

FUTURE DATES

The annual sessions of the **Michigan State Medical Society** are scheduled seven years in advance, as follows:

1952	Detroit	September 24-26
1953	Grand Rapids	September 23-25
1954	Detroit	Sept. 29-Oct. 1
1955	Grand Rapids	September 21-23
1956	Detroit	Week of Sept. 24
1957	Grand Rapids	September 20-22
1958	Detroit	Week of Sept. 22

The **Michigan Clinical Institute** is scheduled for Detroit six years in advance, as follows:

1952	Detroit	March 12-14
1953	Detroit	March 11-13
1954	Detroit	March 10-12
1955	Detroit	March 9-11
1956	Detroit	March 8-10
1957	Detroit	March 13-15

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Norcross, B. M., *N. Y. State J. Med.* **51**: 2356, Oct. 15, 1951.

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Examination of the Heart

One of the primary responsibilities of the Michigan Heart Association is to help the Doctor of Medicine keep pace with the latest scientific information regarding current advances in the cardiovascular field. In order to assist in broadening the scope of this important program, the Michigan State Medical Society has provided a special page in each issue of The Journal *which will be devoted to the Michigan Heart Association's professional education program. Existing knowledge, the most recent scientific discoveries, and the latest advances in diagnosing, treating and controlling cardiovascular diseases will be brought to the medical profession through this medium. The Michigan Heart Association deeply appreciates this opportunity to better serve Michigan's Doctors of Medicine.*



H. E. Ungerleider

"Examination of the Heart," a newly revised manual designed for the general practitioner and other medical doctors concerned with the diagnosis of cardiovascular diseases is now available free of charge from the Michigan Heart Association. Revision and preparation of the manual, which was originally published in 1940, was undertaken by a Special Committee of the American Heart Association under the chairmanship of Harry E. Ungerleider, M.D., Assistant Secretary of the Association and Medical Director of the Equitable Life Assurance Society.

The purpose of the original booklet was to outline the clinical examination of the heart without the help of any instrument other than the stethoscope. The revision adds new material on blood pressure, comments on the use of the electrocardiograph, and on other more specialized procedures employed in heart disease. The booklet includes sections on cardiac rhythms and rates, cardiac enlargement, and cardiac sounds and murmurs.

In an introduction to the new addition of "Examination of the Heart," it is stated:

"In few fields of medicine is it possible for diagnosis to be made with greater accuracy, and with such relatively simple and generally available procedures, as in cardiovascular disorders. The necessity for proper diagnosis is impelling, since apart from indicating the correct therapeutic measures, readjustments in the patient's way of life are often entailed which may occasion social, economic, or psychological dislocations. As much mischief results from the diagnosis of heart disease when it does exist, as failure to recognize its presence."

The booklet adds: "It is important that the practitioner be well acquainted with the potentialities and limitations of physical examination, and that the indications for special study be recognized."

The symptoms and signs of heart disease may be closely simulated by disorders of other organ systems, the manual points out.

"Examination of the heart is never complete without a general physical examination. Much valuable information concerning the functional state of the heart can be obtained by attention to other organs. Thus it should be an invariable procedure to listen for rales at the lung bases and to look for engorgement of the neck veins, enlargement of the liver, and evidences of edema."

In addition to careful examination of the blood pressure, observation should be made of the peripheral vessels, and also of the retinal vessels with the ophthalmoscope.

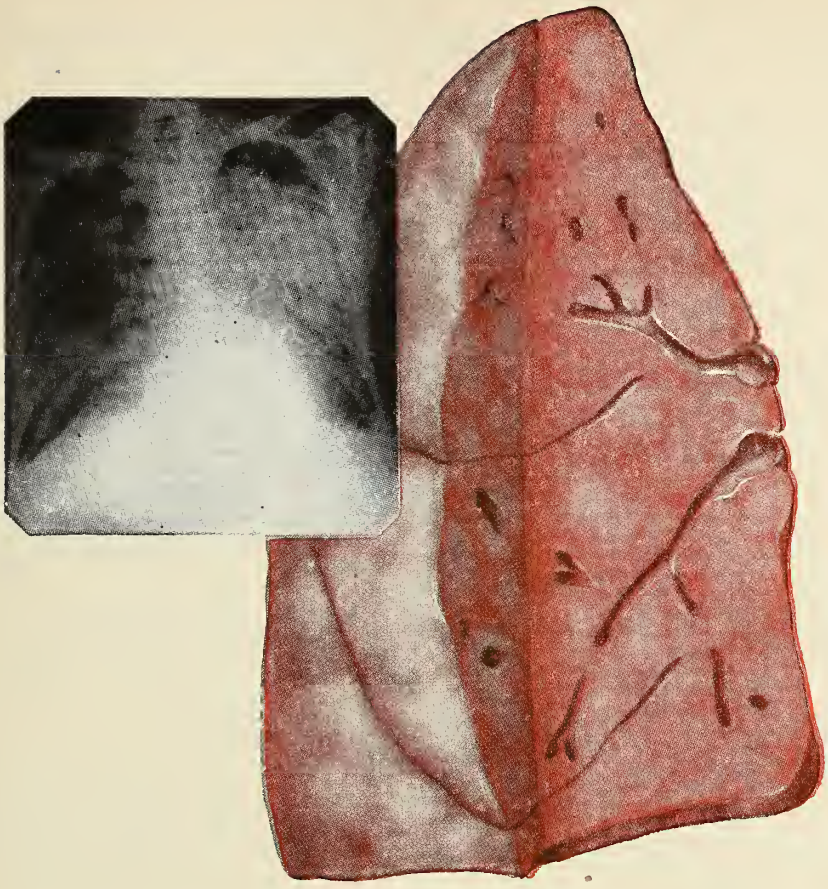
"It must be recognized," the booklet continues, "that severe organic heart disease may exist in the complete absence of any findings on physical examination. This is particularly true in coronary artery disease. Therefore, when a cardiac lesion is suspected and physical examination is inconclusive, further study with special techniques, such as fluoroscopy, X-ray and electrocardiography is advisable before a final decision is made as to the presence or absence of organic heart disease, and the type and severity of lesion present."

Douglas Donald, M.D., Detroit, President of the Michigan Heart Association, stated that the general practitioner has a powerful diagnostic weapon at his disposal if he uses the physical examination of the heart in an organized way, as outlined in this manual.

Recommendations for Human Blood Pressure Determinations by Sphygmomanometer

A revised guide for physicians in measuring human blood pressure, entitled "Recommendations for Human Blood Pressure Determinations by Sphygmomanometer," has been issued by the American Heart Association and is also available

(Continued on Page 22)



in bronchopneumonia:

Clinical responses in bronchopneumonia, Terramycin-treated, are characterized by the same promptness noted in primary atypical and lobar pneumonia. In a series of 31 cases there was "a good response in all cases, as manifested by the fall of temperature to normal in 24 to 48 hours, and by the improved clinical appearance of the patient." Follow-up x-rays made in 10 to 14 days "were completely negative or showed marked improvement."

Potterfield, T. G., and Starkweather, G. A.:
J. Philadelphia General Hosp. 2:6 (Jan.) 1951.

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Michigan Blue Cross-Blue Shield

Summary of Findings of 1951 Survey and Comparison with 1944 Survey

During August, 1951, Fact Finders Associates, Inc., made a study of the public attitude toward the Michigan Blue Cross-Blue Shield.

In all, 1,516 men and women (741 men and 775 women) were personally interviewed in fifteen Michigan cities.

The questionnaire was designed by the Research Department of the New York Office of the J. Walter Thompson Company to determine attitude toward the medical profession and general medical plans, government controlled plans as well as Blue Cross—Blue Shield. A similar survey was made in 1944 by the Chicago Research Department of Foote, Cone & Belding, and the 1951 questionnaire followed the general outline of the questionnaire used in 1944 so that on many points it was possible to compare the results of the two surveys.

In 1944, 4,968 men and women were interviewed in twenty-eight Michigan cities, and fourteen of the fifteen cities covered on the 1951 survey were also covered in 1944. There is no information on how the breakdown of men and women were divided in the 1944 survey. However, we feel that the sample is comparable enough to make valid comparisons.

The following summary highlights all significant points in the 1951 survey and shows comparisons with the 1944 survey wherever possible. The numbers of the points in the summary refer to the numbers of the questions in the questionnaire. A copy of the questionnaire used in the 1951 survey is attached.

Summary

1. *46 per cent of the people interviewed in 1951 and 37 per cent of those interviewed in 1944 selected their present medical doctor through recommendation of friend, relative or other medical men.*

In 1951, 8.4 per cent chose their doctor because he was their "family doctor"—in 1944, 14 per cent gave this reason. In 1951, 7 per cent claimed they had no medical doctor. This appears to be a major finding in 1944, but no comparison percentage is given.

In both surveys, "personal friend or acquaintanceship" ranked higher among the upper income groups.

2. *The majority of people interviewed think doctors of medicine are doing a good job for the public.*

	1951	*1944*
Number interviewed	100%	100%
Think doctors do a good job	79	92
Do not think so	9	4
Don't know	12	4

The principal reasons given for *not* thinking doctors do a good job were:

1951		*1944*	
Don't want to make house calls	12%	Doctors overcharge	24%
Too independent	12%	Keep patients waiting too long	21%
Mercenary, money conscious	11%	Don't give enough time for diagnosis	10%
Don't give enough time for diagnosis	11%		

(Editor's Note: The question of making house calls, and being too independent, another form of the same complaint, exceeds the complaints of keeping the patient waiting too long, which does not appear significantly this year. The overcharge complaint is less than half what it was in 1944. Failure to take time to make a satisfactory diagnosis is almost exactly the same, but should not appear.)

3. *More opinions on medical charges have been formed in 1951 than was shown in 1944.*

		Charge Right Amount	*Too Much*	*Too Little*	*Don't Know*
Medical Doctors	1951	56%	39%	1%	4%
	1944	69%	21%	1%	9%
Nurses	1951	44%	14%	18%	24%
	1944	43%	7%	12%	38%
Hospitals	1951	33%	58%	1%	8%
	1944	46%	27%	1%	26%
Prescriptions	1951	40%	51%	1%	8%
	1944	42%	32%		26%
Other Medicine	1951	59%	31%		10%
	1944	29%	19%		52%

Note—Number interviewed=100%

A much larger portion of those interviewed in 1944 answered with a "don't know"—In 1951, more people have formed an opinion about these costs and, as the table above reveals, found the charges "too much."

4. *In 1951, 74 per cent of those interviewed claimed they or a member of their family belonged to a hospitalization or surgical insurance plan while only 42 per cent belonged in 1944.*

In 1951, the middle income group had the heaviest membership while the upper income group led in 1944.

In 1951, 55 per cent of those belonging to some plan belonged to "Blue Cross"—the figure in 1944 was 31 per cent.

In 1951, approximately half of those belonging had been members of a plan less than five years; 22 per cent had been members for over ten years. (Note—The only information for 1944 was "87 per cent had belonged to a plan for less than six years.")

In 1951, those who did not belong to a plan were asked if they could name such a plan and 49 per cent named Blue Cross.

5. *Approximately 50 per cent of those interviewed in 1951 had been to a hospital or had had a member*

(Continued on Page 20)

Note: In making this condensed report, the editor has eliminated the several pages of questions, as the answers will sufficiently clarify the question.





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(Continued from Page 18)

of their family in a hospital within the past two years.

50 per cent of those entering a hospital went to the one their doctor selected while 44 per cent chose their own hospital.

45 per cent of those who belonged to a plan in 1951 had used it within the past two years.

87 per cent of these people found the benefits satisfactory. The main complaint among those not satisfied was "not enough benefits."

6. *In 1951, 94 per cent of those interviewed had heard of Blue Cross.*

In 1944, 16 per cent had heard of Blue Cross—24 per cent knew of the "medical service plan" and 35 per cent knew of the "hospital service plan."

The recognition of Blue Cross in 1951 was slightly higher in the middle income groups while in 1944, the recognition was greater in the upper groups.

67 per cent of those who had heard of Blue Cross in 1951 did not know who sponsored it.

There were a variety of answers—the leading was "physicians, doctors" with 3.9 per cent followed by "Michigan Hospital—Medical Service" with 3.2 per cent.

When asked how they would go about subscribing to the Blue Cross plan, 23 per cent said "through company, employer, plan board"—10 per cent said "by group; group insurance"—8 per cent said "contact Blue Cross office."

44 per cent claimed you could join Blue Cross on an individual basis. 19 per cent claimed you couldn't and 37 per cent didn't know. (No figures available for 1944).

36 per cent of those interviewed in 1951 had heard of Blue Shield, and 71 per cent didn't know who sponsored it. 8 per cent said Blue Shield was a part of Blue Cross.

8 per cent said you could subscribe to the plan "through shops" while 7 per cent said "through employer or factory." 62 per cent said they did not know how to subscribe.

34 per cent claimed they could join Blue Shield individually, 10 per cent said they couldn't and 56 per cent didn't know.

55 per cent of those interviewed in 1951 thought Blue Cross-Blue Shield rates were "just right"; 32 per cent felt they were too high, while 0.3 per cent said they were too little.

When asked how much it cost per month, the median price of those feeling the cost was too high was $7.00-$7.99, while the median price of those saying it was just right was $5.00-$5.99.

7. *45 per cent of those interviewed in 1951 and 38 per cent in 1944 stated there was a hospital or medical plan available where they worked.*

In the 1951 survey 26 per cent said there was no plan —5 per cent "didn't know" and 25 per cent were non-working housewives.

Of those who belonged to a plan where they work, 59 per cent belong to Blue Cross. 13 per cent didn't know the name of their plan.

When asked what type of a plan it was, 81 per cent in 1951 claimed it was "both medical and hospital." 11 per cent said it was hospital only, and 1 per cent said it was medical only. (No figures available for 1944.)

88 per cent of those who have a plan available where they work belonged to it in 1951—79 per cent belonged in 1944.

The two main reasons for *not* belonging in 1951 were "too expensive" (24 per cent) and "another policy" (14 per cent). In 1944 the main reasons for *not* joining were "isn't worth it," "too expensive" (19 per cent), and "just put off joining," "never thought about it or had never been contacted" (14 per cent). 6 per cent would rather pay for their own illnesses.

8. *57 per cent of those interviewed in 1951 and 32 per cent in 1944 stated that, if other things being equal, the availability of a hospital-medical plan would be the leading factor in their choice between two jobs.*

The main reasons given in 1951 for saying "yes" were "more protection" and "more benefits," while the main reasons for saying "no" were "job-working conditions come first" and "prefer private insurance."

9. *In 1951, 8 per cent of the respondents said they could explain the difference between the Blue Cross Plan and the Blue Shield Plan.*

90 per cent said they couldn't explain the difference and 2 per cent didn't know if they could. The majority of the 8 per cent who claimed they knew the difference did establish a valid difference between the two plans.

24 per cent of the 1951 respondents said there was a difference between Blue Cross-Blue Shield and other types of health insurance while 8 per cent said there was none. 68 per cent didn't know.

Many answers were given by those claiming there was a difference with "more benefit in the Blue Cross" accounting for 15 per cent of them, and "type of coverage is the difference" accounting for 11 per cent of the total. 13 per cent of those claiming they knew the difference admitted they didn't when asked what the difference was.

(No figures available for 1944.)

10. *A comparison of the two surveys on the question "Would you like to have a monthly pre-payment plan for Dental Service and Home Nursing Service?" appears below:*

	Dental Service		*Home Nursing Service*	
	1951	*1944*	*1951*	*1944*
Total interviewed	100%	100%	100%	100%
Yes	40	29	25	18
No	50	61	62	70
Don't Know	10	10	13	12

In the 1951 survey, the lower income groups were more in favor of the plans. More women favored them than men.

11. *51 per cent of those interviewed in 1951 and 43 per cent in 1944 do not favor any sort of government operated medical hospital plan.*

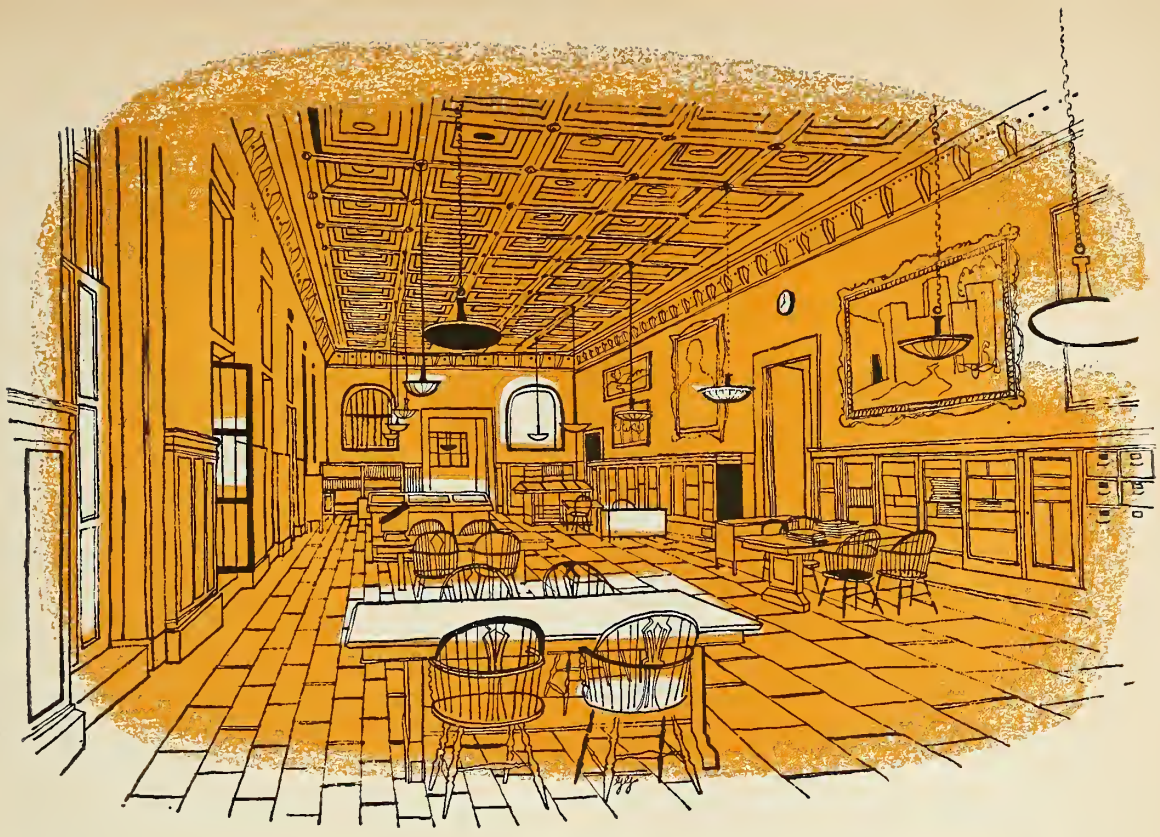
	1951	*1944*
Total interviewed	100%	100%
Do favor government plan	30	39
Do not favor government plan	51	43
Don't know	19	18

In both surveys the largest support of a government plan came from the lower income groups, the younger age groups, and from the men.

In both surveys the main reasons for favoring such a plan were that more people would get medical service and it would be cheaper. The major objection expressed by those against such a plan was that they were against government controls generally—the government has enough to do now.

12. *In both surveys, the respondents were asked to choose between five plans for medical hospital care and the comparison of results appears below:*

(Continued on Page 22)



From among all antibiotics, Internists often choose

AUREOMYCIN

Hydrochloride Crystalline

because

Aureomycin readily passes into the blood stream, whence it diffuses rapidly into all the tissues and fluids of the body.

Aureomycin is a broad spectrum antibiotic that has been shown to be effective in a wide variety of infections of bacterial, rickettsial and large viral origin.

Aureomycin has been reported to be effective in

Acute Amebiasis	Hepatic and Biliary Tract Infections*	Respiratory Infections*
Anthrax	Influenza	Rickettsialpox
Acute Brucellosis	Leptospirosis	Septicemia*
Chancroid	Lymphogranuloma Inguinale	Rocky Mountain Spotted Fever
Shigella Dysentery	Pericarditis*	Boutonneuse Fever
Endocarditis*	Psittacosis	Tick-Bite Fever
Erysipelas	Q Fever	Typhus
Granuloma Inguinale	Rat-Bite Fever	Tick Typhus
	Relapsing Fever	Tularemia

*When caused by Aureomycin susceptible organisms.

Throughout the world as in the United States, aureomycin is recognized as a broad spectrum antibiotic of established effectiveness.

Capsules: 50 mg.—Bottles of 25 and 100. 250 mg.—Bottles of 16 and 100.
Ophthalmic: Vials of 25 mg. with dropper; solution prepared by adding 5 cc. of distilled water.

LEDERLE LABORATORIES DIVISION AMERICAN Cyanamid COMPANY 30 Rockefeller Plaza, New York 20, N.Y.

(Continued from Page 20)

	1951	*1944*
Total interviewed	100%	100%
Regular insurance	9	13
Government controlled insurance	11	15
*Present voluntary plans like Blue Cross-Blue Shield	49	34
Present private practice	8	27
Union controlled	2	1
Don't know	21	10

*In 1944, the term listed was "voluntary, professionally sponsored."

In the 1951 survey, favoring of government controlled insurance increased with age, whereas in the 1944 survey the youngest age group was the most favorably disposed toward it. In both surveys, the lower income group favored government insurance more than the upper, and more men favored it than women.

In the 1951 survey ". . . plans like Blue Cross-Blue Shield" were chosen more by the younger age groups than by the older, and more by women than by men.

The main reason for choosing government insurance in 1951 was "less expensive" while in 1944 it was because more could receive medical care. In both surveys, the principal objections to government insurance was general dislike of government control.

The main reason for choosing present voluntary plans in 1951 was that they had found them very satisfactory, while the main reason in 1944 was opportunity to choose own doctor. In both surveys high cost was the principal objection to present voluntary plans.

13. *The men and women interviewed in 1951 and 1944 were asked if they favored the organization of groups of salaried doctors offering care in home, office and hospital.* The results of the two surveys compare as follows:

	1951	*1944*
Total interviewed	100%	100%
Do favor organization of doctors	31	39
Do not favor	33	41
Don't know	36	20

The main reasons for favoring the organization of doctors were "less expensive" and "better care, better service." The main objection to it was "prefer doctor of own choice."

14. *34 per cent of those interviewed in 1951 and 44 per cent in 1944 would advise a son or daughter to go into the medical, dental or nursing profession if it were under government control.*

	1951	*1944*
Total interviewed	100%	100%
Yes, would advise	34	44
No, would not advise	39	36
Don't know	27	20

In both surveys the upper income groups were more inclined to advise against going into government medicine than the lower income groups. In the 1951 survey the men were more against it than the women.

The main reasons for favoring it in the 1951 survey were "would still be a worthwhile profession" and "more safety, more security." The main reason in the 1944 survey was "better control under the government, more efficiency, doctors on same basis."

The main objection in both surveys was that there was too much government control already.

EXAMINATION OF THE HEART

(Continued from Page 16)

free to medical doctors in booklet form through application to the Michigan Heart Association.

The "Recommendations" replace the booklet "Standardization of Blood Pressure Readings," originally published by the Association in 1939. The revisions were drawn up by a committee appointed by the Council for High Blood Pressure Research of the American Heart Association, under the Chairmanship of Dr. Carl J. Wiggers, Professor of Physiology at Western Reserve University School of Medicine, Cleveland.

In commenting on the publication of the "Recommendations," Dr. Wiggers said:

"The physician, and through him nurses and properly trained technicians, are being constantly kept informed of new discoveries which help to make blood pressure readings more accurate. The measurement of human blood pressure is still a comparatively new tool, the introduction of which is well within the memory of many of the older groups of practitioners. Recognizing that physicians were employing different techniques and criteria in measuring blood pressure, and too generally assumed that instruments sold were accurate, the American Heart Association in 1939 appointed a committee to crystallize the best available thought on the subject at that time by publishing a pamphlet entitled 'Standardization of Blood Pressure Readings.' This has resulted in more precise standardization of methods and has stimulated manufacturers to make improvements in apparatus.

"Since that time, more experience has been gained in laboratories and hospitals, resulting in even greater accuracy in measurement of human blood pressure. This has now been assembled in the new 'Recommendations'."

We know you are pinched for time, so here is a quick order blank that will bring your copy of "Examination of the Heart" and "Recommendations." Just fill in and mail.

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- ☐ Recommendations

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INDIANAPOLIS, INDIANA

Cancer Comment

PHYSICIAN, HEAL THYSELF

For some time the Philadelphia County Medical Society (Pennsylvania) has had a Committee for the Study of Pelvic Cancer whose duties were confined to a study of delays in diagnosis and treatment of pelvic cancer, especially cancer of the cervix, among ward patients in Philadelphia hospitals with a view to fixing responsibility therefor.

A similar committee of seven members for the Study of Breast Cancer recently has been formed with the same object in view. At its initial meeting, the chairman announced that "the purpose of the committee is to check on delay, and the reason for it," and voiced the hope to contact every hospital in Philadelphia in its search for patients who are victims of delay. Investigations are confined to ward patients except that pay patients may be studied with specific permission of the surgeon in charge.

The Committee prefers to have patients referred for study by someone connected with the hospital. A worker representing the committee is then sent to interview the patient in the hospital *only*. While the name of the attending physician or physicians is always obtained, their names do not appear on the worker's protocol. Neither does the patient's name appear thereon.

When the protocol is studied by the committee, the physician concerned in the case is invited to be present to enlighten the committee as to his part in the patient's treatment and care. He is subjected to no critical censure; on the contrary, his mistakes, if any, are pointed out and friendly advice offered for their future prevention.

The chairman has stated:

"Our program is designed to benefit the members of this county medical society. We wish to conduct it so that their good will and co-operation will be automatic. We do not consider ourselves authorities on delay. We make mistakes ourselves. All of us are trying to find out why we make mistakes and, in so doing, educate one another. We are not trying to put anybody 'on the spot.' The purpose of this committee is to study delay and make an attempt by co-operation between all of us, to prevent it as far as we can. There are certain very definite forms of treatment of cancer of the breast. Our policy as to what constitutes delay is uncertain. We will gradually develop it. We may think one case is physician delay, but subsequent investigation may show it is not his fault. Open discussion will often vindicate rather than condemn."

The organization of such committees as those mentioned within local medical societies is an unusual but highly commendable undertaking in the evaluation of diagnosis and treatment of malignant disease. Responsibility for delay in cancer diagnosis and treatment is variously ascribed to the physician and patient and has been the subject of much debate favorable or unfavorable to both parties as the feelings of the speaker or writer may dictate. It would seem that the lay education program, if it is fulfilling its intended purpose, will in time reduce the patient's responsibility, and the work of such committees as have been formed by the Philadelphia County Medical Society will raise the level of diagnosis and therapeutic ability of its members to the point where cases of delay will become fewer and fewer.

It is Utopian to suggest that delays can be completely eradicated. That is too much to expect of human nature, either professional or lay. All thinking persons will agree that improvements are possible. The physicians of the City of Brotherly Love have set an example that might well be copied by many other local medical societies with profit to physician and cancer patient alike.

The most frequent physical findings by the neurosurgeon in brain tumors are papilledema, reflex changes, weakness of muscles enervated by cranial nerves, weakness of extremities, disturbances in co-ordination, speech disturbances, visual field defects and intellectual defects.

* * *

Many patients with longstanding ulcerative colitis whose colons are not removed develop highly malignant carcinomas of the colon.

* * *

The mortality rate from cancer of the colon developing in patients with intractible ulcerative colitis exceeds the risk of colectomy.

* * *

If we implemented usefully all the knowledge we have today concerning cancer, the present poor record of accomplishment could be improved very considerably.

* * *

The strongest carcinogenic agents we have to overcome are inertia and neglect—cancer can and is being cured frequently.

Only Terramycin in *Oral Drops* offers *all* these advantages

1

convenience of a liquid concentrate

Crystalline Terramycin Hydrochloride Oral Drops provide 200 mg. per cc., 50 mg. in each 9 drops—the only broad-spectrum antibiotic available as a liquid concentrate affording optimal convenience and flexibility in dosage schedules.

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Terramycin Oral Drops are miscible with most foods, milk and fruit juices; can be taken "as is" or mixed. Potent oral drops offer rapid broad-spectrum antibiotic activity in a form permitting the utmost simplicity in the therapeutic regimen.

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pure crystalline compound—well tolerated

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Editorial Comment

GOVERNMENT MEDICINE A FACTOR IN RISING MEDICAL COSTS

Several months ago I visited the campus of my Alma Mater. Across the street from the University Hospital loomed an immense, beautiful, modernistic structure almost ready for occupancy—a 500-bed VA hospital.

Recalling the impact upon Vanderbilt University Hospital when Thayer VA Hospital was opened, in terms of the need to match government salaries for personnel from janitors and cooks to technicians and nurses, I asked my friends on the Iowa faculty, "What's this going to do to you and the Iowa City Hospitals?" I was referred to a published answer to my question.* This was a presentation of data analyzed by the superintendent of the University of Iowa Hospitals and the director of Personnel Service of the State University.

In hours of the work week, vacation and holidays the VA employe has an advantage over the employe of the University of Iowa and Mercy Hospitals.

In the nursing field, government nurses are paid on a rank basis, in civilian hospitals on the basis of duties performed. However, the Junior or Associate VA nurse will receive some $1,500 more annually than the general duty nurse at the University or at the Mercy Hospital. The full grade VA nurse will receive about $2,200 more than the head nurse at the other local hospitals. The senior VA nurse will be paid from $2,500-$3,000 more per annum than the supervisor at the University Hospital—Sisters filling this post at Mercy Hospital. Orderlies will be paid $500-$1,200 more than in civilian hospitals. The VA admitted it would concentrate its efforts to recruit personnel within a *35-mile radius* of Iowa City.

The salary differentials for non-professional employes will be somewhat as follows, the *sum representing salary in excess of that paid by the University of Iowa Hospital or Mercy Hospital.*

Social worker	$800-1500	Stenographers	1000
Physical therapist	300-1300	Secretary	700-1000
Occupational therapist	300-1300	Food Service Helpers	400- 700
Electrocardiographer	900	General cooks	500- 700
X-ray technician	550	Specialized cooks	500
Laboratory technician	750	Head cooks	500- 700
		Janitors	300- 500
		Maids	500- 700

With an admitted policy of recruiting personnel for a 500-bed hospital from a city of some 15,000 to 20,000, it requires no seer to realize what will happen to the personnel of the local hospitals when the VA is able to overbid the civilian hospitals in this manner. However, this is so characteristic of centralized bureaucracy, one of whose major shortcomings is inflexibility for adjustment to local conditions. (It is this inflexibility which makes one shudder at the thought of governmental medicine directed by a Washington agency.)

Who pays for the forced increase in salaries of civilian hospital personnel? Quite obviously, it is the patient admitted to the private or local hospital. And ironically he pays twice or three times—once in increased taxes to pay the VA salaries, and again when he is admitted to the private hospital which has raised its rates because of increased overhead and, if he is a taxpaying citizen of a state or community which has a tax supported hospital, he pays a third time because of its increased hospital costs. Yet some of our Washington administrators speak piously of the increasing cost of medical care.

Uncle Sam is in the hospital business. The collection by the Veterans Administration of some millions of dollars a year in Blue Cross and hospital insurance, and from workmen's compensation and other industrial insurance companies, plus the squeeze of increased hospital costs through governmental competition for personnel, indicates that our government is well on the way to force the closure of the doors of the private hospital.—R. H. K., in *Journal of the Tennessee State Medical Association,* October, 1951.

*Hartman, G. and Marks, A. C.: Local impact of Veterans hospitals. J. Am. Hosp. A., 25:41, 1951.

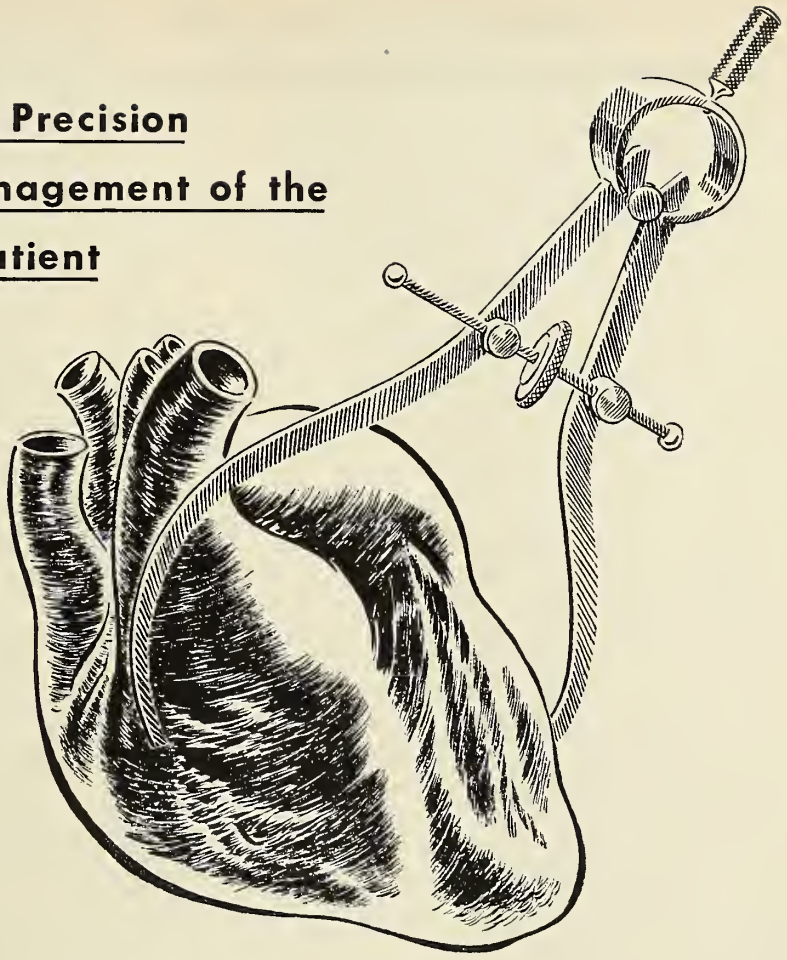
OBJECTORS TO SOCIALIZED MEDICINE MULTIPLY

The Christian Science Monitor said recently that opposition to compulsory health insurance is growing more widespread.

"Public opinion, in fact, is getting better posted as to what such state medicine means," the paper said editorially, adding: "When President Roosevelt first took up government health insurance (later to drop it) little was known of this European system in the United States. But its recent costly experience in Great Britain and parts of Canada has figured so notably in the day's news that American public sentiment is at last becoming informed.

"Danger of enactment seems no longer so imminent as it appeared for a brief time during the New Deal. The diminishing enthusiasm in Congress for health insurance may be credited in part to the number and standing of the national organizations which have recorded their disapproval. Yet sustained opposition is clearly necessary lest the proposal again attain a showing of popularity."

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- fully active by mouth;
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STATES HOLDING UP CIVIL DEFENSE MEDICAL STOCKPILE PROGRAM

Inability or reluctance of some states to get down to business is holding up the nationwide *medical stockpile program,* which in the early part of the year was delayed on the federal level by lack of funds. Now *Federal Civil Defense Administration* has the money for its 50-50 matching share of local stockpiles, but a *majority of the states* still have not sent plans to Washington for approval.

Actually, *only twelve state plans* have been processed to the point where orders have been filed with the Armed Services Medical Procurement Agency, which will do the pooled purchasing. Some of these states should be receiving first shipments during December. Fifteen other states, for which CDA several months ago allocated money—all containing one or more likely target areas—have yet to submit acceptable plans. Available for distribution to the states is the bulk of a $20 million appropriation.

Under the master plan, these U. S. state stockpiles are expected to take care of casualties during the *first four hours after an attack.* By then, it is expected that supplies will be received from regional stockpiles, set up and maintained entirely by federal funds. These U. S. medical depots will be located, wherever possible, within four hours trucking time of critical target areas.

Because funds for the all-U. S. regional stockpiles were voted late in the session, they probably will not be set up for several months. Meanwhile, emphasis is on hurrying state and community programs which would be the first line of medical defense in case of an attack. There are some production difficulties, principally with standard burn pads, certain textiles, duck fabrics and instruments, but no critical delays are expected, provided the states draw up their programs in time.

LEGION REPORTS ITS SURVEY OF MEDICAL FACILITIES IS ABOUT HALF FINISHED

American Legion's survey of medical facilities is about half finished. It hopes the study will give some indication of *areas where Veterans Administration could and should build and staff new hospitals.* The survey will show just where there are empty beds, and where shortages and surpluses of doctors and nurses exist. The Legion anticipates that the information will facilitate expansion of VA's facilities beyond the present 131,000 bed limit, an increase which the group has made one of its major objectives for 1952.

In a Washington speech, Legion Commander Donald R. Wilson referred to the survey's progress as a possible solution to VA's personnel problems, but warned, "whatever progress results from this will be long in materializing and the crisis is now." He also said, "There are some localities where both the patient demand and the available supply of doctors would support a new veterans' hospital or an addition to one already in operation. It behooves the Veterans Administration to take advantage of every such opportunity."

Among the other major targets the Legion has marked up for the coming year, Commander Wilson listed:

1. 10 per cent boost in disability compensation and payments to widows and orphans of veterans in keeping with the cost-of-living pay increase given government employes this year.
2. Increased appropriations for hospital staffs.
3. Granting Korean veterans all benefits given World War II veterans.
4. Defense Department indoctrination of all men leaving Armed Forces on their rights as veterans.
5. Restoration of National Service Life Insurance (World War II) and U. S. Government Life Insurance (World War I).

ARMY BELIEVES EPIDEMIC HEMORRHAGIC FEVER HAS NO RESIDUAL EFFECTS

Army's experience to date with epidemic hemorrhagic fever suggests there is no residual effect, although it is too early to be conclusive on this point. Since June, when the rare disease was first definitely identified among American troops in Korea, there have been 196 cases, with a death rate of 13.3 per cent. Japanese troops stationed in Manchuria had difficulty with the disease from 1939 on. Their death rate was 30 per cent. Major Gen. George E. Armstrong, the Surgeon General, supplies this information about the disease:

The specific organism responsible has not been identified, but it is believed to be above a virus and below rickettsiae. It is thought to be transmitted by mites carried by rodents. None of the antibiotics are of any avail, and no vaccine has been developed, although Army doctors are attempting to produce one. Symptoms of the disease are diarrhea and headache, followed by fever, chills, joint pains, nausea and vomiting. Temperatures usually rise to 104, remain there three or four days. By the seventh day, symptoms subside among patients who recover. During its course the disease is characterized by tiny hemorrhages of the sclera of the eye and in the kidneys, heart and anterior pituitary gland, with possibility of hemorrhages in other parts of the body.

Because the disease is most prevalent in summer and fall, it is not expected to reach epidemic proportions in Korea.

VETERANS ADMINISTRATION MAY ADD 9,000 PSYCHOSIS CASES TO BED LOAD

Veterans Administration faces an almost-certain crisis in attempting to comply with Public Law 239. This provides that *service-connection may be presumed* for all psychosis cases developing within two years after dis-

(Continued on Page 30)



prolonged anticoagulant action—yet . . .

"At no time in any of the patients was there evidence of hemorrhagic manifestations, either systemic or at the site of injection . . . and no sensitivity reaction . . . followed administration of Depo-Heparin."[1]

"Twenty patients were given Depo-Heparin as a postoperative prophylactic measure, while in six it was administered therapeutically for either thrombophlebitis or coronary thrombosis."[1] A single deep subcutaneous injection of 200 mg. of Depo-Heparin "resulted in effective anticoagulant action," achieving "a satisfactory elevation of the clotting time for a period of twenty-one hours for the average patient response."[1] The necessary coagulation time determinations were routinely performed during therapy.

℞ Depo*-Heparin SODIUM

Each cc. contains:

Heparin Sodium	20,000 U.S.P. units (Approx. 200 mg.)
Gelatin	180 mg.
Dextrose, Anhydrous	80 mg.
Water for Injection	q. s.

Preserved with sodium ethyl mercuri thiosalicylate 1:10,000

Supplied with disposable 1 cc. cartridge syringe.

1. Moss, Henry N., and D'Alessandro, Domenic R.: The intensity and duration of the effect of Depo-Heparin on venous coagulation time in man. Am. Practitioner & Dig. of Treatment 2:309 (April) 1951

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VETERANS ADMINISTRATION MAY ADD 9,000 PSYCHOSIS CASES TO BED LOAD

(Continued from Page 28)

charge from service for World War II veterans and those in service since start of the Korean War.

VA estimates that the law may require it to provide *immediate hospitalization or out-patient care* for as many as 9,000 veterans, who before passage of the law were listed as non-service connected and *entitled to hospitalization—but not out-patient care—only if facilities were available.*

VA can see no apparent way out of the dilemma. All of its 53,000 neuro-psychiatric beds now are occupied, and the trend has been toward reducing rather than expanding the total because of shortages of medical personnel. While a number of these hospitalized cases are non-service, and therefore of lower priority than the new cases, the veterans obviously can't be turned out. Current turnover rate is so low—4 per cent a year—as to offer only a partial solution. VA will have to limit incoming patients to service-connected cases until all 9,000 have been taken care of. An undetermined number of the 9,000 are now in state institutions and will probably remain there with VA paying the bill from here on.

Meanwhile, VA has delayed sending out regulations under the new law because the "intent of Congress" is not entirely clear. One question is whether to declare *all of the 9,000 cases eligible,* or to set up a screening process for eliminating those which *could not even be presumed to be service-connected*—those resulting from auto accidents, for example.

GOVERNOR EARL WARREN RENEWS ADVOCACY OF COMPULSORY HEALTH INSURANCE

Governor Earl Warren of California, speaking on a CBS radio broadcast on November 4, again advocated the enactment of a system of Compulsory Health Insurance.

Warren, three times defeated in efforts to inaugurate such a system in California, made it clear that he now favors a system of Government-directed Medical Care for all the American people.

The Governor denied that his program was Socialized Medicine, but the plan he has advocated in California closely parallels the program of Socialized Medicine advocated by President Truman and Federal Security Administrator Oscar Ewing.

The full text of Governor Warren's statement follows:

"It is not sufficient to say that America has developed the finest medical care in the world, even though this is true. We still must find a way to make it accessible to all of our people.

"The well-to-do can pay for good medical care; the indigent receive it from public agencies and through the charitable work of the doctor; but the self-reliant worker, the man in the average or lower income bracket who contributes so much to building our country, and whose greatest ambition and hope is to raise a good American family, cannot bear the financial catastrophe of serious illness.

"I have advocated for California a program of prepaid medical care as a possible solution. The proposal has been called socialized medicine by some who are opposed to it. It even has been given the ugly name of communism by others. It is neither. Nor is it statism as practised in Germany or socialism as practised in England.

"I have never been and am not now in favor of socialized medicine. I do not believe in socialism, but I do believe in social progress, which has been the hallmark and the glory of the American nation from its beginning.

"I am convinced we will enter upon a new era of progress in the cause of health when we make it possible for everyone of our people to protect himself and his family from the economic disaster of backbreaking hospital and medical bills.

"I believe it is the responsibility of the states to undertake to help doctors, hospitals and the public they serve in the solution of what, up to the present time, has been an insoluble problem. I have never held out my proposal as the only solution. It is my proposal until someone offers a better one.

"I am firmly of the belief, however, that our American system is sufficiently adaptable to make possible the solution of the problem of medical care without doing violence to the political, economic or professional concept of all the people who are sincerely interested in the problem."

Our country's population will rise to over 180 million by 1960, an increase of 29½ million over 1950. This is the forecast of Dr. Roy V. Peel, Director of the Census. The increase in the 1940-50 decade was 19 million. The basis for Dr. Peel's estimate is the low mortality rate, high birth rate, and high net immigration.

Cook County Graduate School of Medicine

ANNOUNCES CONTINUOUS COURSES

SURGERY—Intensive Course in Surgical Technic, two weeks, starting January 21, February 4, February 18.
Surgical Technic, Surgical Anatomy and Clinical Surgery, four weeks, starting March 3, June 2.
Surgical Anatomy and Clinical Surgery, two weeks, starting March 17, June 16.
Surgery of Colon and Rectum, one week, starting March 3, April 7.
Gallbladder Surgery, ten hours, starting April 21.
Basic Principles in General Surgery, two weeks, starting March 31.
Breast and Thyroid Surgery, one week, starting June 23.
Esophageal Surgery, one week, starting June 23.
Thoracic Surgery, one week, starting June 2.
Fractures and Traumatic Surgery, two weeks, starting February 4.
GYNECOLOGY—Intensive Course, two weeks, starting February 18, March 17.
Vaginal Approach to Pelvic Surgery, one week, starting March 3, March 31.
OBSTETRICS—Intensive Course, two weeks, starting March 3, March 31.
MEDICINE—Intensive General Course, two weeks, starting May 5.
Electrocardiography and Heart Disease, two weeks, starting March 17.
Gastroenterology, two weeks, starting May 19.
Hematology, one week, starting June 16.
UROLOGY—Intensive Course, two weeks, starting April 28.
Ten-day Practical Course in Cystoscopy starting January 21, February 18, and every two weeks.
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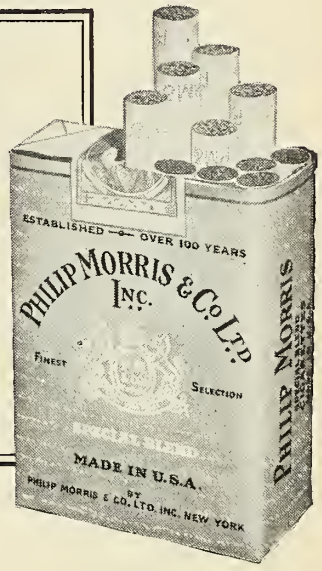
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1. Perloff, Wm. H. (1951), Treatment of the Menopause. II. American J. Obst. & Gynec., 61:670, March.

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Our Responsibility and Opportunity

By John W. Cline, M.D.

President, American Medical Association

San Francisco, California

IT IS a great pleasure for me to be here. I have distinctly enjoyed myself for the past two days in these hospitable surroundings. I am particularly delighted to be at your meeting because, as someone said to me today, "You have more friends in Michigan than you have in California." I am not certain that is true, but I am certain I have fewer enemies.

I wish also to comment briefly upon the splendid organization you have. Your medical society is one of the most active, one of the best organized, one of the most effective of state medical societies in the country. If all medical societies were as well organized, as interested, as energetic as is yours, the problems of American medicine would be greatly reduced.

I was fortunate enough to hear Dr. Christian's report of your delegates yesterday, and what Dr. Christian said concerning the activities of your delegation and the excellence of its personnel I can re-emphasize tonight. From Dr. Luce, the first member of your delegation, whom it was my privilege to know, to Dr. Ralph Johnson, whom I believe to be the most recent member, they are a splendid group of men, who have been interested in only one thing in their activities in the House of Delegates of the American Medical Association—the welfare of American medicine. They have been activated by principle, and never have they given thought to personality except as a means of implementation of principle. To me that is the standard of true service to American medicine.

We all have to realize that while we are doctors, and while we devote our lives almost exclusively, and sometimes to the disadvantage of our families, to our profession, we therefore are bound to be somewhat restricted in our point of view. We may be inclined to accord medicine a place in society which would not be accorded to it by others.

This is not a manifestation of narrow or selfish interest—I think it is simply an absorption in the job we have to do, our love of our profession and our interest in human welfare.

Regardless of the opinions of others, in an integrated society such as ours it is certain that medicine has an important place. If anyone should doubt that, let him simply think of Dr. Page's remarks.* Let him look back over the past years and see the various efforts which have been made to influence the course of medical care and health in this country, both within the profession and without.

The people of this country have become progressively more health conscious. They are more interested in medical news than ever before. They are more interested in the activities of the physicians in this country, in scientific research, in the treatment of disease, and in their organizational activities. This means that we are being brought constantly under closer scrutiny by the public.

That relationship, plus certain external affairs, presents us with numerous problems. Some of these are domestic problems, about which we are able to do a good deal. Others are international in nature, and over those we have little or no control.

Presented at the eighty-sixth annual session of the Michigan State Medical Society, Grand Rapids, Michigan, September 26 to 28, 1951.

*See page 41 et seq.

Council on National Emergency Medical Service

Dr. Page has mentioned some things relative to the military service. Immediately following World War II the Council on National Emergency Medical Service was set up to make preparations for such a circumstance as now confronts us in Korea and which may well become a much larger undertaking as time goes on.

The three Surgeons General have been unusually co-operative with the Council on National Emergency Medical Service, and have held down the demands for medical manpower to a much lower level than at any previous time in our history. The National Security Resources Board, which was designed to relate domestic civilian needs to those of the military, also has been very co-operative. I doubt that any man can say at this time what the demands of the armed forces may be in the future. That is something which lies entirely beyond our control.

But we can look forward, as far as the military is concerned, to better use of medical personnel than previously, and unless we reach a point of all-out mobilization we will not experience a medical manpower shortage which will correspond to that we had during World War II.

There is one thing that we should bear in mind. Our profession has never failed to meet any legitimate demands of duty. Many critical things were said about the program when the physicians' draft was passed. The physicians' draft, in my opinion, was necessary. While it has unquestionably worked a hardship on some and contained some inequities, it is on the whole a good piece of legislation. The medical profession may be proud of sponsoring it.

If we ever have a real mobilization, members of the profession in this state and every other state will respond as they have previously. We need not worry about the patriotism of our members. At the same time let us be continuously aware of some of the home circumstances that might result from such a situation.

Let us not permit our devotion to duty to be perverted into a mechanism of the accomplishment of socialized medicine by governmental chicanery when the same thing cannot be accomplished by direct and honest, straightforward legislative action.

Socialized Medicine

Yesterday here in this hall one of the speakers said that a responsible spokesman for the American Medical Association had said that our problems relative to socialized medicine were over. I don't know to whom he referred because I have heard no such comment by a responsible officer of the AMA.

I would like to call to your minds an instance, in 1946, when the president of the American Medical Association said, "For the first time in years we can breathe in an atmosphere of freedom." The editor of *The Journal of the American Medical Association* said, "Socialized medicine is as dead as a dodo."

Let us then look forward two years, to 1948. Let us consider when President Truman was re-elected. He had campaigned on a personal platform disregarding the pronouncements of his party, and promised many things to many people, including socialized medicine. Those of you who are delegates to the American Medical Association, and perhaps others who were in St. Louis at that meeting in December of 1948, will remember the surrounding atmosphere of tension and gloom under which the House of Delegates met at that time.

But there was a spirit of resistance, a spirit of American resistance in that House. It issued a ringing statement of principles. It directed that a campaign be waged against the effort to socialize medicine. It then voted an assessment upon the membership of the Association, for the first time in its history, to finance that campaign.

A committee was appointed to supervise the operation of the campaign, and Whitacre and Baxter were employed.

The results of that campaign are of some interest to us. We have come a long way since then, and I think perhaps these might be the outstanding results of the campaign in brief:

There has been a crystallization of public opinion in this country. There have been many others who have joined us because of their recognition of the fact that the socialization of medicine would be only one aspect of the broad general plan of socialization which would be put into effect in this country.

There has been a change in public opinion. Almost 11,000 organizations of local, state and

national scope have gone on record with resolutions opposing socialized medicine.

In the State of Minnesota one of the newspapers conducted a continuing survey on the same subjects. It asked two questions in February, 1949: Did the people feel that a plan similar to that in England for the distribution of medical care was needed in this country? Second, did they wish such a plan?

There was some disappointment in the answers to those two questions. More people seemed to feel such a plan was needed than opposed it. The overall average was about 2:1 in favor of such a plan.

A survey in February of 1951 showed exactly the reverse—that the margin was 2:1 against such a plan. This was in spite of the efforts of certain labor leaders and labor publications to convince the members of organized labor that we should have socialized medicine.

Another publication, which maintains a continuing labor-management survey, reported not many months ago that a survey of union and nonunion labor revealed these figures: In favor of socialized medicine, 28 per cent; undetermined, 27 per cent; against, 45 per cent.

These are straws in the wind. In addition, you are conscious of the change in the character of news stories which appear in your newspapers—and the character of editorial comments. Over 90 per cent of the newspapers in this country are now on record as being opposed to socialized medicine.

You also are conscious of the change in certain labor organizations. You will recall Mr. Hutchinson's speech last December and Mr. Beck's speech this June. Such things show some of the trends.

As a result of these trends, there has been a change in administration policy. In the 81st Congress, because these trends were already apparent—it was obvious that the omnibus bill, the Thomas bill, could not be passed. The administrative strategy was to concentrate on the so-called fringe bills—Federal aid to medical education and Federal aid to public health units, under circumstances which would have placed local public health units under the domination of the Federal Government.

Doctor Shortage

There has been extensive propaganda to convince the people of this country that there was an acute doctor shortage, and that there was serious maldistribution. What are the facts?

The ratio of doctors to population in this country is about one to 730-odd. It is estimated that the increase in the efficiency of the average physician over the past twenty years has been some 30 per cent, due to improved methods of communication, improved roads, improved transportation, and the more extensive use of auxiliary personnel.

Our medical population has increased more rapidly than has the general population for the last thirty years. At the present time we have more students enrolled in medical schools preparing for careers in medicine than at any time in our history. It is conservatively estimated that by 1960 we will be producing 30 per cent more doctors than we produced in 1950.

We recognize that with the increased interest in health and medical care the people of this country have evidenced, there will be an increased demand for medical service as time goes on, but we know there is no shortage of physicians at present and none will exist in the foreseeable future.

What are the possible methods of expansion of the number of physicians? The establishment of new schools is a sound method but it is slow. We would welcome new schools placed in such positions where they could draw upon adequate clinical material, and if they were supported by organizations which would guarantee their continued operation. That takes time. The University of California at Los Angeles this year is taking its first twenty-seven students, ten years after the appropriations were made by the California legislature.

We could change some of our two-year schools to four-year schools. However, only five of them remain, and most of those are situated in areas where there would not be adequate clinical material for teaching.

Further expansion of enrollment could be undertaken by some of our schools, in all probability; but that is a decision which must be made by the administrative officers and faculties of the individual schools, because, as Dr. Page pointed out in quoting Dr. Rappleye, we cannot afford to have any deterioration in the quality of medical education in this country. We do not need one single additional poorly trained doctor.

We could resort to the accelerated program of World War II. Probably a good many of you did

as I did—teach during that period. I hope never to see that type of program reinstituted. We did not do the job we should have done by our students. Worse than that, I watched them become progressively fatigued and unable to absorb the material presented to them. I sincerely hope we will never see a return to that program.

The only other alternative is to shorten the medical curriculum, such as was done in Germany during the last war and ended up by training doctors who were little better than surgical dressers.

Medical Education

While these things are true, we have also heard much of the economic situation of our medical schools. One of the most difficult things to ascertain is the actual cost of medical education. Most of our medical schools are associated with universities, and follow the accounting systems prescribed by their parent institutions—and those systems are extremely variable. We find costs that run from a few hundred dollars on up to several thousands per student per year. Some institutions include only the actual cost of education of the student; others include hospital deficits and the research programs, and so on.

One thing, however, stands out—our medical schools are in financial need. There are two methods of meeting that need. Federal subsidy for continuing operations is one. I think Federal subsidy of any type can be very reasonably compared to a narcotic drug: it produces an illusory sense of well-being, it produces addiction on the part of the recipient, and the withdrawal symptoms are horrible.

It would take a rather rugged individualist and a rather strong character who, once his institution had begun to accept Federal subsidy, would not bow to the threat of its removal. That in itself could bring (and in time *would* bring) our medical schools directly under the control of the bureaucrats in Washington.

It also would produce a shrinkage of other income. People would not contribute to the medical schools as they have contributed in the past, and our state legislatures would be inclined to be much less generous with the state schools because the Federal Government would have undertaken the financial maintenance of the schools.

In addition, there is still an unreversed decision of the Supreme Court in which Mr. Justice Jackson said, with reference to the case of a farmer by the name of Wickard, in Ohio, in November 1942, "It is not lack of due process that the Federal Government may regulate that which it subsidizes." If the bureaucrat could not establish by control the threat of withdrawal of support, he still would have the means of enforcing it by law.

If we are going to say that the Federal Government should not supply the necessary financial support for our medical schools, it is not sufficient for us simply to stand in opposition. We must, in turn, supply a positive answer. The attitude of the American Medical Association is well shown by its action last December when it gave $500,000 as a nucleus to stimulate private enterprise to supply the funds necessary for medical education without resort to Federal subsidy.

A number of state associations, a number of specialist organizations and the Women's Auxiliary also have donated substantial sums. It was necessary to establish the American Medical Education Foundation at the time of this action by the AMA because, while the National Fund for Medical Education (the honorary chairman of which is Mr. Herbert Hoover, and the board of directors of which is composed of professional, labor, and industrial leaders), was in the process of formation, it was not at that time willing to have its imminence announced.

The funds of the two organizations have been merged, and the first distribution of money was made a few weeks ago. Something over $1,100,000 was distributed to the medical schools of this country.

Both organizations will persist. The American Medical Education Foundation will continue to solicit doctors and medical organizations for funds. The combined budget of the two organizations for the next year will be in the neighborhood of five million dollars. Of that, it is hoped that about one million dollars will come from the medical profession.

I believe we all recognize that we have a duty as citizens to see that medical education is protected and furthered in this country. As doctors, we have a much greater duty than that. As far back as the time of Hippocrates, it was the job of the physician to train the youth to succeed him. Certainly, we have a duty to our successors.

Beyond that we have a duty, each one of us—

to support medical education in this country. No one of us paid, in whole, the cost of his medical education. The deficit between what was paid in tuition and the cost of medical education was supplied, for those of us who attended state schools, by the taxpayers of the state. For those of us who attended private schools, it was supplied by some philanthropic segment of society which chose to endow those schools.

Now the funds are more difficult to obtain from both sources, due to altered tax structure, medical education must be supported on a broad basis. It is time for us, as physicians, to recognize that we have a particular responsibility to support medical education. I sincerely hope that you will all contribute generously and promptly to that end. As Dr. Christian told you yesterday, you may designate the school to which your donation is to go.

Independent Voluntary Medical Service

Much the same thinking applies to our attitude toward socialization. We have taken a steadfast stand against the socialization of medicine. I use that term almost consistently because to me the details of any proposed plan matters little—as long as the scheme applies to a large segment of our population, and is tax supported and governmentally operated, it is socialized medicine.

If we are going to preserve our freedom we must present a realistic answer to the distribution of the cost of medical care. That was in my mind when I spoke today to your Michigan Medical Service. You have made splendid progress, but it grieved me to see that there was one county in your state in which there was only 8 per cent participation of physicians in the Michigan Medical Service.

The medical profession must realize that unless it is willing to stand squarely behind the whole voluntary program in this country, we are going to fail ultimately in our efforts to stop the socialization of medicine. The progress of the voluntary plans has been satisfactory on the whole.

In a significant sense, voluntary health insurance in this country is only about ten years old. We now have more than half of our population—something over seventy-five million people—covered for some of the costs of illness. We have over forty-four million people enrolled in Blue Cross, and about twenty-two million people hold membership in Blue Shield and other medically sponsored organizations.

The aim for this year is to have eighty million people covered, and ultimately to include the vast majority of our population.

A survey not long ago showed that Blue Cross, over the country, paid 82 per cent of the hospital bills, and Blue Shield 60 per cent of the medical bills for the people who had that coverage.

In addition to the necessity which confronts us to sponsor and expand these organizations, we have long recognized that the physician has a dual obligation to his patient—to render the best medical care possible to him, and to treat the patient fairly in all respects, especially in the economic sense.

If one expands the thinking from the individual physician and the individual patient to the medical profession and to the public, do we not have the same obligation to provide the mechanisms for prepayment of medical care for the public in general? Perhaps it might be objected that we do not have a greater moral obligation to do so than does any other group which supplies essential services for the remainder of society. On the other hand, the traditions of service of our profession and our own enlightened self-interest certainly dictate that we so do.

There are times when we become so close to the picture—when we become so involved with these things which are vital to us, that we may not be the best judges. In the past year and a half I have traveled very extensively about this country. I have talked to many people concerning the various plans which medicine has, and what they thought medicine should plan for in the future. I shall mention a few of these, if I may.

Among them were Senators Taft, Byrd, Nixon and McClelland; James Byrnes, who has held almost every office in this country, except that of President; Stassen, Dave Beck, Mrs. Anna Rosenberg, and half a dozen public relations experts who have had nothing to do with medicine, and many others.

Those people who had opinions—and all those I have named did—said that unless we continue to expand and improve our voluntary plans to meet the demands of the people, we shall not be making full use of the one effective mechanism we have for protecting the practice of medicine from Socialism. Certainly, one of the great weak-

nesses of the English medical profession was that they had none, and that is one of the reasons why they became socialized.

When I say "improve," I am not exactly certain what direction the improvement should take. It is possible that we have tried to be too broad in our coverage. Perhaps we have tried to do too many things, and perhaps we have not gone quite far enough toward protection against the truly expensive illness.

There are many experiments in progress all over the country. Your plan here and ours in California strongly resemble each other. Many of the other plans differ very widely. Out of this great welter of experiment will come a general agreement as the result of evolution concerning what will constitute the best coverage for the least amount of money. When we arrive at that answer we can then say with some assurance what we should do in various parts of the country. Until that time the present type of experimentation should continue.

Public Relations

I would like to speak for a moment about public relations. Public relations of medicine at all levels needs to be improved. Again I wish to compliment your society for the splendid steps that have been taken on the state level. I want to speak more particularly, however, about public relations at the national level and at the purely local level.

If one were asked what large organizations in this country had enjoyed the worst public relations for many years, one could scarcely fail to include the American Medical Association. There were a good many reasons for that, which we need not go into. Not the least of them was that a systematic campaign of vilification was waged against the American Medical Association. That was the most vicious and the most extensive campaign of abuse ever waged against a large and self-respecting organization operating in the public interest.

The response of the American Medical Association was clumsy, and as a result it became an ideal whipping-boy for every cheap politician who wished to make a rabble-rousing oration.

Fortunately, that situation has undergone a considerable change, and is undergoing further change; it cannot be acomplished from Washington —it cannot be done from Chicago or from any other particular city. If we are really to accomplish a better public relations situation, this must be achieved at the grass roots level throughout the country.

What is the American Medical Association? In one sense it is 140,000 doctors. You are the American Medical Association. In another sense it is a huge public service organization, occupying at 535 North Dearborn Street in Chicago a nine-story building, and employing more than 800 people who are working full-time, either directly or indirectly in the public interest.

Consider a few of the things that the American Medical Association does. Think of the influence of the Council on Medical Education and Hospitals in the improvement of medical education and the standardization of residency programs in this country.

Think of the two tremendous meetings each year, with the papers and exhibits, planned by the Council on Scientific Assembly.

Think of the publications: *The Journal of the American Medical Association,* which is the finest and most widely read general medical journal in the world, the nine specialty journals, and *Today's Health.*

Think of the tremendous program of the Bureau of Health Education in educating the public in ways of health.

The Bureau of Medical Economic Research is continuously ferreting out information which will be of value in the extension of medical care.

The Council on Industrial Health works with both labor and management in an effort to remove industrial hazards, and holds an industrial health congress each year.

The Council on Pharmacy and Chemistry examines new drugs, new pharmaceuticals, for their potency, their purity, their toxic hazards, and the accuracy of advertising claims.

The Council on Physical Medicine and Rehabilitation does the same thing in the field of physical appliances, such as hearing aids.

The Council on Medical Service, with seven subcommittees, is continually trying to extend medical care.

The Committee on Rural Health and the Bureau of Investigation, which is making an endeavor to stop quackery and get rid of nostrums throughout the country, also are very busy.

It is up to every doctor to know and to tell the story of the American Medical Association. It is

not well known, and it has never been told adequately. The positive telling of it, the telling of the actions of your organization, will do far more than any denial of the accusations made against it. After all, it is your American Medical Association, and how it is known the country over depends upon you.

Let us think for a moment of local public relations. It is worth-while for us to resort to genuine, sincere, impartial self-appraisal if we can. It is extremely difficult to be objective, as far as we ourselves are concerned. Let us, therefore, look into the mirror of public opinion and, if we don't like the image, let us not blame that on a defect in the mirror. Let us bring the object out into a good light and look at it closely.

I have talked to enough doctors since I have been here to know that circumstances in Michigan are about the same as in Maine or California or Florida—that a very small segment of our profession is responsible for most of our troubles, and that no state, city or community has a corner on these people, and that likewise none is free from them.

Let us start by admitting that everything is not sweetness and light in the medical profession. If we are going to maintain public respect, we must deserve it. The public has a legitimate interest and a legitimate voice in the conduct of medical affairs. It is the other half of the doctor-patient relationship.

Some years ago you conducted a public relations survey in Michigan. We also did in California. It has been done elsewhere in the country. As I have traveled about, I have found that the complaints of patients against the medical profession are practically identical everywhere.

The first complaint is against what they consider exorbitant fees. The second is the availability of medical service. I heard a story today of one community in Michigan where this has been a particularly trying situation. The third complaint is that of frankness in dealing with the patients—or what the patient considers frankness. We are a little too inclined to talk in professional mumbo-jumbo that the patient does not understand, and we may not see that our patients really understand what their symptoms and diagnosis mean. We do not explain adequately the treatments we have outlined for them. Even common courtesy is sometimes said to be lacking.

Most of these things are on the basis of misunderstanding, and that misunderstanding originates in the first contact of the doctor with his patient in his office or in the patient's home. Some are not the result of misunderstanding. There are what I call facultative chiselers in our profession, and there are some who are congenital chiselers. The facultative chiselers will occasionally take advantage of their patients. If they are led to think about their responsibility to their patients and to the profession, they will not chisel. The congenital chiseler is the individual who produces most of our fundamental troubles.

Code of Ethics

We have a code of ethics. This is substantially the code of a gentleman in the practice of medicine. A vast majority of our members —probably more than 95 per cent of our members—would abide by this code even if it didn't exist, because they are gentlemen. The other 5 per cent continuously embarrass the 95 per cent. If a man does things which are not in conformity with the code of ethics, he no longer deserves to be in the company of gentlemen, and we cannot afford to do other than exclude him from that company.

We must have grievance committees which are active, available, courageous and well publicized so people know how to bring their complaints to them. When there is a legitimate complaint it may be dealt with forthrightly, and, when the complaint is not legitimate, that fact may be equally thoroughly established.

Public Affairs

I would like to mention press relations for just a moment. It has been my experience, in dealing with newsmen over a good many years, that the reporter, the editor and the publisher, are generally fine, decent, honest fellows who desire to paint for their readers the best word picture they can. Each has a job to do, just as we have. We must be more cooperative and more helpful to them. When difficulties arise, let us sit down and discuss those matters frankly and in a friendly fashion. We can do far more by that means than by any other to adjust our press relations on the local level.

In line with your program of yesterday, and that of last year, I would like to make a few

remarks concerning citizenship. The average citizenship of the medical profession is extremely high, but it is too often of the passive type. At a luncheon in Pittsburgh a few days ago where public relations representatives of the larger firms in Pittsburgh were present, the principal complaint against the medical profession was that it did not participate actively enough in public affairs and in matters of community interest. Certainly, the community looks to the medical man for leadership in everything which pertains to health and medical care—but also the doctor, as an educated man, is one with a sincere purpose to obtain good government at every level. He must exercise not only his duty but his right as a citizen.

He must take an active part in politics. You need only look at some of the results of last November's election to see what can be done.

It is difficult, in large states with large populations and multiple issues, to ascertain what the effect of any group of people may be upon the outcome of an election. On the other hand, if you take the word of Senator Pepper of Florida, Senator Graham of North Carolina, Senator Taylor of Idaho and Senator Thomas of Utah, the medical profession was largely responsible for defeating them in their campaigns for re-election. Certainly, the same could be said in congressional elections in Omaha and Milwaukee.

Neither the American Medical Association nor a state association nor a county society—none of them—ever engages in politics, but certainly the doctors as individuals and in informal groups have that right and that duty. If we are to preserve the type of government that we want in this country, they must do so.

To return to the national situation which we confront, I would say that the battle against socialized medicine is about half won. This is no time for complacency. All you need to do is to think of the recent activities of Mr. Oscar Ewing; or to read the news out of San Francisco, where Mr. William Green has been making statements concerning what is going to be done next year, to bring home to yourselves the fact that we are far from being in the clear.

We must continue our campaign against socialism. We must convince larger segments of people of the rightness of our position. That is particularly true in the field of labor. The poll which I mentioned earlier indicates that the rank and file of labor does not necessarily agree with some of its leaders; but there is still a determining segment of labor which has not made up its mind.

We must improve our public relations at all levels. We must expand and improve voluntary health insurance. We must support medical education. We must participate in public affairs and in politics.

This is a changing world, and nothing in it is static. Change is inevitable. Let us neither accept nor reject change because it is change.

To every proposal for change, let us apply these two criteria: Does it contribute to the medical welfare of the people? Does it respect the legitimate rights of the profession? If the answer be "No" to either of those questions, then let us reject such proposals. If the answer to both be "Yes," then it is a change which we can embrace with confidence.

It has been said that this is the golden age in medicine. The advances in the past fifty years lend some credence to that belief. We have new knowledge, new facilities, new techniques, new abilities; but to me it seems much more likely that we are standing on the threshold of a much greater era. There is no such thing as manifest destiny, until the future has become history. It lies within the power of men to shape its course.

This is our responsibility and our opportunity.

MSMS

Michigan has a greater percentage of folks in the middle-high income group than any other state, with 55.3 per cent of her families in the $3,000-$7,000 bracket in 1949 (latest figures available). The median family income here was $3,532, an average topped by three other states—but no state had such a heavy concentration in this bracket.

* * *

About 600,000 workers have retired under the old-age and survivors insurance program in the first eight months following the adoption of the 1950 amendments. There were in April, 1951, over 2 million workers and 1.9 million dependents receiving benefits under the Act. While almost nine years elapsed before the first million old-age beneficiaries were receiving monthly benefits, the 2 million mark was reached in approximately two and one-half years. During the first four months in 1951 more than three times as many new employe accounts were opened as in the corresponding period a year ago. A substantial number of the newly covered workers are household employes. Employes of state governments are now eligible for social security as soon as the state and the Federal government sign agreements. Seven states had done so by mid-May and eight others were negotiating agreements.

Doctors and the Federal Medical System

The Problem, the Findings and the Solution

By Robert Collier Page, M.D.

New York, New York

THE DOCTORS of America are faced with a problem which vitally affects them both professionally and as citizens. The vast and uncontrolled growth of our far-flung federal medical systems in recent years has produced serious maldistribution and under-utilization of medical manpower, with growingly adverse impact on all our voluntary and community facilities.

These developments were clearly foreseen by the bi-partisan Hoover Commission[1] when it made its historic report to Congress in 1949. The Commission found that the federal government today is obligated, in whole or in part, for the care of some twenty-four million citizens, of whom nineteen million are veterans; and also, under the Hill-Burton Act, for assistance to voluntary and community hospitals in building or expansion operations. Because the government has no co-ordinated plan of operation for its facilities, the result has been waste, inefficiency and much confusion through the duplicating operations of five large, and over thirty smaller, federal medical systems.

These agencies, which include the Army, Navy, Air Corps, Veterans Administration, and the Public Health Service, are operating completely independent of each other. Even among branches of the military service there is still insufficient co-ordination. Soldiers are not easily or efficiently admitted to Navy hospitals in the United States, and vice versa. Sick or injured men in active military service are barred from Veterans Administration institutions where highly trained specialists are career employes of the government. Facilities of one agency are often crowded, while those of a different branch, quite possibly nearby, are half empty and their personnel correspondingly idle.

Presented at the eighty-sixth annual session of the Michigan State Medical Society, Grand Rapids, Michigan, September 26 to 28, 1951.

In 1945 the training of medical students, which had reached a high point of excellence under the system of specialty boards devised by the AMA, was abolished at the insistence of the Army and Navy. Dr. Evarts Graham, eminent St. Louis surgeon, has clearly outlined the complexities of present-day medical education and emphasized how essential it was, in the interests of all parties concerned, for the armed services to assign professional personnel according to their training and ability.

He stated, "One might suppose that a plan that has been demonstrated to be effective in the preparation of medical officers would be allowed to continue in order to supply replacements of the same caliber. . . . Paradoxical as it seems, the program which probably supplied the best prepared officers of any group of the civilian population has been destroyed."

Admittedly, there has been some improvement to date; nevertheless, much more remains to be done. The present attitude of the average doctor who had active military duty in World War II toward government medical service leaves much to be desired.

Hoover Commission

Federal medical activities now cost above two billion dollars a year. The Hoover Commission, aided by a research "task force" of experienced physicians and hospital administrators, delved deeply into every detail of these activities in a study lasting more than a year. It is the Commission's recommendation that federal medical facilities be unified. This would mean a "Department of Health," by which means, the Commission contends, it would be possible to effect economy in manpower, space and equipment. It would assure wise use of professional talent and proper economic usage of existing facilities.

The Hoover Commission was unanimously created by Congress, and consisted of twelve high-minded men, six Democrats and six Republicans, selected equally by President Truman and the presiding officers of the Senate and House of Representatives. At President Truman's suggestion, former President Herbert Hoover was named chairman. The commissioners were aided by twenty-four research committees called "task forces," comprising 300 eminent experts. Members of the Commission served for fourteen months or more without pay, and sometimes to the neglect

of their regular affairs. Each member had an earnest desire to serve his country.

The Hoover Report has been called "the most objective and complete survey ever made of the United States government." On the basis of the savings resulting from enactment of one-half of its recommendations by the 81st Congress, its full adoption would save this country some 5.4 billion dollars annually with no harm to any essential government service—in fact, with definite improvement in a number of areas.

The men who formed the medical "task force" which did the spade work, digging into records and questioning government employes concerning medical activities, were outstanding experts in their respective fields. As research men they were unemotional about their findings. Eleven of the seventeen members were doctors, and the rest were experts in hospital administration. Seven were veterans.

The medical members of the task force included:

Frank R. Bradley, M.D.; Robin C. Buerki, M.D.; Michael E. DeBakey, M.D.; Goldthwaite H. Door; Paul R. Hawley, M.D.; Henry P. Isham, M.D.; Hugh R. Leavell, M.D.; William C. Menninger, M.D.; Hugh J. Morgan, M.D.; O. H. Perry Pepper, M.D.; Alfred Newton Richards, Ph.D.; Charles F. Rowley, M.D.; Allen O. Whipple, M.D.; Ray Lyman Wilbur, M.D.; Edward D. Churchill, M.D., vice chairman; Tracy S. Voorhees, M.D., chairman; Joel T. Boone, Rear Admiral (M.C.), M.D., U. S. Navy, secretary.

It was upon the date supplied by this task force that the Commission recommended unification of the federal medical services. These recommendations are now before Congress embodied in Senate Bill S. 1140 and House Bill H. R. 3305.

As a member of the medical profession, each practicing physician has a personal interest and should play a role in any program which would provide a more equitable distribution of doctors and nurses, the greatest use of all medical facilities, and more co-ordinated action in regard to hospital construction. From the standpoint of efficiency and economy, to say nothing of preparedness for a possible major catastrophe, these subjects merit personal consideration by all members of our profession.

There is a wide divergence of opinion regarding this entire problem. It is extremely difficult to reconcile conflicting beliefs. The groups which favor as well as those which oppose suggested solutions of the problem are composed of large numbers of influential people with many powerful supporters. For example, the Health Resources Advisory Committee of the Office of Defense Mobilization has estimated that there will be a shortage of 22,000 doctors and 49,200 nurses by 1954.

It has been suggested that enrollment in the medical schools be increased 15 per cent. On the other hand, it has been demonstrated that 40 per cent of the nation's physicians were in military service in World War II, leaving 60 per cent to care for the civilian population. In this latter view, an enrollment increase would result in a surplus of doctors by 1960.

Medical Education

Rappleye, of Columbia, disputes the fact that any potential shortage can be remedied by a speed-up in medical education. In a recent statement to the press, Dr. Rappleye pointed out that increased enrollment in medical schools would carry a threat to the quality of the doctors produced. The solution, he states, "lies in a better distribution of doctors."

There is virtually universal agreement that the complexities of modern medical science have made more painstaking and costly the training through which the upcoming generation of medical practitioners must pass.

Currently we hear that the training of competent doctors and medical scientists is imperiled by the financial crisis in the medical schools. We hear also that if this condition is allowed to continue it will affect adversely the nation's health. Educators have remarked that there are potential dangers to academic freedom in the situation. Economists have gone on record to this effect.

All this presents definite problems, and the question is: What is to be done about it? Again, there is a diversity of opinion.

Simmons, in a speech before the Philadelphia College of Physicians, recommended unification of all government medical services except those of the armed forces, in a "Department of Health" of Cabinet rank. This, he said, would permit "a closely integrated national program to conserve the health of both the civil population and the armed forces."

The American Medical Association, in a statement submitted to the Senate Committee on Labor and Public Welfare on July 11, 1950, agreed in principle with the recommendations of the Hoover

Commission, but objected to some of the provisions of S. 2008 which would effect unification of the medical services, and suggested further study by the Senate.

The American Legion has announced itself, in its publications and through the testimony by its former National Commander George N. Craig, before the House Committee on Expenditures on July 29, 1950, as opposed in toto to any reorganization affecting Veterans Administration medical agencies.

Thus, there is a wide field for discussion of this problem in order that these differences might be ironed out.

This is the time, it seems to me, when doctors should make their voices heard. Their opinions must be made known to Congress. The National Doctors' Committee for Improved Federal Medical Services was formed to explore the thinking of doctors with the idea that their views could be voiced when the matter comes before Congress.

The situation is such that something will almost certainly be done about it. Unless doctors make their position clear, some legislation will be engineered by politicians or nonprofessional interests which will result in dis-service to veterans, men in the armed service—in fact, the entire American public.

The Findings

The conditions of inefficiency and waste in the government's medical services, as disclosed in the Medical Activities Report of the bipartisan Hoover Commission, are astonishing, especially to doctors; but more astonishing still is the fact that very little, if anything, has been done about them.

For two years legislation intended to correct conditions in the thirty-five government medical agencies has lain on the desks of members of Congress. The delay in calling these bills up for action is regrettable in these days of national emergency when the needs of the armed services and of the civilian population demand the most effective use of the nation's medical manpower and facilities. It is of the greatest importance that members of the medical profession inform themselves and make their opinions known on this question which so vitally affects their calling.

The report of the Hoover Commission was based upon the results of a two-year survey of government medical activities by a task force of seventeen experts, eleven of whom were doctors, and most of the others authorities on hospital procedure. In its report to the Commission, the task force stated:

"For the faults which we have found, we blame principally the competitive organizational climate in which the various agencies have striven to maintain themselves, rather than the agencies themselves.

"This enormous and expanding enterprise is devoid of any central plan. Four large and various smaller agencies obtain funds and build hospitals, each to care for its own clientele. They compete with each other for scarce personnel. Generally, none of them considers the facilities of or the needs of the others. No one has responsibility for any over-all plan. There is not even any clear definition of certain classes of beneficiaries for whom care is to be planned.

"The government is moving into uncalculated obligations without an understanding of their ultimate cost, the lack of professional manpower available to discharge them, or the adverse effect upon the hospital system of the country.

"In general, in federal medical services the authority of the professional medical personnel is limited and actually subordinate to that of the non-medical personnel.

"In the Veterans Administration, lay control by the Administrator includes decision not only of what hospitals will be built, but also of the location. Both of these matters should be initiated and finally decided by the highest medical authority in the agency.

"The purchase of purely medical items, which we may describe loosely as those used to treat patients, is a technical function requiring extensive professional knowledge and continuing adaptation to the changing techniques of the medical profession. The principle is violated in the Veterans Administration in which the supply service is on an equal basis with and wholly independent of the Department of Medicine and Surgery."

The survey by the task force uncovered incredible examples of confusion and ineptitude in government medical affairs. For example: More than two-thirds of the cases in Veterans Administration hospitals have non-service-connected injuries or illnesses. Out of 103,576 cases 67,769 were of this category, and only 35,807 had wartime disabilities.

According to the Hoover Commission, four Army and Air Force hospitals in the New York area alone might well be closed, with a consequent 80 per cent reduction in medical personnel.

In the Los Angeles area, five hospitals, or about 30 per cent of the total capacity in twelve federal hospitals, could be done away with, while in the San Diego area it was held that two or three hospitals could do the work of ten.

The Veterans Administration had an excess of

voluminous printed instructions on internal methods and procedures which defy intelligent execution. It published eighty-eight different manuals, 665 varieties of technical bulletins, and over 400 circulars of various kinds. The Veterans Administration expanded nine pages of Public Law into 994 pages of "explanation." To cut this red tape, a thorough reorganization of the Veterans Administration was advocated.

The unification of the armed services has helped governmental medical services somewhat. It is paving the way for a more standardized and consequently more efficient and economical approach to the multitudinous commitments that the government already has in the field of medicine.

Under a directive of the Department of Defense, "Any member of the Army, Navy or Air Force may be admitted to the nearest military hospital regardless of the service which operates it."

Acting under the authority of the Secretary of Defense, the Armed Forces Medical Policy Council in 1950, created under the National Security Act, put into effect a unification of the medical services of the three branches of the armed forces in Korea. This policy has extended even to the Veterans Administration hospitals. In the period from February to June (inclusive) of this year, 1,512 casualties from the Korean theater were transported to the United States and placed in VA hospitals here.

In response to many statements which have appeared from time to time in the public press by Rusk, Meiling and others, extolling the many improvements of military medical services, Dr. A. R. Koontz has stated the following:

"As to statements that our wounded are being taken care of in the Korean war better than ever before in our history, medical officers returning from Korea, who have been handling our wounded there, give a somewhat different picture. These officers report that we do not have the number of sufficiently trained men to take care of these casualties properly, and that the men who are handling the casualties, without sufficient training, have no one to turn to for help when they need it. They say that requests for consultants have been turned down by local higher authority (in Korea, the 8th Army Surgeon). I am reliably informed that no neurosurgeon ever got as far as Japan until September. If this is true, it is obvious that our neurological casualties could not have been handled properly.

"This is not written as a criticism of the Surgeon General's Office. On the contrary, it is written to show the handicaps under which the Surgeon General works, in his responsibility for the care of casualties in wartime, under the present Army organizational setup.

"The Surgeon General has no real control over what goes on medically in any theater of war. Often theater commanders select their theater surgeons because they happen to like them personally, and regardless of whether they have any qualifications for the job or not. Theater commanders seldom know enough about the technical problems involved to be able to judge the professional qualifications of the surgeon."

Criticism of government inefficiency in other areas of federal medicine than the military have come from doctors in all parts of the country. Here are a few excerpts from their letters:

Dr. Jim C. Barnett, Hazlehurst, Mississippi: "Trained in the VA and the Navy, I know the waste of medical manpower in federal services."

Dr. Charles Edward Harold Bates, San Francisco, California: "About 80 per cent of the beds at Fort Miley, San Francisco, are filled with non-service-connected disabilities. Most of these patients could and should pay for private care. Veterans medicine has become a political joke."

Dr. Anthony J. Cummings, Scranton, Pennsylvania: "As a former member of two hospital staffs, I can see room for great improvement."

Dr. H. Verrill Findlay, Santa Barbara, California: "Clear the non-service disabled patients out of the Veterans hospitals."

Dr. Clayton Prater Wangeman, Seattle, Washington: "I believe physicians should resign their consultantships for the VA until the administration listens to the doctors."

Dr. W. Ray Hill, Milford, Nebraska: "Keep Uncle Sam out of medicine as much as possible."

Dr. Carl K. Kaufman, Las Vegas, Nevada: "I just had a patient who was awarded a 10 per cent disability for a contact dermatitis of the penis due to a rubber condom. How ridiculous can they get?"

Dr. Daniel C. Hackett, Westfield, New Jersey: "I spent four years in the U. S. Public Health Service. We certainly need better organization and efficiency there.

Dr. Harrington Bidwell Graham, San Francisco, California: "The location of federal hospitals is a disgrace and a tragedy, especially in the west."

There is another aspect of the unregulated expansion of the federal medical services without coordination: It is the effect it has upon the federal operation under the Hill-Burton Act.

This Act permits the government to assume one-

third of the expense of constructing or enlarging voluntary community hospitals. It is intended to assure a nationwide system of such hospitals for the protection of the civilian population and to serve as auxiliary to government hospitals in times of great emergency.

Up to the end of the 1951 fiscal year, June 30, the government has approved construction of 1,596 projects, of which 494 are completed; 990 are under construction. The total cost to the government is $433,978,400.

Because there is no over-all program of hospital construction, this plan has been interfered with by the construction of federal hospitals in the neighborhood of voluntary hospitals which, because they offer higher pay and more security for personnel, have in some places seriously crippled the staffs of these community hospitals.

The following table illustrates the dangers resulting from a lack of co-ordination between the Veterans Administration and the military authorities. In some sections big VA hospitals are going up, while nearby military hospitals are being shut down. These are a few outstanding of many similar cases throughout the country:

LACK OF CO-ORDINATION—1949

Planned VA Hospitals	Military Hospitals Being Closed	
Boston, Mass. GMS 1,000 beds		
Brockton, Mass GMS 1,000 beds	Murphy General Waltham, Mass.	715 beds
Philadelphia, Pa. GMS 500 beds	Valley Forge General Phoenixville, Pa.	1,650 beds
Atlanta, Ga. GMS 500 beds	Oliver General Augusta, Ga.	1,500 beds
Ann Arbor, Mich, GMS 500 beds	Percy Jones General Battle Creek, Mich.	1,200 beds
Los Angeles, Cal. N.P. 1,000 beds	U. S. Naval, Long Beach, Calif.	1,500 beds

Not only is there duplication and lack of co-ordination in the urban areas, but extreme dislocation has been found in cases where hospitals were built for political considerations. The Miles City, Montana, hospital, is only one of the many.

Miles City has a population of 9,184 and, with a Public Health Service estimated need for hospitals at 3½ beds per 1,000 people, is already well serviced with a hospital GMS of 135 beds. There are thirteen doctors in Miles City, of whom six would be unable to aid the VA hospital. The result is that the new VA hospital has a layman manager, no medical director nor chief of medical services, and no patients. Moreover, the location of Miles City (350 miles from the nearest railroad division point) makes it extremely inconvenient for it to be reached by VA patients. At $50,000 a bed, this is an extraordinary waste.

Two more striking examples: a big new VA hospital was opened recently in West Virginia with great fanfare. At last report it had a staff of two physicians and no patients. In Dublin, Georgia, there stands a 1,000-bed hospital, in which the VA is authorized to staff and use 500 beds. At this time only 300 beds can be used because of the staff problem and because transportation facilities to this installation were so poor that an airfield had to be built to bring patients in. The nearest Pullman sleeper facilities are 53 miles away at Macon, Georgia.

The government, therefore, is doing an injury to the civilian population and to the medical profession by stockpiling doctors in unnecessary institutions.

Another disservice results from laxity in the enforcement of law by which many veterans obtain admission to government hospitals for free care simply by signing a "pauper's oath" that they are unable to pay. According to Senator Paul H. Douglas of Illinois, outstanding exponent of economy in government, this practice costs the government several hundred millions annually.

There is also a subterfuge which is frankly employed by the VA itself, which has proved a costly evasion of the law. Under the authority of Congress, the VA was permitted to give care to non-service-connected disabilities provided accommodations were available. According to the report of the medical task force, the VA has taken advantage of this permission by building numerous hospitals solely for the care of such patients. Veterans with service-connected injuries, meanwhile, were moved to other hospitals.

There, in brief, is a picture of the present federal medical system. All the evidence—the findings of the medical experts who have studied the federal medical system for the bipartisan Hoover Commission, the experience of hundreds of private physicians and many thousands of veterans who have been confined in federal hospitals—points strongly to two basic conclusions:

1. Government medical services, through the years, have grown without over-all supervision into a confused, extravagant collection of competing agencies. They are wasting medical manpower and facilities and getting in each other's way. An-

other is a maldistribution of doctors to the detriment of large areas of the population.

2. This is a doctor's problem. Every action of the government in the area of medicine affects the private practitioner in one way or another. Our federal government, you will recall, is by far the largest single employer of doctors and the biggest operator of hospitals in the land. It is required to provide some form of free medical care for some twenty-four million people at an annual cost of approximately two billion dollars. These are the facts. Each doctor must voice his objections to the government for ignoring the needs of the civilian population by the wasteful use of medical manpower by building more hospitals than it can staff, and allowing lay officials to oversee doctors in the purely medical functions of the VA.

The present situation calls for action—action by doctors. The stark fact is that there is now pending before Congress, legislation that would set up a Federal Department of Health (bills S. 1140 and H.R. 3688 and 3305). In the opinion of many, these bills are good ones. They would cure many of the evils that presently exist. Others, however, feel the bills are not strong enough, that the medical profession is not adequately protected. And still others, of course, believe that nothing should be done.

That something *will* be done, however, is clear. It is also extremely clear that unless the doctors of the country make their voices heard in Congress, some legislation engineered by lay groups may be passed that could have disastrous results for the medical profession. Certainly Congress cannot be blamed if they are not informed as to how the doctors feel about this important legislation. Certainly Congress cannot be blamed if medical men have not enough self-interest to state their position.

The Solution

There are many anomalies and contradictions in the working of our federal government, as you have seen, and not the least of these lies in the fact that in the movement for the reorganization of the federal medical services the 208,000 doctors of the country have not been consulted.

As I have said previously, the nation's health is first of all a doctors' problem. The public health is their business. Their ranks are increased each year by the graduation of 6,000 students from seventy-nine medical schools. The annual cost of medical education in the country is $80,136,000.

These young doctors plan a life of service to the ailing public, and they, with their elders, are properly disturbed by unregulated operations of the government in the field of health and by the dislocation and maldistribution of doctors by government agencies. Therefore, in the forthcoming hearings on the reorganization bills (S. 1140 and H.R. 3688 and 3305), designed to streamline the confused setup of government medical agencies, the views of the medical profession will be essential and should merit attention.

It is quite possible that if the doctors had been consulted in the expansion of the government medical agencies, we might be in a very different situation; but they weren't.

The huge two-billion-dollar structure, involving the care of twenty-four million citizens legally entitled to federal health service, was created and expanded, even in its professional and medical aspects, by laymen. Certain doctors, like Dr. Paul Magnuson, former medical director of the VA, raised protests against lay authority over purely medical matters, without avail. They were either ignored or, as in the case of Dr. Magnuson, summarily dismissed by General Carl Gray, administrator of the VA.

However, the Hoover Commission, when it surveyed the whole field of federal medicine with the mission to make recommendations for its improvement, realized the need for professional medical opinion, and as a result, when it named the seventeen-man task force to carry out the actual investigation in this area, eleven of the appointees were doctors, and most of the others were experts in hospital administration.

So, it was doctors who made this study, and it was doctors who made the recommendations of the task force which later became substantially the recommendations of the Hoover Report.

And unless we doctors follow through and see that this legislation, or some remedial legislation, is enacted to correct the scandalous conditions of duplication and waste in the federal system, laymen again will take over, and we could easily be right back where we started.

I have told you what the Commission found—a vast, competitive organization, of which the parts cared nothing about the whole, and where unnecessary hospitals were thrown up in inaccessible places to please some politician. And how, in a

cut-throat competition, the various agencies competed for scarce medical personnel and enticed away, by offers of higher salaries, medical personnel from community hospitals sponsored by the government under the Hill-Burton Act.

Now, let's see what the Hoover Report recommended to reform these evils. The Commission made eleven recommendations, all having to do with a plan for the unification of all federal medical services under a single control, and then appended this comment on the results of the adoption of its recommendations:

1. The general standard of federal medical care would be improved.

2. There would be central supervision of the major federal medical care, public health, and medical research activities. Unified responsibility is the key to good management. The President, the Congress, and the public could look to one man for results.

3. Construction costs could be standardized and reduced.

4. Federal hospitals could be utilized to the fullest extent by eliminating present distinctions as to the particular types of beneficiaries for which each can care. After all, a patient is a patient whether he is a veteran, a merchant seaman, or in the Army, Navy or Air Force.

5. The medical manpower at the call of the federal government could be used to the fullest extent, and present deficits in skilled personnel could be greatly reduced.

6. The need for any draft of medical manpower in time of peace would be greatly lessened.

7. The cost of health and medical services would be clearly identified and known to Congress.

8. The facilities of private hospitals and the skills of physicians in private life and in the universities could be utilized far more effectively than they are now.

The bills now before Congress contain the recommendations of doctors who had in mind the effects of the present system upon their own profession and upon the welfare of the whole people. It was considered highly desirable to explore the thinking of all the doctors, and to bring this thinking into a focus upon the legislative action before these bills come up for action. This was the motivation that resulted in the formation of the Doctors' Committee for Improved Federal Medical Services.

Mr. Hoover and Dr. Robert L. Johnson, president of Temple University and chairman of the Citizens' Committee for the Hoover Report, asked me to undertake the formation of such a committee. I was glad to do this not only because I was concerned over the whole question of federal medicine and apprehensive over the possible fate of the proposed legislation in the hands of politicians and laymen.

At a meeting held in my home in New York we organized the committee and were able, at that meeting, to form an advisory committee of representative medical men from all parts of the country. They represent all of the recognized branches of medicine. This is the committee:

Charles Fletcher McCuskey, M.D., Anesthesiology, Los Angeles, California. Frank Carmia, M.D., Dermatology and Syphilology, New York, New York. Samuel Arthur Garlan, M.D., General Practice, New York, New York. Maxwell Myer Wintrobe, M.D., Internal Medicine, Salt Lake City, Utah. George Edward Burch, M.D., Cardiology, New Orleans, Louisiana. Richard Hale Young, M.D., Medical Education, Chicago, Illinois. Howard Clifton Naffziger, M.D., Neurological Surgery, San Francisco, California. Charles Denton Kerr, M.D., Obstetrics and Gynecology, Houston, Texas. Donald Marshall, M.D., Ophthalmology, Kalamazoo, Michigan.

Lewis M. Overton, M.D., Orthopedic Surgery, Albuquerque, New Mexico. Clair Michael Kos, M.D., Otolaryngology, Iowa City, Iowa. Thomas Byrd Magath, M.D., Pathology, Rochester, Minnesota. Lee Palmer, M.D., Pediatrics, Louisville, Kentucky. George D. Wilson, M.D., Physical Medicine, Asheville, North Carolina. James Barrett Brown, M.D., Plastic Surgery, St. Louis, Missouri. Brigadier General James Stevens Simmons, M.C., Preventive Medicine and Public Health, Boston, Massachusetts. Herbert Spender Ripley, M.D., Psychiatry and Neurology, Seattle, Washington. Arthur Bradley Soule, Jr., M.D., Radiology, Burlington, Vermont. Richard Kennedy Gilchrist, M.D., Surgery, Chicago, Illinois. Henry Swan, M.D., Thoracic Surgery, Denver, Colorado. Charles Rieser, M.D., Urology, Atlanta, Georgia.

With this nucleus we began the recruiting of state chairmen of the national committee, and are fortunate at this writing to have state chairmen in thirty-nine states. They are, as you will see, a very representative group of doctors. This is the list:

Gordon M. Hankins, M.D., Fairfield, Alabama
J. B. Wharton, Jr., M.D., El Dorado, Arkansas
Dwight L. Wilbur, M.D., San Francisco, California
M. P. Pitock, M.D., Bridgeport, Connecticut
W. Edwin Bird, M.D., Wilmington, Delaware
Elwyn Evans, M.D., F.A.C.P., Orlando, Florida

Bernard P. Wolff, M.D., Atlanta, Georgia
Harlan English, M.D., Danville, Illinois
Joseph B. Davis, M.D., Marion, Indiana
William B. Bean, M.D., Iowa City, Iowa
Thomas Findley, M.D., New Orleans, Louisiana
Cecil D. Snyder, M.D., Winfield, Kansas
Adrian H. Scolton, M.D., Portland, Maine
Wetherbee Fort, M.D., Baltimore, Maryland
Richard Warren, M.D., Dedham, Massachusetts
L. W. Hull, M.D., Detroit, Michigan
C. D. Creevy, M.D., Minneapolis, Minnesota
Herbert Randolph Unsworth, M.D., Pass Christian, Miss.
Joseph C. Edwards, M.D., St. Louis, Missouri
Lynn T. Hall, M.D., Omaha, Nebraska
Fred M. Anderson, M.D., Reno, Nevada
Radford C. Tanzer, M.D., Hanover, New Hampshire
Stuart Zeh Hawkes, M.D., Newark, New Jersey
C. M. Thompson, M.D., Albuquerque, New Mexico
Brittain Ford Payne, M.D., New York, New York
Duane F. Pile, M.D., Crosby, North Dakota
K. F. Swanson, M.D., Tulsa, Oklahoma
W. J. Weese, M.D., Ontario, Oregon
T. Grier Miller, M.D., Philadelphia, Pennsylvania
Vince Moseley, M.D., Charleston, South Carolina
Edward A. Rudolph, M.D., Aberdeen, South Dakota
H. H. Shoulders, M.D., Nashville, Tennessee
Chauncey D. Leake, M.D., Galveston, Texas.
Kenneth B. Castleton, M.D., Salt Lake City, Utah
E. Berkeley Neal, M.D., Roanoke, Virginia
Ernest Martin Burgess, M.D., Seattle, Washington.
E. L. Gage, M.D., Bluefield, West Virginia
Russell F. Wilson, M.D., Beloit, Wisconsin
Russell I. Williams, M.D., Cheyenne, Wyoming

The Doctors' Committee for Improved Federal Medical Services is in no sense a policy group. It is nonpolitical, nonpartisan. It requires no fee. It is purely temporary, and was set up purely to find out what the doctors of the country think about the proposed reform of the federal medical system and to try to bring that thinking, whatever its nature, to bear upon the congressional consideration of the problem. The Committee is not trying to proselyte for the bills. It is not so much concerned with what the doctors think about the subject as that they do think and, we hope, will make their opinions known to Congress.

Information on this whole subject is available at the office of the Doctors' Committee for Improved Federal Medical Services at 15 West 46th Street, New York 19, New York, and I suggest that you write for this material.

There are three steps which the doctors can take in the solution of this national problem:

1. Become informed and aware of the gross injustices which have been imposed upon the medical profession and the public.

2. Write to the chairmen and members of the Senate and House Committees on Expenditures in the Executive Departments which have the medical services bills under consideration. They are:

Congressmen William L. Dawson, Illinois; Chet Holifield, California; Hender L. Lanham, Georgia; Porter Hardy, Jr., Virginia; Frank M. Karsten, Missouri; John W. McCormack, Massachusetts; Herbert C. Bonner, North Carolina; John A. Blatnik, Minnesota; Harold D. Donohue, Massachusetts; M. G. Burnside, West Virginia; Richard Bolling, Missouri; John F. Shelly, California; W. J. Bryan Dorn, South Carolina; Sidney A. Fine, New York; William C. Lantaff, Florida, and Walter S. Baring, Nevada.

Clare E. Hoffman, Michigan; R. Walter Riehlman, New York; Cecil M. Harden, Indiana; George H. Bender, Ohio; Charles B. Brownson, Indiana; Thomas B. Curtis, Missouri; William E. Miller, New York; Marguerite S. Church, Illinois; George Meader, Michigan; William E. McVey, Illinois; Alvin R. Bush, Pennsylvania.

The Senators are: John L. McClellan, Arkansas; Clyde R. Hoey, North Carolina; Herbert R. O'Conor, Maryland; Hubert H. Humphrey, Minnesota; A. S. Mike Monroney, Oklahoma; Blair Moody, Michigan; T. R. Underwood, Kentucky; Joseph R. McCarthy, Wisconsin; Karl E. Mundt, South Dakota; Margaret Chase Smith, Maine; Andrew F. Schoeppel, Kansas; Henry C. Dworshak, Idaho, and Richard M. Nixon, California.

3. Join the Doctors' Committee for Improved Federal Medical Services. Try to stimulate discussion on this problem and try to interest the medical associations to which you belong to hold open discussions on the subject.

The doctors of this country, I believe, now have perhaps their last opportunity to use their influence to bring order into the chaos of federal medicine.

JMSMS

Two to four million physically handicapped persons in the United States represent the "most workable and most willing and eager workers" of all groups from which additional labor must be recruited by industry to ease the manpower shortage, declares Dr. Howard A. Rusk, chairman of the Health Resources Advisory Committee of the Office of Defense Mobilization. Rusk states that evidence showed that in many instances handicapped people now employed had a better production record, a better absentee record, a lower accident rate, and five to nine times less labor turnover than other persons.

Subtotal Gastrectomy with Postoperative Complications

A Case Report

By Harry C. Saltzstein, M.D., and
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THERE WAS A saying in the first World War that it was no disgrace to be caught with cooties (lice), but it was a disgrace to keep them. By a weak analogy, one cannot always avoid postoperative complications, but with the means at our disposal today, there are very few postoperative complications which one cannot surmount. It is sometimes remarkable what the human organism will stand and overcome, provided the clinical signs and laboratory data are read and interpreted correctly, and the proper regime is instituted. The following case is reported in this spirit.

After a difficult subtotal gastrectomy for duodenal ulcer, the patient in rapid succession developed pulmonary atelectasis, massive thrombophlebitis of the right leg, probable pulmonary embolism or spreading embolic pneumonia, massive leakage from the duodenal stump, dehydration and postoperative azotemia from the second operation (jejunostomy) and then a period of cerebral confusion. Convalescence was not unduly delayed, and he was entirely restored to normal.

The patient (Mr. B., aged forty-three, referred by Dr. Sugarman and Dr. Sandweiss) had had a chronic duodenal ulcer for a number of years. For the past five years "he never went anywhere without a bottle of milk." He had enjoyed his liquor, but he was not able to take any for the last five years because of the ensuing pain.

On February 26, 1951, a subtotal gastrectomy was done. The patient was a rounded, muscular, heavy-framed individual weighing 225 pounds, with a heavy intra-abdominal panniculus making any kind of exposure difficult. Each intra-abdominal maneuver had to be done carefully, and any loosely clamped bit of tissue bled freely. In addition, he took a rather difficult and poorly-relaxed anesthesia. The stomach was short, high under the costal margin, and it was exposed with difficulty. The incision was mid-line from the ensiform to the left of the umbilicus, and even with a 3-inch cross-cut at the level of the right costal margin, exposure was not too easy. The duodenum was cut across at the pylorus. The deep ulcer crater in the bed of the pancreas on the superior border of the duodenum was then easily visualized. This could not be closed satisfactorily, although it was thought that with multiple opposing sutures (the upper edge of the duodenum could not be inverted) the closure was adequate. The stump region was drained with one Penrose drain. The gastric resection was done fairly high, and routine posterior Hoffmeister-Polya anastomosis was done, using a short proximal loop.

The Pulmonary and Vascular Complications.—Next day the patient was slightly cyanotic and had a temperature of 103°. With considerable pounding on the right chest posteriorly, he coughed up a large mucous plug, which we thought remedied his pulmonary atelectasis. The following day there was swelling in his right calf and localized tenderness. Depo-heparin was started on the second postoperative day; however, 400 mg. intramuscularly initiated some fresh blood coming through the Levine tube after twelve hours, and it was discontinued. There had been no bleeding via the Levine tube until then. Clotting time, taken twenty-four hours after this, was twice normal (20 min.—normal 10 min.).

On the third postoperative day (March 1, 1951) he developed sudden pain in the left chest, and then in the right chest one day later. This was accompanied by fine moist râles in both lower lung fields. X-ray showed no evidence of any (embolic) pneumonia. The chest finding subsided slowly. For the next ten days one could hear fine moist râles in the right base; the left chest was clear.

The right leg and thigh became quite swollen and painful. On March 6 (eighth day postoperatively), the right leg 7 inches below top of patella was 2½ inches larger in circumference than the left, and the right thigh 7 inches above the top of the patella was 1 inch larger than the left. A right para-vertebral injection was given by Dr. Hesselschwerdt (12-3 and 3-4. 10 cc. 2 per cent procaine and 2 to 5 cc. eucupin in oil at each site).

The pain in the leg was considerably relieved. The edema subsided slowly.

Anticoagulants were started again on the sixth postoperative day (tromexan, 1500 units in twenty-four hours, given by mouth dropped the prothrombin time to 32 per cent of normal). It was then given through the jejunostomy tube (see below); 600 mg. per day were required to keep the prothrombin time in the 30 per cent range. There was no cumulative action, such as one sees with dicoumarol. When he left the hospital (March 25, 1951) the right calf was about ¾ inch larger than the left, and there was no difference in the thighs. When walking about the room, there was a bluish discoloration of the right leg, and some edema at and above the ankle would develop. However, with an elastic stocking this was not uncomfortable.

The Duodenal Leak.—Two days postoperatively there was some show of biliary drainage on the abdominal dressing. Within three or four days this lessened, and it was hoped that there was only a mild leak. But on about the fifth or sixth day, duodenal contents poured forth out of the abdomen in a very profuse fashion. A Bellinger ileostomy cup was fitted onto the abdomen; this kept the abdomen dry for a time, and all of the discharge contents could be collected; however, after three or four days the secretions got underneath the glued rubber cup and it had to be discontinued. A Sump drain was then

From the Surgical Service, Harper Hospital.

inserted into the wound (March 7); this kept the skin dry and worked in a perfectly satisfactory fashion for the three weeks in which it was used. It undoubtedly was a major factor in saving his life, because it kept the secretions from pooling in the depths, and by being collected into a bottle, all of the lost upper intestinal secretions could be re-fed to the patient through the jejunostomy (see below).

The drainage from the leaking duodenum was now (seventh day postoperatively, March 5) pouring out at the rate of 1200 to 1500 cc. in twelve hours (Fig. 1). In spite of the fact that the patient was still running a fever and had signs of pulmonary involvement, it was decided to do an emergency jejunostomy for feeding purposes; otherwise one could not maintain his fluid ballance. This was done on March 7. Following this, his temperature rose to 104°, pulse 140, and the patient became quite dry. At times he was a bit irrational. Blood nitrogen rose to 62. Two or three days of rather careful hydration (blood chlorides were never a problem since they were replaced accurately as lost) corrected this. Then followed (March 10) two or three days of more restlessness, disorientation and violent thrashing about the bed. At times it required three or four nurses to hold him. During these few days, however, the nitrogen blood level was subsiding, and his disorientation was thought to be merely the residual extra-renal azotemia which the patient was correcting by himself. The gastrointestinal continuity functioned O.K., and there was never any uncertainty about the peristaltic efficiency. His bowels had moved within three or four days after the gastrectomy. After the jejunostomy was made, as soon as one could hear bowel sounds (after about forty-eight hours), jejunal feeding could be done efficiently and adequately. The drainage from the duodenal stump was saved and re-introduced through the jejunostomy tube. Since this was about 3000 cc. a day, this amount of electrolytes and other intestinal juices were saved for the patient. By about March 10 (three days after jejunostomy) in addition to the re-fed intestinal contents, a jejunal formula could be added. There was slight diarrhea for one day only, and stools then became formed—never more than three per day.

March 14: Patient had been taking some ice chips by mouth. Methylene blue introduced into the jejunal feeding tube did not come through the abdominal drainage site in twenty-four hours. Evidently the jejunum accommodated itself to the feeding and did not dam back, even though 250 cc. an hour was introduced. When given by mouth, however, it came through in fifteen minutes. Therefore, absolutely everything by mouth was stopped. The duodenal drainage now rapidly decreased in amount.

March 17: The duodenal drainage now dropped to 350 cc. in twenty-four hours, and three days later there was only 35 cc. in twenty-four hours. The sump drain was removed on March 20. Feeding by mouth was started on March 22. Jejunostomy tube was removed on March 24.

There was no further abdominal drainage after the sump drain was removed. Feedings by mouth were well tolerated and stepped up rapidly to a modified ulcer diet on March 24. He was discharged on March 26, 1951.

Progress Note.—Following his discharge from the hospital, he was maintained on anticoagulants for three weeks (tromexan 600 mgm. every day; his prothrombin time (quick) was kept at 50 to 55 per cent of normal). The drug was then discontinued.

There was slight residual edema of the right leg, which slowly improved. There was no postprandial gastric distress.

On April 24, 1951, one week after stopping the tromexan, and one month after his discharge from the hospital, he suddenly felt weak and vomited bright red blood. Shortly he had a black tarry stool. He was immediately hospitalized. He was in shock, blood pressure 70/40, pulse 140, with some air hunger, pallor and slight cyanosis. His blood pressure stabilized after he received 1500 cc. of blood. Bleeding continued for twenty-four hours, during which time he received another 1500 cc. of blood. There were some tarry stools during the first twenty-four hours, and a few intermittently during the next two to three days, but after that there was no further bleeding.

Seven days after admission, while in the hospital, he had a sudden right lower mid-axillary chest pain with slight cough and blood-streaked sputum. Râles were heard in right lower lateral chest region. X-ray showed lobular areas of atelectasis, compatible with the diagnosis of pulmonary infarct. It was felt that this was a pulmonary infarct from the old thrombophlebitis of the right leg.

He was discharged again on April 29. At this time there was only an occasional râle in the right chest.

When last seen, July 5, 1951, he had no complaints; no dumping syndrome, no further bleeding. He eats a full diet without distress, and is gaining weight. He gets about his work (sales manager automobile company) without any discomfort or disability from his right leg. There is no enlargement of his right leg.

Comments

Duodenal Stump Closure.—As more and more duodenal ulcer patients are being "cured" medically, the surgeon gets more and more of the complicated, scarred and obstructed duodenums to operate upon. In fact, unless such is the case, the operative indication should be seriously reconsidered. There are certain cases in which the duodenum cannot be closed in a satisfactory fashion. These are usually duodenal ulcers abscessed into the pancreas, multiple ulcers, ulcers near the entrance of the common duct or below it, or those causing cicatricial contraction and shortening of the duodenum, so that nothing remains above the ulcer bed to suture.

In this situation, which cannot always be predicted, one has several choices. The usual method

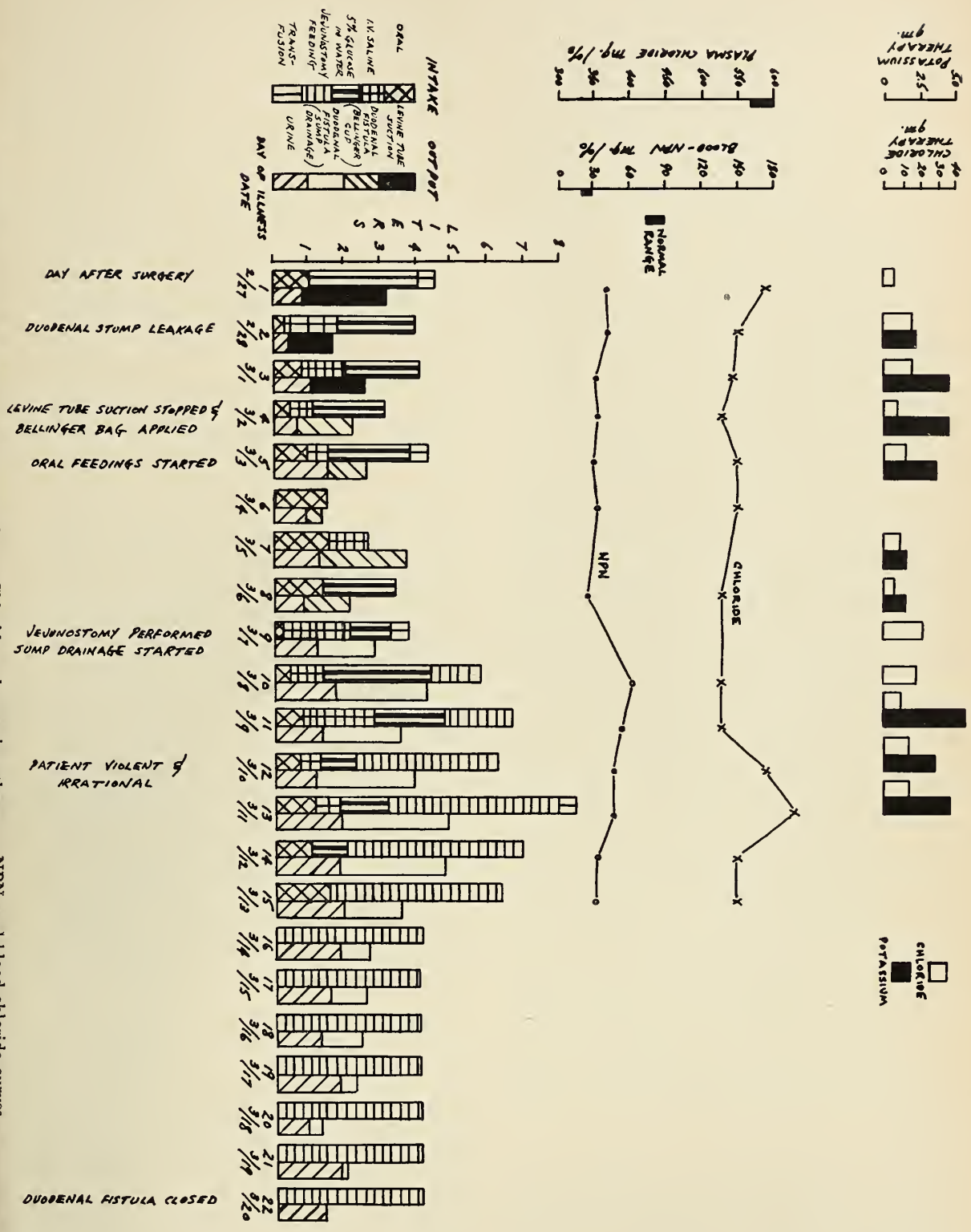


Fig. 1. Clinical course of patient. Intake-output chart. Chloride and potassium therapy. NPN and blood chloride curves.

is to fold the duodenum onto the open base of the ulcer in the pancreas, with whatever security of the suturing one can obtain. Another choice which has become popular recently is to divide the stomach 2 or 3 centimeters proximal to the pylorus, carefully cone out the mucous membrane to the duodenum, and oppose the two walls of the remaining stomach together with multiple suture lines. The disadvantage is that a very small bit of gastric mucosa left in may later regenerate and produce recurrent ulcer by acid stimulation from the antral mucosa.

A third choice is to divide the stomach high up, do the routine gastroduodenal anastomosis, then at a second stage, six weeks later, and after the inflammatory mass about the pancreas has subsided, remove the antrum and close the duodenum. The second stage must be done no matter how well the patient feels; otherwise there will be 100 per cent chance of marginal ulcer (McKittrick).

An old principle which dates back to Bilbroth (1881) is to leave a duodenal fistula with drainage of some sort when one could not close the duodenum satisfactorily. In 1949 Welch,[19] of the Massachusetts General Hospital in Boston, advocated leaving a catheter in the duodenum, and enfolding the duodenum about it, if one could not close the duodenum satisfactorily. It is an expedient and a last choice apparently, because some of his cases had a stormy convalescence. Priestley[14,15] of the Mayo Clinic recently advocated the same procedure and reported two cases where there was duodenal drainage for only a week or ten days, and this closed spontaneously. It is similar in theory to a T-tube drainage after exploration of the common duct, and the advantage is merely that "it is preferable to drain the duodenum directly by a catheter rather than to drain the periduodenal area with a piece of rubber tissue" (Priestley). In our case, in retrospect, perhaps a duodenostomy catheter drainage would have been preferable. However, the duodenum had been sutured over with several layers of omentum and pancreas, etc., and once the sinus started healing, there was evidently sufficient depth to the tract so that it healed promptly.

Duodenal Fistula.—When a duodenal fistula develops, it must be handled promptly and adequately, and it is not necessarily fatal. If massive peritonitis ensues, that is usually the end. However, most of them will close in a matter of some weeks if nutrition and electrolyte balance are maintained. This happened in our case. We were concerned when the duodenal stump leaked as much as 3000 cc. in twenty-four hours, but on learning that a duodenal stump can drain as much as 5000 cc. in twenty-four hours,[9] we were a bit comforted. The sump drain, introduced to surgery by Babcock[2] of Philadelphia, consists simply of an outer metal shell with multiple small perforations and an inner aspirating metal tip going down to the bottom of the well. The tissues do not press in and stop up the drainage opening, and there is no pooling in the depth. Wangensteen suction applied to this inner tip was adequate. Sometimes heavier suction is required, such as a Stedman pump or a nose and throat aspirator. Electrolyte balance was maintained throughout; as noted in the chart (Fig. 1), at no time did the chlorides drop below 500 mg. per cent.* He was a robust and heavy man and surmounted all his body chemistry problems with a good deal of stamina.

Jejunal Feeding.—Jejunal feedings, either for poorly nourished patients unable to eat, or for the immediate postoperative period following gastrectomy, have never become popular. The reason probably is that the formulas heretofore available, chiefly the Scott-Ivy formula[16] and that introduced a few years ago by Hollander,[8] contain whole milk. The jejunum is intolerant to the fat in whole milk, and cramps and diarrhea ensue.

Fraser[6] of England recently has propounded a new theory of fat digestion in the intestine. The previous (lipolytic) theory has been that all fats are completely hydrolized in the intestine by the pancreatic enzymes, absorbed through the lining of the intestine as fatty acids, and then resynthesized in the intestinal mucosa into phospholipids. Fraser thought that, in addition to this, there took place in the intestine an emulsification of the fat

*Chlorides, given as intravenous saline, were replaced as lost in the urine and duodenal secretions. He never required more than 1 or 2 liters of normal saline to keep him in balance. Potassium (1 or 2 ampoules 1.5 gm. each) was added to the intravenous solution throughout the period when nothing was given by mouth. When he was dehydrated, became irrational, and had nitrogen retention, he needed chiefly water. The jejunostomy was now functioning, and, as indicated in the chart, 4000 or 5000 cc., could be introduced in twenty-four hours. Thus, on March 11, 1951, he received 5000 cc. via jejunostomy tube, of which 3000 cc. was aspirated duodenal contents, 1500 cc. intravenous glucose and water, 1000 cc. intravenous saline and 500 cc. blood. (Fig. 1.)

Protein hydrolysates were not used. He required only four small transfusions. Urine output was adequate, even when his blood nitrogen was elevated.

(by some of the fatty acids and bile salts) whereby the fats were broken down into particles less than 0.5 micron in diameter and not hydrolyzed. These are absorbed directly as unchanged fat through the intestinal mucosa and pass directly into the lacteals to the thoracic duct, or into the blood stream to the liver.

On this basis, Case, Zollinger and their associates[3] in the Ohio State University Hospital tried homogenized milk, which is simply milk in which the fat globules have been broken down to one-fifth their previous size. Whereas the fat particles in normal milk are 4 micra in diameter, in homogenized milk they average 0.76 micra, about one-fifth as large. Homogenized milk in their hands was an adequate food and caused no cramps or diarrhea.

Milk is still the ideal food for jejunostomy feedings. It is universally available, of moderately high caloric value, almost complete nutritionally, and inexpensive.[18] A liter of homogenized milk contains 750 calories and 35 grams of protein; 0.6 cc. of Vi-Syneral per liter (vitamin mixture containing A, D and all of the elements of B) is all that it is necessary to add. The jejunum will tolerate 50 cc. of 5 per cent glucose in normal saline every hour, starting six hours after operation. Next morning 50 cc. of homogenized milk can be given every hour, and on the second postoperative day 100 cc. every hour, then on the third day 200 cc. every two hours. If long-term feeding is necessary, Zollinger found by trial and error that the jejunum would tolerate, in addition to the homogenized milk, 50 grams of protein-hydrolysate (Mead Johnson) per liter, and 60 grams of Dexin (starch hydrolysate) (Burroughs Welcome). This made a mixture of 4 per cent fat, 5 per cent protein hydrolysate, and 6 per cent starch hydrolysate. Fifty grams of pureed liver, which is available as canned baby food, were added. This gave 1100 calories and 82 grams of protein per liter; 3000 cc. would contain 2,500 calories and 180 grams of protein.

In our patient, the short-term jejunostomy feeding of Zollinger worked beautifully. At first 50 cc. of the mixture was given; the following day it was stepped up to 100 cc. per hour, and on the third day he was receiving 200 cc. per hour. At no time were there any cramps or diarrhea. We were careful not to overload the jejunum until after bowel sounds indicated peristalsis. As stated above, the gastrointestinal motility in this patient was never a problem, and within forty-eight hours after the jejunostomy he had a spontaneous bowel movement. The homogenized milk feedings were then introduced quite readily without any discomfort.

Thrombophlebitis.—The therapy of postoperative thrombophlebitis still presents its problems. We have never been advocates of prophylactic femoral ligations, and have never done them. Where repeated pulmonary emboli with hemoptysis continued in spite of adequate anticoagulants, we have occasionally ligated the superficial femoral vein. It is evident from the literature that at present thrombophlebitis is being dealt with largely by anticoagulant therapy. Lahey[11] states that in 1949 their clinic employed femoral ligation only ten times in all of their surgical material. Their indications were: (1) hemorrhagic disease, (2) severe liver disease, (3) intensive bleeding cases such as ulcerative colitis, (4) brain surgery, (5) where bleeding may be expected in the immediate postoperative period, such as posterior resection for carcinoma of the rectum or resection of the prostate, and, (6) recurrent pulmonary embolism in ambulatory phlebothrombosis. Everts Graham,[7] in the 1950 *Year Book of General Surgery,* states: "Anticoagulants are favored except in patients with advanced degenerative diseases, in those with a bleeding hazard, or in those who have had repeated or septic emboli during anticoagulant therapy." Kirby and Fitts[10] of Ravdin's Clinic state that their enthusiasm also was dampened by "the occurrence in October, 1947, of two deaths from pulmonary embolism following prophylactic ligations." They also quoted a study by Erb and Schumann[5] from the Philadelphia General Hospital (personal communication) of 100 consecutive cases of patients with hip fracture. Bilateral superficial femoral ligation was done on alternate patients. Deaths from massive pulmonary embolism occurred in two of the fifty ligated patients and in two of those not ligated. In addition, nonfatal pulmonary infarction occurred in seven patients following the ligations, and in four who were not ligated.

Anticoagulants.—Anticoagulant therapy by the drugs available at present is not easy, and still is not entirely satisfactory.[1] Sterling Nichol[12] in a questionnaire survey of 136 physicians experienced in anticoagulant therapy, which included 15,000 patients receiving either dicoumarol or heparin,

found that there were 2 per cent major hemorrhages and 12 per cent minor hemorrhages. The major hemorrhages were predominantly from the urological tract, but many of them were gastrointestinal, pulmonary or associated with the postoperative site. Ninety per cent of the deaths followed dicoumarol therapy. Heparin is a better drug than dicoumarol (DeTakats[4]). It prevents all of the factors of coagulation, whereas dicoumarol inhibits only the prothrombin formation in the liver. The laboratory control is easier, and it is not accumulative in its action. This does not apply to depo-heparin, which is subject to all depo-medication of this sort, in that accumulation is possible.

The use of dicoumarol has its worries. The requirements from patient to patient fluctuate greatly, the laboratory control is not always reliable, there is a delay of thirty-six to forty-eight hours before it protects against thrombosis, there is a danger of hemorrhage if sufficient dicoumarol is used to be of positive and undoubted value (at least according to some authorities) and the effects last so long that it may be dangerous.* We had one patient, a frail woman, with an advancing abdominal malignancy, in which it was difficult for us to stop hemorrhage from the gastrointestinal tract for several days following a dose of dicoumarol (150 mg.). The effect lasted for a week or ten days; when a small dose was again given some weeks later, the same phenomena occurred.

New drugs are being brought out to remedy the above defects in anticoagulant drugs. Tromexan,[17] a new drug in the dicoumarin series, in clinical use seems to avoid some of the difficulties inherent in dicoumarol. The effect is much more predictable. A single dose acts within eighteen to twenty-four hours, and so far as we have observed in several cases in which we have used it, there is no accumulation. If the drug is discontinued, prothrombin time shoots up to normal within twenty-four hours. The dose is larger—1200 to 1800 mg. may be necessary to bring the prothrombin time down to therapeutic level (the same as for dicoumarol, 25 per cent of normal activity), and maintenance dose varies from 300 mg. (1 tablet) to 600 mg. or sometimes 900 mg. per day. Because it is so rapidly destroyed, the drug must be given in divided doses every eight or every twelve hours.

*It is bound to the plasma protein and may remain in the blood stream a long time. The summation effect is greater than mere addition of the effect of the same dose given daily.

In the above case, it worked to our entire satisfaction. Also, it was continued in the ambulant phase, and the massive thrombophlebitis which he had subsided, although slowly. Olivier,[13] by using phlebography before and after treatment, showed that even "removal of the obstruction in the vein resulted from early intensive and prolonged treatment with anticoagulants."

Summary

A patient underwent subtotal gastrectomy for duodenal ulcer. Postoperative complications were: pulmonary atelectasis, massive femoral thrombophlebitis, possible embolic pneumonia, massive duodenal leakage, extra renal azotemia and dehydration following a secondary jejunostomy.

The clinical course and the therapy are detailed and discussed.

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Painful States of the Shoulder and Arm

Diagnosis and Treatment

By Robert C. Bassett, M.D., and
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PRECISE LOCALIZATION of the origin of pain in the shoulder and arm is one of the most difficult problems confronting the physician. The reasons for this are structural mobility of the cervical spine, complexity of the shoulder joint, and intimacy of neural and skeletal structures, facilitating overflow of reflex sensory nerve ending stimulation to the neck, shoulder, arm, and hand. Apparent radicular pain on this basis may easily mask the primary source of the pain.

The usual lesions responsible for this picture fall into two groups according to their origin, namely; those disorders directly affecting the nerve supply to the shoulder and extremity and disorders of the musculo-skeletal system. Keeping these origins of shoulder and arm pain in mind, one then has the basis for more accurate differential diagnosis for which appropriate therapeutic steps may be taken.

Basic Neuromuscular Disorders

Root Syndromes

It is in this group of disorders that overlap of skeletal etiology for shoulder and arm pain is outstanding.

Compression Fractures with Hypertrophic Changes (Lipping).—This is one of the commonest causes of radicular pain in the upper extremity. The pain radiates over the course of the median nerve usually due to compression changes in the bodies and foramina of C-5 and 6. These two vertebrae are most subject to trauma, since at this point the cervical spine has its greatest freedom of motion (Fig. 1). Pain in the shoulder, inner arm, and thumb side of the forearm and hand is the area of distribution. When C-7 and D-1 are involved, the pain is on the little finger side of the hand. There is associated suppression of the triceps reflex. There may or may not be weakness of grip, and hypesthesia to anesthesia in the segmental distribution involved. These findings are definite and pronounced when frank extrusion of the intervertebral disc is present.

Results of conservative treatment are satisfactory in most instances with specific use of head-halter traction, heat and salycilates.

Herniated Cervical Disc.—As described above, this picture is characterized by severe neck, shoulder and arm pain associated with spasm of the deep muscles of the neck, and radicular pain, usually in the distribution of C-5 and 6, and not infrequently in the distribution of C-7, 8 and D-1 (Fig. 2). There is hypesthesia to anesthesia in the segmental supply involved and variable weakness of grip with absence of the triceps reflex. The pain is usually sudden in onset, associated with some torsion or flexion injury of the neck, or it may come on gradually after the traumatic insult. Such trauma need not necessarily be violent and need only assault the cervical spine when it is in a position of mechanical disadvantage to resist compression and extrusion of the disc. With total extrusion of the disc the pain is intractable, unrelieved by any of the above conservative methods, and usually made worse by traction rather than helped. It is necessary to employ narcotics for the control of pain. If pain persists at complete rest with the cervical spine maintained in the anatomic axis with traction, surgical treatment is usually necessary. Total extrusion with the initial insult is not the rule, and fortunately, the largest percentage of these lesions respond to conservative measures.

The cervical disc may give recurrent difficulty over a period of years and when long-standing may be associated with calcification and overlap by the hypertrophic lipping of the posterior borders of the vertebral bodies, particularly about the lateral plate and foramen. The disc itself may become calcified. In this instance the involved roots may be decompressed by unroofing the foramina.

The persistence or recurrence of pain following adequate root decompression in any of the above instances is usually due to intraneural scarring or local functional mechanical defect, and if no relief is obtained by recumbency or halter traction, section of the involved posterior roots may be necessary. Residual numbness from this procedure never exceeds the initial defect, and relief is complete and permanent.

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Spinal Cord Tumor.—Tumors of the vertebral column, spinal cord or its covering may produce isolated roots signs early. However, they rarely enter into the differential diagnosis here since they are usually accompanied by other obvious signs.

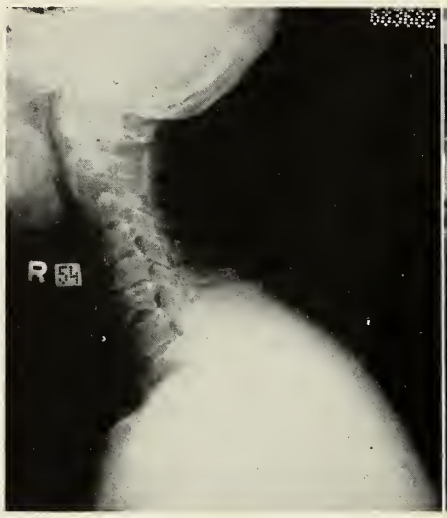


Fig. 1. Old compression fracture C-4 with marked hypertrophic lipping posteriorly associated with marked reduction of the interspace between C-5-6 and encroachment upon the foramina, producing root pain.



Fig. 2. Obliteration of interspace between C-6-7 due to total extrusion of intervertebral disc.

Brachial Plexus Syndromes

In this group of disorders the clarifying differential point is the absence of purely segmental peripheral changes seen with root involvement. Commonest of these are the anterior scalene syndrome and the cervical rib syndrome, the latter being associated with the former. Anterior scalene compression of the plexus occurs without the presence of supernumerary rib.

Anterior Scalene Syndrome.—This can be qualified as an occupational disorder since it is seen most frequently in individuals, particularly women, whose occupation requires more or less constant use of the hands and upper extremities. It occurs in individuals having a particularly low riding shoulder girdle or, in other words, in those people whose upper thoracic cage tends to be conical—the slope-shouldered, long-necked individual.

This variant in relationship between the shoulder girdle and the superior thoracic cage causes undue stretch and compression of the neurovascular structures. Furthermore, added compression may occur due to increased acuteness of the relationship between the clavicle and the first and second ribs.

Classically, the picture is one of increasing difficulty in the use of one or both upper extremities with prolonged and repetitive effort such as typing, ironing, piece work in production, washing dishes, wringing out of clothing, hair dressing, bouts of protracted coughing with long-standing pulmonary disorders, and in particular in young mothers not yet used to lifting and carrying infants and young children. These people complain of "dropping things" even without apparent paralysis. The hands may become colder with use. Usually these patients volunteer that their hands are always cold. The pulse can be diminished or abolished by downward thrust of the arms and drawing back the shoulders. There is usually subjective tingling and hypesthesia in the distribution of the ulnar nerve, particularly in the hand.

Primary disability is due to compression of the plexus and subclavian artery by the hypertrophied anterior scalene muscle and its ligaments across the arch of the first rib.[6] Peripheral vascular insufficiency is of little consequence in this picture.

The pain may follow many patterns depending upon the relationship of the brachial plexus to the constricting anterior scalene muscle and rib. This

pain may be in the distribution of the cervical plexus, radiating into the neck, face and head where it has been confused with migraine, or it may radiate into the pectoralis region and on the left side occasionally be mistaken as cardiac in origin, particularly if neck, face and arm are involved.[7] The usual location of the pain is in the distribution of the lower cord, radiating to the medial surface of the arm.

Treatment consists of sectioning the anterior scalene muscle just above its insertion on the first rib. Care must be taken in making certain that the medial-most portion of the muscle, the vertebral costal ligament, is sectioned as well; otherwise symptoms and signs will persist.

Cervical Rib and Anomalous First Rib.—The picture here is similar to that of anterior scalene muscle syndrome, however, more pronounced and associated with vascular changes in the extremity and hand, ranging from coldness and absence of pulsation to frank gangrene of the fingertips. The anomalous rib (either supernumerary cervical or unusually shaped first rib) compresses and elevates the subclavian artery from below (Figs. 3 and 4). Symptoms develop as tension and hypertrophy of the anterior scalene muscle occur, and with settling of the shoulder girdle on the thoracic cage.

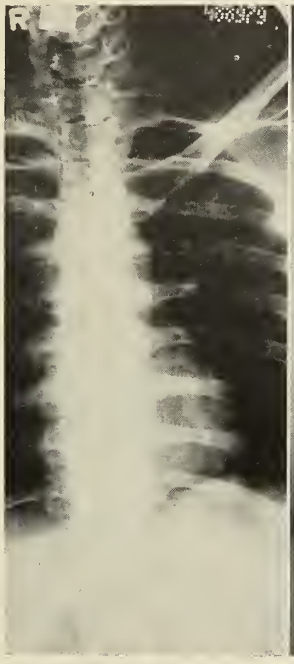


Fig. 3. Bilateral cervical ribs resected to their heads. The first rib on the left had to be partially sectioned as well to completely decompress the subclavian artery and the brachial plexus.

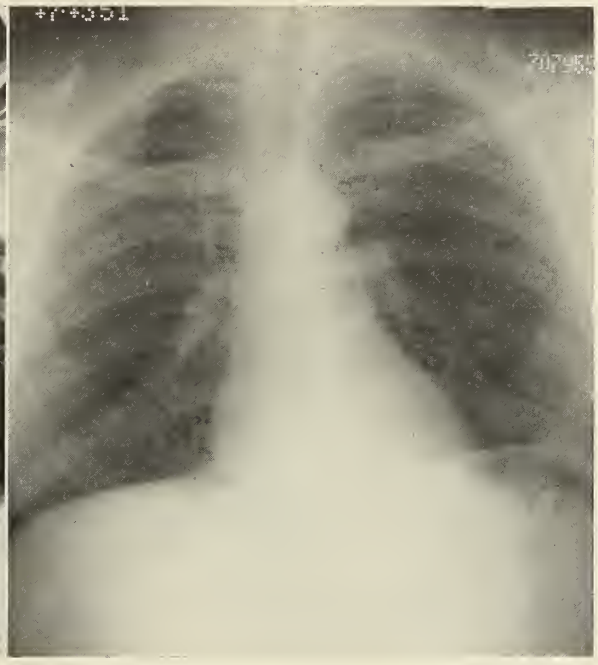


Fig. 4. Abnormally high-riding and deformed first rib which had produced gangrene of the finger tips.

Early in the clinical course of this disorder, vascular insufficiency and pain may be noted only in certain positions, such as recumbency with the arms extended or while driving a car with the elbow resting on the door. These people are awakened at night and usually get relief by allowing the arm to hang out of bed. When the condition is long-standing, varying degrees of thrombosis of the subclavian artery may occur. Gangrene of the fingertips in these cases is not uncommon. Cerebral embolism has been reported as occurring in retrograde fashion from such thrombi.[5] Aneurysmal dilatation of the proximal portion of the subclavian artery may occur.

The diagnosis is easily confirmed by x-ray. Treatment consists of sectioning the anterior scalene muscle and resecting a sufficient amount of the rib to allow total decompression of the neurovascular bundle and, in particular, the subclavian artery.[1,6] When marked peripheral vascular in-

sufficiency is present, a ureteral catheter can be placed along the sympathetic trunk and the wound closed tightly. Long-acting blocking agents can be instilled through this catheter to facilitate restoration of blood flow.

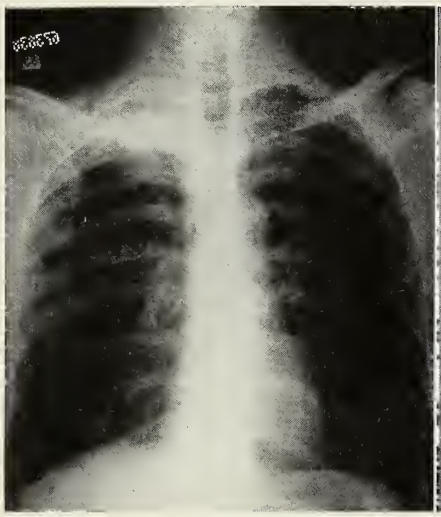


Fig. 5. Superior pulmonary sulcus cancer (Pancoast tumor) with severe right shoulder and arm pain.

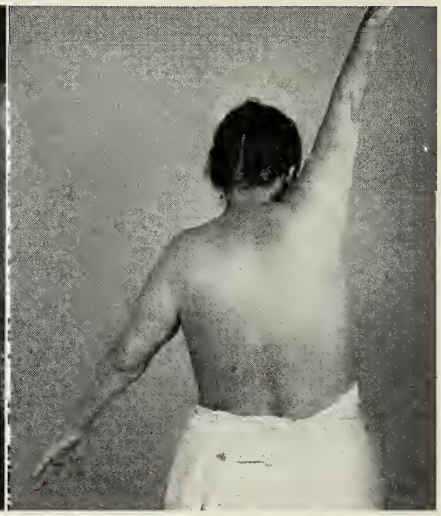


Fig. 6. Marked limitation of shoulder motion on left due to periarthritis (frozen shoulder).

Neoplasms Involving the Brachial Plexus.—Primary neoplasms of neurogenic origin do occur here and should be constantly suspected. These lesions are usually manifested by peripheral neurologic changes and local evidence of tumor before they produce pain. On the other hand, metastases and lymphogenous neoplasms usually produce pain.

An easily missed and not uncommon neoplastic lesion producing pain in the shoulder, neck and arm is the primary superior pulmonary sulcus cancer or Pancoast tumor (Fig. 5). These patients have severe pain involving neck, shoulder and arm with or without objective signs and in most cases have an associated Horner's syndrome which should make one suspicious of the diagnosis. X-ray of the chest confirms the diagnosis.

Peripheral Nerve Lesions

Completely transected nerves are never painful; however, if regenerating fibers are misdirected through faulty anastomotic repair, painful local neuromata develop. These can be repaired by excision of the wandering, regenerating fibers and reopposing the nerve sheath snugly in continuity.

Any nerve may become constricted by neighborhood scarring following trauma, particularly with fractures about the elbow. Here proliferation of callous is apt to become troublesome, with particular regard to the ulnar nerve. This structure must then be chiseled out of its bony tunnel and transposed anterior to the median condyle of the humerus beneath the fascia of the flexor carpi ulnaris muscle.

Intraneural scarring may occur as a result of perforating injuries to the nerve by such instruments as needles, slivers or fine shot. Such incomplete peripheral nerve lesions may set up profound reflex autonomic disturbances marked by exquisite pain, excessive hyperhydrosis, and coldness of the extremity. Local revision of such a lesion has no effect other than to re-establish continuity of the nerve sheath. Repeated upper dorsal sympathetic block is indicated, and if symptoms persist, sympathectomy gives lasting relief in most cases.

Basic Orthopedic Disorders

Shoulder pain may be extremely difficult to describe or even localize since reflex pathways may mask the source of irritation.[2] Therefore, careful examination of joint and muscle function bearing in mind the following common disorders and their diffcrential features is necessary.

Periarthritis of the Shoulder.—This may be a primary inflammatory process occurring in the subacromial bursa or the tendon of the long head

of the biceps. Here the patient has onset of pain in the shoulder with resultant muscle spasm and voluntary restriction of motion. As the inflammatory reaction passes from the acute to the chronic phase, adhesive scarring occurs within the periarticular structures. An adhesive tendonitis, capsulitis and bursitis actively blocks any attempt at active motion.

On inspection the arm is adducted and internally rotated. A break of normal abduction rhythm exists and that motion present is scapular and not gleno-humeral in origin (Fig. 6). If one attempts passively to abduct or rotate the arm, a block is demonstrated. Complete restriction of motion is not necessary to produce symptoms since occasionally the loss of the last 10 to 15 degrees of abduction or external rotation may be accompanied by pain.

X-ray examination may be negative except in long-standing cases in which disuse atrophy of the greater tuberosity of the humerus may be seen.

Treatment must be active. This is not a self-limiting process. Recovery of motion and relief of pain does not occur until the adhesions have been broken down. Vigorous active shoulder exercises carried out by the patient is the best method of maintaining or regaining motion. In the chronic phase, where a so-called "frozen shoulder" exists, passive manipulations carried out properly are of immense value. These must be very gentle and, if carried out under anesthesia at two to three day intervals, will in most instances allow motion after three or four manipulations. This method if done forcefully is dangerous, as the capsular structures may be completely torn or fractures of the humerus produced.

Where periarthritis is secondary to some other condition such as fracture dislocation of the shoulder, the degenerative process of healing may so affect the joint that the above therapeutic measures will not suffice. In these patients arthrodesis of the shoulder may be necessary in order to restore function to the extremity.

Calcification in the Supraspinatus Tendon and Subacromial Bursa.—Whenever degenerative changes exist in the supraspinatus tendon the process of repair may be accompanied by the precipitation of calcium salts (Fig. 7). Whether or not this will produce pain in the shoulder is entirely dependent on the amount of irritation produced in the floor of the subacromial bursa. X-rays of the shoulder frequently demonstrate collections of calcium in a tendon that may never have been symptomatic. If, however, the inflammatory response to the irritation is severe enough, pain of great intensity may suddenly develop.

Pain in the shoulder is usually accompanied by radiation into the supraclavicular and cervical regions and the arm and forearm. Muscle spasm about the shoulder is great, making voluntary restriction of motion by the patient mandatory. Cardinal points of diagnosis are: loss of ability to move the joint through its normal rhythm of abduction and external rotation, point tenderness just lateral and anterior to the tip of the acromion, swelling, redness and increased heat may be found in the same area. These are signs of subacromial bursitis, therefore, if this is an acute primary condition calcific deposits are not found.

X-rays taken in the anteroposterior view in complete internal and external rotation (if possible) demonstrate calcification. The calcium deposits may be in any of the tendon structures of the shoulder producing a similar picture.

As the acute phase becomes chronic, the symptomatology may be quite different. In these cases a dull intermittent aching of the shoulder may be present in addition to the symptoms of periarthritis of the shoulder.

Insofar as treatment is concerned a number of methods are available, but all have one primary purpose: to relieve pressure within the subacromial bursa or irritation to the floor of the bursa. Considerable confusion exists in selecting a method of treatment if this is not kept in mind.[4] In the acute phase the following methods are used.

Diathermy creates a reactive hyperemia increasing the fluid content of the bursa sufficient to cause spontaneous rupture, thus relieving pressure.

X-ray therapy is thought to bring relief by the same mechanism.

Needling the bursa with a large gauge (16) needle frequently may be sufficient to release the calcific material from the tendon or bursa into the surrounding tissues. This procedure requires local anesthesia.

Surgical incision and excision—this is a certain method of treatment. When the above procedures fail, operative incision of the bursa with excision of the calcific material gives uniformly good results.

In the subacute phase variable results are ob-

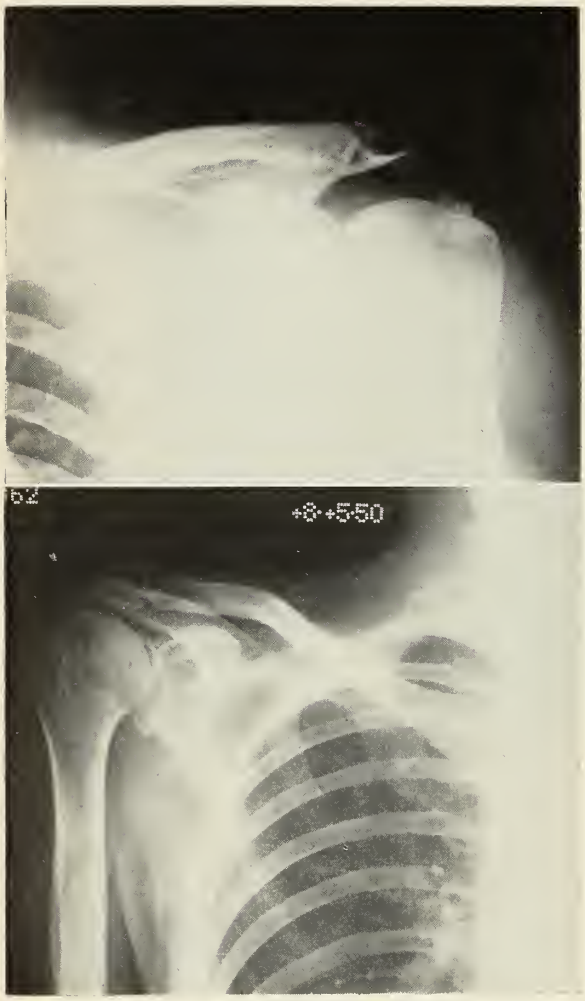


Fig. 7. Painful shoulder due to calcification within the supraspinatous tendon.

Fig. 8. High-riding head of humerus due to tear of the musculo-tendinous cuff.

tained by the conservative methods, depending on the state of the deposited calcium. If it is hard and inspissated, anything short of surgical removal is seldom of value. In the chronic phase where the salt composition approximates that of bone, surgery is the only satisfactory form of treatment.

Rupture or Tears of the Musculo-tendinous Cuff.—The frequency of diagnosis of partial or complete tears of the abductor cuff of the shoulder depends entirely upon the examiner's awareness of the condition. There are a number of common factors present that aid one in diagnosis. The lesion occurs most commonly in men past middle age who for a number of years have done heavy labor or who have suffered an acute injury to the shoulder. As a result of continued impingement of the rotator cuff beneath the acromial process in the act of abducting and rotating, attritional changes occur. These changes leave an anatomical weak point in the capsule, therefore, even a slight injury may produce significant tears. The prognosis depends almost entirely on the severity of the tear. If the tear is complete, complete restoration of function is unlikely.

The clinical picture presented is quite characteristic. In most cases a history of a fall on the outstretched hand is given. Immediate pain in the shoulder occurs with accompanying loss of function. The patient is unable to initiate abduction of the shoulder since the supraspinatus muscle group cannot "lock" the humeral head in the glenoid fossa (Fig. 8). Consequently, the deltoid is unable to abduct the arm. The patient shrugs the shoulder in an attempt to abduct. If he has learned to passively abduct the arm 20 to 30 degrees and thus fix the humeral head in the glenoid fossa, he may then be able to carry out the remaining range of motion. This depends upon the amount of pain present; if it is sufficiently severe, he will resist any motion of the joint. If one passively abducts the shoulder and places it in a position of external rotation above his head, he may again be able to hold it in this position. However, as he actively brings the arm down to his side, it will fall suddenly when it reaches a position of about 80 degrees abduction. X-rays show the humeral head riding high on the superior glenoid lip in comparison to the opposite side as a result of the upward pull of the deltoid. An excellent method of demonstrating the completeness of the tear is to place the patient in 90 degrees of abduction (by splint or traction). Allowing seven to ten days for the acute symptoms to subside, tests of shoulder function are instituted. If there is early improvement in function, the tear is probably minimal.

Early treatment is essential, otherwise disturbing sequellae which may be severely incapacitating result. Periarthritis of the shoulder is the most commonly observed complication. The part should be kept at rest until most of the pain is absent and then gentle active exercises given. Passive manipulation should not be done as one may enhance the existing lesion. As function returns, the degree of active exercises is increased. If after a period of seven to ten days the patient is still show-

ing complete inability to use the arm, operative intervention is indicated. Depending on the degree and type of tear present, various reconstructive procedures are available for repairing the defect. If the patient is not seen until months after the injury, sufficient secondary damage may have resulted making reconstruction impossible and arthrodesis mandatory for restoration of function.

Acromio-clavicular Arthritis.—Following hypertrophic or degenerative changes in the acromioclavicular joint, one may be left with dull aching shoulder pain difficult to localize. These changes may be the result of specific trauma to the joint or accompany a generalized form of arthritis. The diagnosis should be suspected if prominent acromioclavicular joints are present and especially if local pressure increases the pain. X-ray will show the changes present. If local therapy such as heat and limitation of motion and salicylates do not relieve symptoms, surgical therapy is indicated. Excision of the distal end of the clavicle lateral to the coraco-clavicular ligament is a very satisfactory procedure.

A number of less commonly seen conditions include slipping of the biceps tendon; rupture of the biceps tendon; and tumors, benign or malignant of some portion of the shoulder girdle.

Lateral Epicondylitis of Humerus or "Tennis Players' Elbow."—Although this lesion is located in the region of the elbow, it gives origin to a vague aching radiating type of pain that is felt in the shoulder and the hand. The etiology is associated with trauma from use of the arm in repetitive pronation and supination. An area of inflammation occurs at the point of insertion of the extensor carpi radialis muscle in the lateral epicondyle of the humerus. Occasionally this is accompanied by bursal formation and calcareous deposits in or about the area. The physical findings are quite characteristic: (1) Localized severe tenderness directly over the tip of the lateral epicondyle. (2) Pronation or extension of the wrist causes pain. (3) Voluntary weakness of grip is present. (4) There is loss of complete extension of the elbow.

The condition is self limiting, however, patients may be sufficiently incapacitated as to require active treatment. Splinting of the forearm and wrist will often relieve symptoms in from one to four months' time. However, few people are content to spend that amount of time in obtaining relief from pain. Repeated injections of 2 to 4 cc. of local anesthetic into the area of joint tenderness may be effective. X-ray therapy is used by many in an effort to hasten the process of repair. Our results with this method of treatment are variable with no accurate method of predicting which will respond to irradiation. If the individual is sufficiently incapacitated, surgical stripping of the muscular insertions in the epicondyle is done. Results of this treatment are good, however, it should not be used unless the condition remains refractory. Manipulative tearing of the insertion was rather widely used in the past but is not to be recommended.

Radial Stylalgia or DeQuervain's Stenosing Tenosynovitis. — This condition was formerly thought to be rare but is being seen with increasing frequency.[3] An inflammatory process occurs in the tendon sheaths of the abductor muscles of the thumb at a point where the tendons glide through an osseous groove in the distal lateral one inch of the radius. This occurs most commonly in women, especially in those whose occupation requires repeated flexing of the thumb in apposition to the fingers; i.e. typing. The chief symptoms complained of are: (1) pain over the distal radial styloid, (2) loss of strength with use of the thumb. (3) indefinite radiation of pain into the forearm and upper arm. On examination, the tendon sheath of the abductors is found to be enlarged and crepitation may be elicited within the sheath. If the process is allowed to progress contracture of the sheath may occur from scarring and a "snapping" thumb may result. Splinting of the forearm and thumb should be carried out for a period of about one month. If symptoms are relieved by this measure, nothing more need be done. However, if upon resumption of function exacerbation of symptoms occurs, surgical treatment is indicated. Linear incision of the tendon sheaths at the point of involvement is a relatively simple and effective method of treatment. The sheaths are left open and the part splinted for three to four weeks.

Summary

The most common causes of shoulder and arm pain are briefly presented with a discussion of their differential diagnoses and treatment.

(Continued on Page 67)

The Principles and Problems in Psychotherapy With Veterans

By Thomas V. Hoagland, M.D.
Detroit, Michigan

A VETERAN'S ILLNESS is the problem and responsibility of all physicians, regardless of their specialty. As doctors, we are entrusted with their care by the government and service organizations. The illness in many of the veterans is said to be service-connected, which implies that the disability originated or was precipitated by their service experience, while others are non-service-connected, indicating that our government does not recognize the illness as relating to their service. Now, of the former, or the service-connected disabled veterans, 52 per cent of this group are said to be psychiatric casualties; in the second group, whose illness is non-service-related, it is found that a large proportion of these have emotional problems. The illness in these veterans most usually originated following discharge but in some cases existed prior to service.

Throughout the recent years many concrete facilities have been developed and expanded to service these men. Hospital beds have been added and out-patient clinics developed. Additionally, contracts have been made with physicians and private hospitals to extend prompt medical attention to those with a service-connected disability.

That they receive priority in medical service is evident. However, those with non-service disabilities are absorbed by the Veterans Hospitals as quickly as possible.

Specifically, I would like to focus our attention on the role of the therapist, whether he be found in the office of the general practitioner or the specialist. With the latter I do not wish to delineate the location of this specialist as to his private office, the clinic or the hospital. It is my purpose to indicate his relationship and function. It become immediately evident that the media of therapy is contingent upon several variables. First of all, how capable is the therapist and what is his depth of orientation? Does he recognize his limitations and is he aware of his needs? Though perhaps completely competent in the therapeutic sense, is he in any way dependent financially on this relationship and does it cloud his perception? It is my personal opinion that all too often this problem complicates the picture. As a general statement, the role of the therapist is dependent upon the insight and demands of the patient. In those cases where insight is lacking or, at best, superficial, it is evident that relationship can be carried on by the general practitioner or the psychiatrist who lacks extended training in psychodynamics. Accordingly, those patients who have some understanding of the etiology of their illness and ask for attention and correction of this problem should establish relationship only with the skilled therapeutician.

Now, as to the patient, what is his orientation? Are we to relate to him in superficiality through support and direction, or is deep therapy permissible? Here, again, we must consider some variables which influence this decision.

First of all, we must keep in mind one very important issue. Does the patient accept this illness as one that is basically emotional? Can we convince him of this to the point where he will accept treatment? Unfortunately a great number rationalize the cause of their illness in reference to an outgrowth of an accident or injury sustained in former years and will not permit themselves to see this in any light except that which is organic in nature. Accordingly, it is then impossible to establish a positive treatment program of any favorable degree or depth. His need to see this in the organic light is to him a defense which is of service to him and is to be regarded as a symptom—a symptom which most usually is quite tenacious and unresponsive. To recognize his illness as a correctable psychological problem would mean that ultimately he would give up his dependency role and the needs for his illness. Here I might ask that we remember that the sickness in itself is a flight into illness which affords a primary gain to the individual. It is a solution, though a poor one, to his conflicts—primarily a retreat into immaturity and dependency—a compromise. Now, if additionally we add to this the secondary gains which the veteran receives because of the illness, we almost irreversibly complicate and crystallize the sickness.

What are these secondary advantages? The most important, of course, is the pension—a pen-

Presented at the eighty-sixth Annual Session of the Michigan State Medical Society at Grand Rapids, September 27, 1951.

sion which continues as long as there is continuing evidence both in the subjective and/or objective sense. Specifically he is paid for his illness. Does this encourage dependency? A deeper feeling of passivity and inadequacy? Of course it does. What are the other general advantages that the disabled veteran enjoys which, in the adjunctive sense, further weld this dependency? There are, of course, the service organizations offering aid through legal, nursing and social service facilities. And last but by all means not the least is the arrangement whereby his hospital and medical fees are provided for at government expense. With these gains it is not surprising to now find him in the role of complete dependency.

Now let us remember that one of the cardinal rules and requisites of successful psychotherapy is in reference to the need for the patient to pay out of his own pocket the cost of the treatment. Experience has taught us, that, in the main, treatment is unsuccessful if this factor is obviated. There are, of course, a few exceptions. There *are* illnesses where the emotional disorder manifests itself through continuing intense anxiety. This in itself pushes the patient onward in treatment. However, it is common to find alleviation of the anxiety early in the relationship of the patient and the therapist without the development of insight or understanding as to the etiology. It seems, in these cases, that the therapist acts as a crutch, as a protector, and gives support to the patient. This type of relationship may continue indefinitely with the recurrent anxiety acting as the motivating force for continuing treatment. As an example, I have in mind a veteran who has established a dependency relation with the therapist and who passively continues in treatment. Recurrently he is confronted with interpersonal problems which brings his anxiety back into focus only to find alleviation through direction and support from a physician. I think of another example of a veteran with 100 per cent disability whose contacts with his therapist have continued uninterrupted, for the most part, since his parole from a mental institution. He has not developed insight, nor is it probable that he will. However, again, in this instance, his physician helps him in his ability to adjust in his environment. At times he has abortive psychotic episodes, which necessitates a rather constant surveillance by the physician and members of the family for a short period of time, wherein he returns to his occupation and, for the past year, through such support, has been able to sustain the financial status of the family. It is quite evident that without such guidance he would have been returned to the hospital long ago. In those instances where continued adjustment is impossible, the veteran is immediately hospitalized in whatever emergency facility is available, and later, when beds are obtainable, he is sent to the Fort Custer facility. It is interesting to note the general attitude of most hospitalized veterans. In the service-connected individual the dependency seen at hospital level is most marked. They are prone to insist on sedatives and various medications. The complaint threshold is low and their demands ever constant. This general picture is likewise seen in the non-service-connected veteran observed in other hospital facilities. Here, again, they are prone to settle down for a continued period of hospitalization and react unfavorably when it is deemed permissible by the hospital staff to discharge them. Of interest is one favorable distinction—the response to group therapy in the non-service-connected veteran is much more favorable than those pensioned. It is not uncommon for them to gain sufficient understanding of their illness to bring about the necessary motivation to take them into treatment with a private psychiatrist after discharge from the hospital.

Again let me emphasize the need for insight as the basic requisite for entering into treatment. Too, I must make it clear that the primary and secondary gains are not conscious processes but are primarily unconscious in nature. It seems that, in the minds of some patients, their reluctance to recognize their illness as one that is psychological is akin to being accused of malingering or deception.

What then, providing that the veteran understands the nature of his illness and wants help for it, are the goals in treatment? Are there any risks? Unfortunately there are. First of all, in the married veteran, the marital structure itself may be threatened. Keeping in mind that it is not uncommon that a neurosis marries a neurosis, would it not be apparent that when one member of this union develops insight and gives up his neurotic needs, the other is stranded in her neurosis. This complication must then be met and dealt with in one of three ways. Either the veteran adjusts to his wife, understanding her continuing neurotic needs or, if possible, convinces her of her need for treatment. If these solutions are not effected, the mar-

riage, of course, ends in separation or divorce.

An additional risk is his recognition that his very choice of a trade or profession was motivated originally by his neurosis and that in substance his life's work was an expression of his basic conflicts —in essense, an acting out of the problem.

Accordingly, the therapist must evaluate the patient in the total sense and decide the type of treatment program to be used. For, in the main, we can divide the field of psychotherapy into two groups—the superficial and the deep. By the former I simply mean the inclusion of any supportive technique which, through its use, effects a reasonable adjustment of the veteran to his environment. By this method I mean the use of encouragement, suggestion and reassurance, of occasionally direct and pointed observations which help him to adjust. This, of course, does not get to the roots of the illness but it does help him to get along. We might also find occasion to support him with mild sedatives and multiple vitamin preparations. However, to attack the over-all problem from the point of view that this is, in essence, a vitamin deficiency is to raise the question in our minds of malpractice.

What, then, of depth therapy? How is it used and by whom? It is not my purpose here to enter into a discussion of the psychodynamics of personality development, nor to point out the years of training required in preparation for the special role of the psychoanalyst. I have stressed the importance of the patient's responsibility in assuming the financial relationship and the inadvisability of granting a continuing pension for this type of illness. I stress it because it markedly interferes with a successful outcome in treatment.

It is redundant to point out that there is a woeful lack of skilled therapists in this field. However, until the pension and fee program is revised, their efforts are better spent with the non-veteran. All too often one hears the off-the-record comment from therapists that it is their feeling that it is much more gratifying to work with a patient who is himself paying at least part of the treatment expense, for in them the progress is obvious and sustained in comparison with those that have free treatment.

In conclusion, I ask that we ultimately seek review and correction of our fee and pension system.

Could we not simply settle upon the veteran a just and final lump sum of money for his service-incurred illness? Could we not revise our fee schedule wherein the veteran would assume part, if not all, of the treatment cost? This plan, of course, has been widely adopted in the out-patient clinics sponsored by city, county and state authority. The over-all financial picture is studied by the department of social service and the physician. It is then decided that the patient will pay a certain fee per hour—one that is not in itself an added burden to his problems but one that is fair and in keeping with his or her income. I remember a veteran that I once had in treatment whose personal income was in the vicinity of $20,000 a year. He was quite insistent that the government assume the role of the benefactor in the cost of the treatment, and accordingly, as I have pointed out before, one of the basic requisites in the field of therapy was violated and the patient talked about the weather rather than himself. It is, in general, true that when we pay for something, we are sure that we are going to get the full benefit of our expenditure. In this and other veteran's cases, unlike other patients, they frequently present excuses whereby they break the appointment for the treatment hour or they may simply forget that they had an appointment. To combat this, others, to include myself, point out to the veteran when he enters the treatment program that, within reason, any hour that he misses in such a manner shall be charged to him. I might say that this is a very effective tool. Obviously it does not matter to the physician whether his fee comes to him through individual or governmental sources. Our primary concern as physicians is to get the patient well.

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SUBTOTAL GASTRECTOMY WITH POSTOPERATIVE COMPLICATIONS

(Continued from Page 54)

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Know How to Live

By The Very Reverend William T. Reeves, Jr.
Dean, St. Mark's Cathedral
Grand Rapids, Michigan

THE PHYSICIAN can be of inestimable value in influencing people to know how to live, and so can help immeasurably in maintaining the freedom which we hold to be so sacred and so dear in this, our land.

You men and the colleagues you represent in your various county medical societies are leaders in your community. People look up to you; they listen to you; they take your advice; they tell their friends and their families what you have told them.

I know that people are always trying to badger you on the street, and talk shop to you—talk treatments and medicine and health on the golf course, and at parties and at groups and gatherings. I know that is loathesome to you—that you shy away from it—that you have to be guarded in what you say. But, gentlemen, I want to tell you this morning that those are golden opportunities, if you are to help people to know how to live.

I hope you will look upon those occasions as opportunities to help your fellow American and your great country at a time when both so desperately need help.

I don't mean that you should go walking around freely dispensing medical advice or indiscriminately throwing out verbal and oral prescriptions, but rather that you should look upon these contacts with your fellows as a definite means of teaching people to know how to live, and so a definite means of strengthening our American democracy and her freedom.

The little hints you drop, the asides and the comments you make in casual conservations, are going to be passed on and on in a never-ending chain in your community.

Gentlemen, your influence is tremendous! I beg of you to use it and not abuse it, because using it depends a great deal upon whether or not we keep our freedom.

This summer, in a railway train in England, I listened to a beloved British physician tell me the pathetic story of state medicine in Great Britain, and what it had done to the physician—and, worst of all, what it had done to England. He told me that he thought the doctors were largely to blame, and one of the reasons why they were to blame was that they were so guarded in their conversations—they were so smug, so aloof, so otherwordly from the masses of people. They were persistent in their refusal to get next to people and to talk to them about these matters of knowing how to live.

Socialized medicine, as we know today, was just the beginning, over there in England, and now the British have lost many, many of their freedoms, until now they are hopelessly socialized. more so than Russia herself. And, of course, the death knell has long since begun to toll for that once mighty Empire.

Gentlemen, that can happen here, too. What they and other countries have lost in the last few years, we can lose in America today. The seeds already have been planted. They are widespread, and therefore it behooves you and all of us to do everything within our power and everything at our command to root up those seeds, lest they grow tall and high as any noxious weeds will, until they choke the very existence out of our American way of life.

As you full well know, you medical men, there are tensions existing today that are detrimental to people's health physically, mentally and emotionally, and that are also detrimental to American freedom. These tensions, of course, stem from problems having a wide variety of causes, but when those causes are understood—when they are thought through in the light of our American heritage and freedom—then those tensions can be released into energy that can help to solve those problems and those causes.

But, of course, if the tensions are not recognized, if those causes are not understood, then those tensions will release destructive energy, threatening both individual health and corporate freedom. And then people become prey for, and fit people for, socialistic ideals that we see cropping up on the shores of the world today.

It is an imposition for me, a layman, to come before you this morning and tell you how to live. It is ridiculous. You do a magnificent job of it in your offices and in the hospitals. You tell your patients very explicitly how to live.

Address delivered at the Formula For Freedom presentation before the House of Delegates, Michigan State Medical Society, Grand Rapids, Michigan, September 24, 1951.

I just want to ask you to carry that on into their political life, into their moral and social and spiritual life. I want you to mix in a little good, sound Christian philosophy with it, and tell them how this accelerated pace and these tensions are not only affecting them and other individuals physically and mentally, but are affecting America politically.

First of all, let's tell them to reduce the pace—just calm down and quiet down and think things through. A doctor once told a go-getter American businessman, who was overworking and in need of medical advice, that he ought to take a few hours off every day, and one afternoon off each week, and spend that time in the cemetery.

He said, "I want you to go to the cemetery and look around at those tombstones and reflect that many of those people thought they carried the world and their business on their shoulders too—and now they are forgotten." "Mr. Jones," he said, "if you persist in your ways you will be there too, before very long, and you will be forgotten, and the business and the world will carry on without you."

A famous crew coach of the University of Washington, who has won many more intercollegiate regattas than any other crew coach, used to tell his boys at the beginning of the season, "Boys, if you want to go fast and win races, you've got to learn to go slowly."

You men understand that. The person who has been the victim of tensions and high tempos, simply has to quiet down and get the peace of God in his heart and soul and in his muscles.

Another thing we ought to tell people, whenever we get the opportunity, no matter where it is, is that they ought to think peaceful thoughts. Once a famous orator said that when he came to a city to make a keynote address at a banquet he was met by a be-badged committee and hurried around from one autograph party to another and from one reception to another, and from one luncheon to another; then he was dumped at his hotel and was told he had exactly twenty minutes to get dressed for his banquet, at which he was to be the keynote speaker.

He tore off his clothes and jumped into the shower. As he was hurrying into his clothes, the phone rang and a voice said, "Hurry, hurry! We can't wait for you!"

He hurried into his clothes and ran down the hall toward the elevator, feeling that he wasn't entirely dressed. All of a sudden he came to himself and said, "What the hell are you trying to do, anyway?" He turned on his heel and walked back to his room and shut the door; then he called the banquet chairman and said, "Go ahead; I will be unavoidably detained. I'll be down a little later."

He took off his shoes and tie and coat, and picked up the Gideon Bible and read peaceful old Psalms. Then he redressed (he doesn't know yet how much later it was), and he went to the banquet—and gave one of the best speeches of his life!

Gentlemen, that experience gave that man a tremendous sense of the healing presence of Almighty God. Let's advise people to do that, especially when they are busiest, just to prove that they are the masters of their own business.

Thirdly—and this goes much deeper—you know what it is that drives people, don't you? You know what it is that produces these noxious, insidious tensions. You doctors know better than anyone else that the human being, when he comes off the assembly line in the delivery room of a hospital, is a well-integrated, perfectly organized mechanism, every part working in perfect harmony with every other part.

Well, then, what is it that drives them off base after they grow up? What is it that causes these emotional upsets, neuroses and psychoses and coronaries and depressions and all the rest? What is it that is helping to break down the freedom of our American way of life, and that is making our people here fit subjects for a police state—a socialized society?

It's the wrong we do! It is, as the prayer book of my Church says, "The doing of those things that we ought not to do, and the not doing of the things that we ought to do, and therefore there is no health in us."

How true! No health in us as individuals—no health in us as an American society. It is the latest insight into human nature, isn't it? It is as modern as today's newspaper; it is what you men have been telling patients for years. It is why you have been telling them that if they want to get well and stay well they had better be good. It is why we preachers don't get up in the pulpit and tell people they ought to be good because they had better be good. No—we get up and say, "If you aren't good you are going to be sick; you are going to have tensions which are going to break you down physically and mentally, emotionally and morally, and so break down the whole structure of our

great American society and freedom along with it."

A debonair, well-to-do, affluent businessman went to a specialist one day, who had been referred to him by his own physician. He said, "Doctor, I am a big man in this community, as you know. I have got to have help. I have twinges of pain all over. I can't sleep. I am short of breath. My appetite is poor. I used to play eighteen holes of golf on a Sunday, and now I can't play nine without getting utterly exhausted."

The doctor examined him and put him in the hospital for five days, and gave him all the routine tests. They were all negative. Finally, the doctor went to the man in his room and said, "There is nothing wrong with you physically."

"Quit kidding, Doctor; there must be! It's my heart or lungs or liver. Give me some more tests. We'll run it down."

"I have run it down," said the doctor. "You have a sick conscience."

The patient was furious. He raised himself on one elbow and flushed with wrath, and said, "Doctor, that's none of your business!"

"Ah," said the physician, "but it is my business. It's my business to get you well, and I can do it if you will co-operate with me. Come clean, now. Tell me what's on your mind."

There was a painful, embarrassing silence. The doctor stuck it out and wouldn't budge from the chair. Finally, the fellow began to unburden himself, and he told the physician how in his craze to get to the top of the business and financial world he had seen a chance, through a clever stock manipulation, to euchre his partner out of the business, and it caused the partner and his family to live in penury and disgrace. Oh, it was all quite legal, sure; but it was a dirty, rotten, unfair, scheming trick, and the man knew it.

"All right," said the physician. "You have confessed this thing to me, and I respect your confidence. I will order your clothes and your release from the hospital. On your way home I want you to stop into a church and fall down on your knees and confess this thing to Almighty God, and ask Him, of His mercy and charity, to forgive you, and continue thus to pray for the rest of your life. Then, tomorrow morning I want you to start immediately making restitution to that man and his family whom you have so grievously wronged. Come back and see me in a month."

I don't have to tell you that the man was completely cured in a month.

Gentlemen, don't you see why we call Jesus Christ the Great Physician of the Soul? There is healing in His touch. Likewise, He comes to you and to me, and likewise we should go to all of our people, on the street corners, the golf courses and everywhere else, and say, "Look! Reduce the pace. Slow down. Think peaceful thoughts. Come and tell us and tell God what is on your heart and mind."

Please God, we will do that, because if we do we shall have helped so much in teaching our American fellows how to live, and helped so much in restoring these precious American freedoms which Almighty God in His wisdom and in His goodness has given us, and which we must at all costs preserve.

MSMS

BLOOD TRANSFUSION

Pope Pius III was bled, his blood being replaced by the blood drawn from two young men, and his blood in turn being used to replace theirs. It is interesting to note that all three died.—J.M.S.M.S., page 149, April, 1910.

PAINFUL STATES OF SHOULDER AND ARM

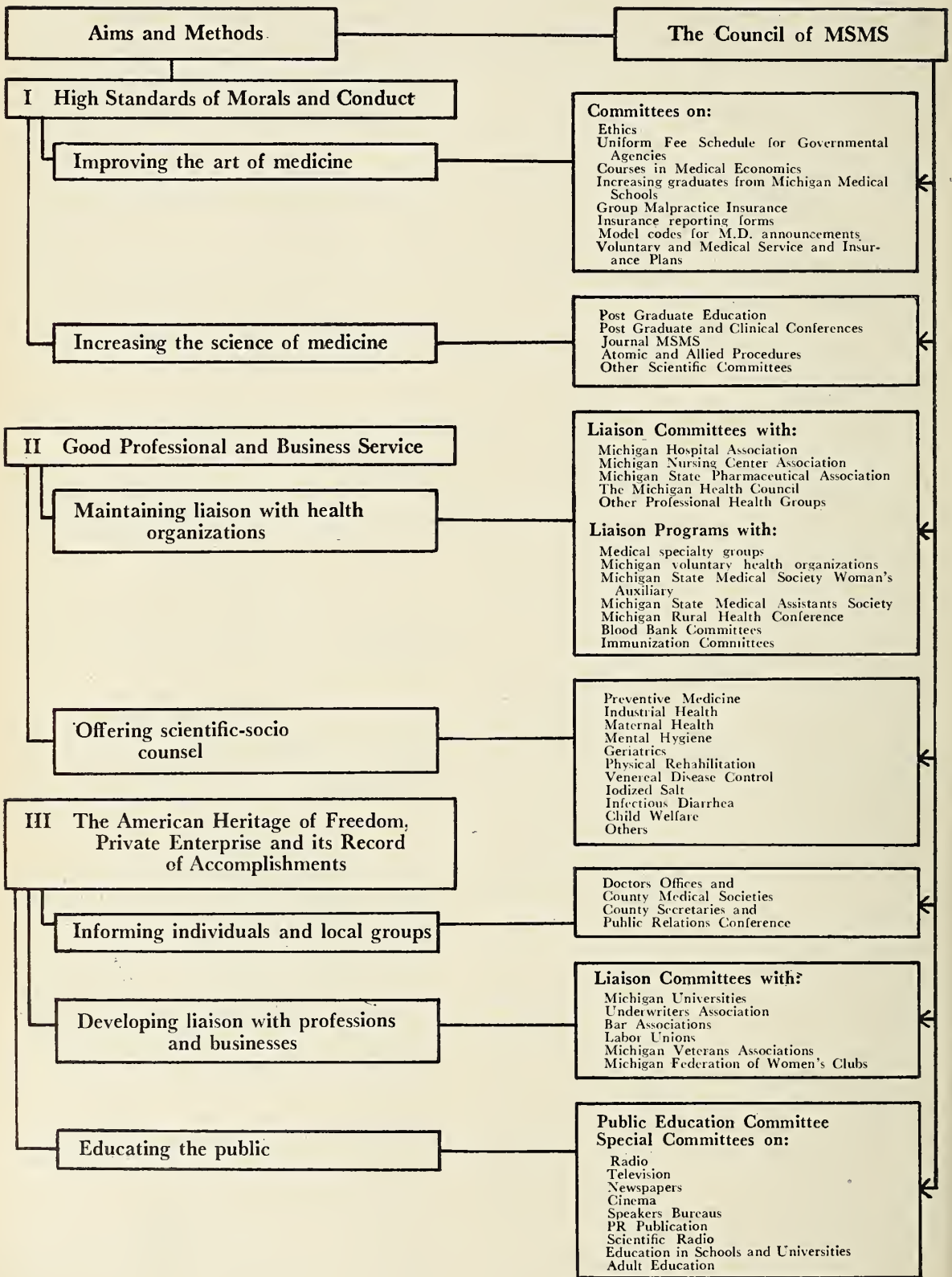
(Continued from Page 61)

Fractures have not been discussed as they usually do not enter into the differential diagnosis of pain in the shoulder other than of the acute type.

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Know How to Live



FORMULA FOR FREEDOM

A Formula that Works for All

(Part II)

Know How to Live

The Know How to Live element of the Formula For Freedom requires the knowledge and ability to:

(a) Know how to put your personal knowledge to work in order to maintain your freedom.

(b) Know how to work with others so that greater success can be gained through co-operative effort.

(c) Know when, where and how to take action so that freedoms will not be lost.

(d) Develop the attitudes and energies to take the necessary actions that you know must be taken if a free society is to be maintained.

Just as any individual must "make his way in the world" or he becomes subject to the orders of other persons, so must a profession live in and work for society or it becomes subject to the rule of societies leaders.

Such a concept is not limited to any individual or any single profession. It is recognized in every profession and in every society. However, it is particularly important in a democracy and it is particularly important to the medical profession since that profession has the primary responsibility for a basic freedom of the people —their health.

Here is how the medical profession is discharging its obligation in this element of the Formula For Freedom. *(Refer to chart.)*

I. The MSMS offers its membership aid in adopting both the art and science of medicine to modern living. Society will take compulsory measures to gain the advantages inherent in the progress of medical art and science if the public is not supplied these advantages by the voluntary action of medicine itself.

II. The medical profession is learning how to live with others in the health field through liaison with health organizations and giving scientific counsel to interested groups, medicine is not isolated from the rest of society. It maintains its freedom by knowing how and when to contribute to the public welfare. It maintains its superiority to cultists and fakers by *both* scientific excellence and health leadership.

III. Doctors as a group have learned that if they are to live and practice free from galling restraints they must constantly inform the public. This includes not only the presentation of scientific progress but also the policies of medicine relating to the *application* of that scientific knowledge and the reason for those policies. This is being done through the work of public education committees, the new adult education program, and liaison with other professions and business. The stake that each profession and business has in the others' freedom, and particularly in the freedom of medicine, is one of the basic interpretations of our American Heritage of Freedom.

Medical service includes guidance to patients in the art of healthful living. Such guidance is sought after by the patient and is a basis of the most effective physician-patient relationship. Each doctor of medicine has a responsibility to learn how to live within his profession and aid his medical societies in discharging their responsibility to society.

Editorial

THE TREND TOWARD SOCIALISM

THE EDITOR received a letter from one of the members of the Michigan State Medical Society on December 5, 1951, inviting attention to socialized medicine and the communist aims. One sentence we are quoting from the doctor's letter: "The present progress of Voluntary Health Insurance in the United States is the voluntary route to Compulsory Health Insurance." During the past twelve years, in which Michigan doctors of medicine have been offering their best efforts to curb the demand for compulsory medicine, or state or political medicine, we have heard that same charge from a small coterie of members, most of whom were opposing our program. Senator Vandenburg years ago answered the statement. He said, "The doctors of Michigan have the only workable answer, and the only hope of staying socialized medicine. As long as the doctors can demonstrate the possibility of making medical and health service available to the people on a voluntary basis, as you have, the Congress will never enact socialized medicine."

Oddly enough, the same day this letter was received, the American Medical Association House of Delegates, meeting in Los Angeles, heard from two leading United States Senators, Robert A. Taft, of Ohio, a Republican, and Harry F. Bird, of Virginia, a Democrat. Both talked of the very dangerous and alarming movement of the Federal Government toward Socialism, not only in medicine, but agriculture, business and industry. They credited the American Medical Association and its fight against socialism with having held up the progress of the evil, and complimented the medical profession for a job well done, but urged that there be no let-up.

It has been the considered opinion of the Michigan medical profession that through our voluntary health service we have delayed the socialistic program, and we have been so assured by many wise observers. Our voluntary health program, we believe, is a bulwark for independence so long as we can prevent government control. Years ago we suspected Federal interest and have steadfastly refused any form of government intervention or subsidy. We must have foreseen a certain court decision stating that what the government subsidises it may control, for when we evolved the Michigan plan for home-town care of the veterans, we refused to make any profit on that program. Michigan Medical Service pays the doctors for services to veterans as authorized and merely is reimbursed by the Veterans Administration, plus the actual cost of the processing. The government auditors come into the Blue Shield, Blue Cross offices to check those accounts. We are an independent self-governing service; as long as we remain on the same high standard of independence, we shall oppose national socialism. The voluntary route is the opposite direction to the compulsory way!

OUR DISJOINTED TIMES—A CHALLENGE!

"I'LL TEACH that so-and-so to shine his bright lights on me," muttered a boy joy-riding (and drinking) with two other boys and two girls in Michigan. He gripped the wheel and steered deliberately into the oncoming car carrying the parents of eleven children all under fifteen years of age.

Crash! ! ! Only one girl survived from the two cars.

"Today three teen-agers were convicted of murdering a nurse—two first degree, one second degree."

"Crazy teen-agers," we say. "Hoodlums"—"Thoughtless"—"Headstrong"—"Ghastly."

How about it? How much are these teen-agers at fault? What example have they seen? Not a one of them has lived under any other circumstances than government by emergency. They have seen utter disregard for their rights, or others, by their elders. How about the unrest of labor? capital? employment? management? government? When a situation becomes out-of-hand, government declares an emergency and seizes industry. If we are not mistaken, the railroads are now under army administration under a two-year-old seizure to settle a strike which neither management or labor were willing to settle, but which in no way took account of the rights of the public.

You say youth has too much money and spends it for drink. What can they do with money? Government has had no respect for it—has used it recklessly. There seems to be no limit to the supply. No use saving it, for its value is constantly lessening.

What example has been set for these children? Have their elders used caution and discrimination in every action—or have they rushed heedlessly into one new debacle after another?

Unless we wish more of these horrors, some intelligent method of child raising, some useful outlet of young energies, some idea of responsibility for themselves and for others must be aroused.

Has our generation defaulted with regard to the oncoming group? There is a responsibility. Intellectual leaders have a duty to perform, or the next stage of civilization will not be worth salvaging.

RESTRICTED RETIREMENT FUNDS

AGAIN we propose that the Federal Income Tax laws be so amended as to allow self-employed professional persons, whose adequate income years are limited, to reserve part of their income temporarily tax free, and invest in certain government-specified bonds, which will mature after retirement as an annuity, taxes to be paid as they mature.

THE JOURNAL for several years has made this or similar suggestions,* and felt this last summer that our suggestion might bear fruit when Senator Irvin M. Ives of New York introduced an amendment to the Appropriation Bill. However, that amendment was withdrawn just before the bill was enacted.

We still believe there is a reasonable need for this legislation and a justification. Executives in industry are allowed a similar benefit. Industry may provide an annuity fund for its executives and charge the cost off as tax exempt. All that medical men, dentists, architects, lawyers, engineers and the clergy ask is equal opportunity and equal consideration.

The bill which Mr. Ives proposed had a rather complicated modus operandi, involving the necessity of the profession interested to set up some form of company or organization to administer the program. Maybe it is best that this particular plan did not become law for it seems that a much more simple plan could be worked out.

We would suggest that the limit of amount to be segregated be fixed at 20 per cent, or at Mr. Ives' 15 per cent. That amount of one's income could be reserved tax free, when and if it is immediately invested in certain specified Government "tax anticipation bonds" of low interest rate. The government would benefit by having the use of this money at low interest, offsetting the tax most of it would have become. At the age of retirement, or optionally in later years, these bonds could be retired, paying the income tax as of that year.

Just recently one of our members asked if there were not some way in which we as doctors could provide for our future. We believe there is. We are again offering the suggestion.

BLUE SHIELD AND THE MEDICAL PROFESSION

PREPAYMENT INSURANCE is ideal to care for medical and health catastrophies, the long or expensive illnesses which plague our patients, and which just as surely concern the doctor in attendance. The past few years have seen a tremendous increase in this form of protection. The medical profession led the way, attacking the problem when insurance companies dared not because there were no experience tables upon which to base their formulas. Medicine could and did do the job because the profession was willing to run the risk. They were offering their services at a predetermined price, but with the distinct provision that if the funds were not enough, the profession would pay themselves pro rata. That is exactly what Michigan did, and Michigan was the pioneer in mass voluntary prepayment health insurance.

The medically sponsored plans are the very heart and sinew of the whole voluntary system which has grown to an immense total coverage. Such an entirely new venture and philosophy must *work* to prove its value. It necessarily is not perfect, but has very successfully done its most significant service—taking the calamity out of the health misfortunes which strike our people.

We have complaints. We would be surprised if we did not. Some of the complaints come from our subscribers: not every risk is covered. But these same people carry automobile insurance with

*Sept. 1945, page 1013; Sept. 1949, pages 1171-2; July 1950, page 810; April 1951, page 410; May 1951, page 514.

a deductible clause. The automobile insurance premium is less if the first twenty-five dollars must be paid by the subscriber. A fifty-dollar deductible policy is still less. How many people carry full coverage automobile insurance? None, for the companies will not even sell it now—the cost prices it out of the market.

A medical health insurance which covers every risk can be written. We did that when we first started Michigan Medical Service, but we lost plenty. It could be sold now but the cost is prohibitive. In constantly increasing numbers, our patrons are taking the limited coverage which is salable, and is sold.

Occasionally, a patient comes to the doctor with complaint of some item which supposedly is not covered; for instance, hospitalization for diagnostic reasons. He demands the services because, "I have carried this insurance for five or six years, and have never collected on it; therefore, this particular service is due me." This same man undoubtedly carries fire insurance on his house. The same reasoning would call for a fire so he could collect on his fire insurance. But he does not want a fire.

Our doctors sometimes complain that they were not paid enough for some particular service. Did he give in his report an adequate description of the service? These service claims are paid according to the schedule, if the case is strictly classifiable. Otherwise, it must be presented to the Medical Advisory Committee to determine what should be paid, and a complete and exact description of the service will solve the difficulty. This committee frequently has to recommend to the Board a special payment for a special case.

Medical reports of cases come in at from 40,000 to 50,000 a month, and each report takes several handlings. At one time Michigan Medical Service made payment in less than two weeks, but is now taking approximately four or five weeks. That is due to more business.

Doctors wishing to co-operate, to make the work most sure and prompt, should make their reports clearly, exactly, but concisely. Make only one report, but be sure the patient's name and address, as well as his policy numbers, are exact. If there is undue delay in receiving payment, do not send in another report, but write a letter of inquiry, giving all the facts. Michigan Medical Service is eager to expedite the work, to please the doctor, and to please the patients.

Many of our doctors forget, but all these voluntary prepayment health services are our own Society-sponsored plan, and to be a success they must have our co-operation and consideration, as well as complete loyalty. The patients and the doctors will benefit most when there is complete understanding of our motives, our ideals, and the complications and considerations necessary to economic and proper function. If we cannot do a good job and do it with satisfaction, we have failed. But, *we have not failed.*

BEAUMONT MEMORIAL

IN MICHIGAN we have the site of one of the greatest advances of medicine in modern times. In 1822 at the American Fur Company Store on Mackinac Island, Alexis St. Martin, a French-Canadian boy of eighteen, was shot in the stomach. Dr. William Beaumont, the Army surgeon at the Fort, cared for the patient who had a permanent opening into his stomach. Every medical man has heard this story and has been proud of the fact that one of our profession recognized his opportunity and pioneered modern research.

The Michigan State Medical Society a few years ago was apprized of the danger of losing this shrine and took steps through a special committee to purchase the place. Extensive studies have been made to give us an exact picture of what that old trading store actually was at the time of the shooting. Only a small part of the building standing on the site is the original. There have been two major remodellings and additions.

The Michigan State Medical Society, having acquired this property, proposes to restore the place to its original condition. Timbers from the old part of the building will be used, and the masonry. The northern country will be combed for like material, both timber and stone, so that the reconstructed building will have a considerable percentage of the old timbers and walls, but the whole building so far as is humanly possible will be an exact duplicate of the original.

It is estimated that this will cost somewhere around $40,000. The committee hopes this may be primarily a medical undertaking with contributions mostly from our own group of doctors. Anybody who is interested is invited to send a check to the Beaumont Memorial Committee, care Michi-

(Continued on Page 81)

Sixth Annual

Michigan Clinical Institute

SHERATON-CADILLAC HOTEL, DETROIT

MARCH 12, 13, 14, 1952

E. F. Sladek, M.D., Traverse City, *General Chairman*

Information

- **HEADQUARTERS.**—Sheraton-Cadillac Hotel; Assemblies, Exhibits and Press Room on Fourth Floor; Luncheons in English Room on Mezzanine Floor.

- **REGISTRATION.**—Tuesday noon through Friday, March 11-14, Sheraton-Cadillac Hotel.

- **ADMISSION BY BADGE ONLY** to all meetings and to the exhibits. Present your MSMS, State or Canadian Medical Association membership card to expedite registration.

 NO REGISTRATION FEE FOR MSMS OR OTHER STATE MEDICAL SOCIETY MEMBERS, OR FOR CANADIAN MEDICAL ASSOCIATION MEMBERS.

- **ADVANCE REGISTRATION WILL SAVE YOUR TIME.**—Preconvention registration is arranged for Tuesday, March 11, 1:00 p.m. to 4:30 p.m. Registration will resume Wednesday, March 12, at 7:30 a.m. Avoid waiting in line by registering Tuesday afternoon or early Wednesday morning, if possible.

- **SUBSCRIPTION LUNCHEONS.** — Wednesday, Thursday, Friday, March 12-13-14, English Room, Sheraton-Cadillac Hotel, 12:15 noon to 2:00 p.m. with a thirty-minute scientific address following each luncheon. See Program, pages 75, 78, 80.

- **TELEPHONE SERVICE.**—Local and long distance telephone service will be available in the Sheraton-Cadillac Hotel, fourth floor. In case of emergency, physicians will be paged from the meetings by announcement on the screen. Call the Sheraton-Cadillac Hotel, Detroit, Woodward 1-8000, and ask for the Michigan Clinical Institute extensions on the fourth floor.

- **CHECKROOM** is available in the Sheraton-Cadillac Hotel, fourth floor.

- **GUEST ESSAYISTS** are very respectfully requested not to change time of their lecture with another speaker without the approval of the Committee on Arrangements. This request is made in order to avoid confusion and disappointment on the part of members of the audience.

- **PAPERS WILL BEGIN AND END ON TIME.**—Nothing makes a scientific meeting more attractive than by-the-clock promptness and regularity; therefore, all meetings, luncheons, and panels will open on time, all speakers will be required to begin their talks exactly on time and to close exactly on time, in accordance with the schedule in the Program. All who attend the Institute are respectfully requested to assist in attaining this end by noting the schedule carefully and being in attendance accordingly, in order not to miss that portion of the program of greatest interest.

- **TECHNICAL EXHIBITS.**—74 interesting and instructive displays—will open daily at 8:30 a.m. and close at 5:30 p.m., except on Friday when the exhibit breaks up at 3:30 p.m. Frequent intermissions to view the exhibits have been arranged daily before, during and after the assemblies and luncheons.

- **REGISTER AT EVERY BOOTH.**—There is something of interest or education in the large exhibit of technical displays.

- **SAVE AN ORDER FOR THE EXHIBITOR AT THE MICHIGAN CLINICAL INSTITUTE.**

- **POSTGRADUATE CREDITS** are given to every MSMS member who attends the Michigan Clinical Institute.

- **PARKING.**—Do not park on Detroit's streets. Rates for inside parking, supplied us by two of the several garages written for this information, are as follows:

 Book Tower Garage, Inc.—Daily rates 50c first hour, 10c each additional hour up to 8 hours and then 5c an hour up to 24 hours. $2.00 the first 24 hours and $1.50 each additional 24 hours. Weekly rates—$10.00 a week, payable one week in advance. The weekly rate includes in and out service any time during the 24 hours.

 National Garages, Inc.—$1.50 for each 24-hour period or $7.00 per week if the car is not moved during that time. Weekly rate with in and out service $9.00. If the car is picked up or delivered to the hotel, the charge would be 50c each way.

- **INFORMATION OF PRACTICAL VALUE IN DAILY PRACTICE** will be found at the Michigan Clinical Institute. All subjects on the Institute Program are applicable to clinical medicine. They stress diagnosis and treatment, usable in every-day practice.

• **SCROLL TO CLAYTON L. WILLISON, M.D.,** Sault Ste. Marie, chosen by the Michigan State Medical Society as "Michigan's Foremost Family Physician of 1951." Dr. Willison will be honored on Thursday noon, March 13, 1952, when a Scroll emblematic of his new title will be presented to him.

* * *

• **SCROLLS OF APPRECIATION** will be presented on Thursday noon, March 13, 1952, during the Michigan Clinical Institute, to (a) Leo H. Bartemeier, M.D., of Detroit, President of the American Psychiatric Association; and (b) J. Milton Robb, M.D., of Detroit, President of the American Academy of Ophthalmology and Otolaryngology.

Testimonial Dinners, sponsored by members of their respective specialty groups, have been arranged, toasting Dr. Bartemeier on Wednesday, March 12, and honoring Dr. Robb on Thursday, March 13.

* * *

• **SCROLL OF COMMENDATION** will be awarded the Hillsdale (Michigan) County Medical Society on its successful plan of cancer detection.

* * *

• **MEETINGS OF SPECIAL SOCIETIES, ALUMNI AND AUXILIARY GROUPS.**

To date, arrangements have been made by the following groups to meet in Detroit coincident with the Michigan Clinical Institute:

1. **Michigan Chapter, Arthritis and Rheumatism Foundation** will hold a dinner and business meeting on Thursday, March 13, 6:30 p.m. in the Founders' Room, Sheraton-Cadillac Hotel.

2. **The Woman's Auxiliary to the Michigan State Medical Society** will hold an all-day business meeting on Wednesday, March 12, in the Founders' Room, Sheraton-Cadillac Hotel, beginning at 10:00 a.m.

3. **Michigan Chapter, American College of Surgeons,** will hold a business meeting with election of officers on Tuesday, March 11, 2:00 p.m. in the English Room, Sheraton-Cadillac Hotel.

4. **The Michigan Branch of the Academy of Pediatrics** will hold a meeting on Wednesday, March 12, Founders' Room, Sheraton-Cadillac Hotel. Cocktails at 6:00 p.m. with dinner at 6:45 p.m. followed by business meeting and scientific address by James L. Wilson, M.D., Ann Arbor, Professor and Chairman, Department of Pediatrics, University of Michigan, on "Practical Aspects of the Physiological Problems of the Fetus and the Newborn."

5. **The Michigan Regional Committee on Trauma, American College of Surgeons,** will hold a luncheon on Thursday, March 13, 1952, 12:00 noon to 2:00 p.m. in Parlor H of the Sheraton-Cadillac Hotel, to be followed by a symposium from 2:00 to 5:00 p.m. in the Pan American Room, Sheraton-Cadillac Hotel. The Greater Detroit Committee on Trauma, American College of Surgeons, has arranged the following Trauma Symposium:

"The Treatment of Lacerations of the Neck"—Homer M. Smathers, M.D., Detroit.

"Simple Method for Guidance of Insertion of Smith-Peterson Nail"—Frederick P. Maibauer, M.D., Wyandotte.

"The Treatment of the Severed Flexor Tendon"—Joseph L. Posch, M.D., Detroit.

"How to Avoid Anesthetic Difficulties in the Emergency Treatment of Trauma"—A. B. Stearns, M.D., Detroit.

"Open Reduction in the Treatment of Fracture of the Os Calcia"—Lee A. Lewis, M.D., Detroit.

"The Importance of Accurate Reduction of Colles Fracture"—Herbert E. Pederson, M.D., St. Louis.

"Important Diagnostic Criteria in Management of Acute Head Injuries"—John E. Webster, M.D., Detroit.

"Present Concept of the Treatment of Shock"—Alfred M. Large, M.D., Detroit.

This meeting is part of a statewide educational program devoted to the surgery of trauma. The Greater Detroit Committee on Trauma is the largest and one of the most active in Michigan.

The officers of the Michigan Committee on Trauma (Duncan A. Cameron, M.D., Detroit, Chairman, and Vernon C. Abbott, M.D., Pontiac, Secretary) cordially invite all members of the Michigan State Medical Society and guests of the Michigan Clinical institute to attend this symposium.

6. **The Michigan Proctological Society** will hold a dinner meeting on Thursday, March 13, 6:30 p.m., Parlor H, Sheraton-Cadillac Hotel, Detroit.

6:30 p.m.—Cocktails
7:00 p.m.—Dinner
8:00 p.m.—Symposium on "Chronic Ulcerative Colitis," with the following topics and doctors on the panel.

"Etiology"—Joseph W. Becker, M.D., Detroit
"Influence of Pregnancy"—Herbert I. Kallet, M.D., Detroit
"Medical Management"—Ralph M. Burke, M.D., Detroit
"Surgical Management"—Norman D. Nigro, M.D., Detroit
Round Table Discussion
Moderator—Jacob F. Wenzel, M.D., Detroit

7. **The Michigan Diabetes Association** will hold a dinner-meeting on Thursday, March 13, 1952, beginning at 6:30 p.m., Sheraton-Cadillac Hotel. Speaker will be Garfield G. Duncan, M.D., of Philadelphia.

8. **The Wayne University Alumni Association** will have a headquarters-suite at the Sheraton-Cadillac Hotel during the Michigan Clinical Institute.

* * *

• The **Michigan Clinical Institute** gratefully acknowledges the cooperation of the **Michigan Heart Association** in sponsoring the six heart speakers on Friday morning, March 14. Also in providing Samuel A. Levine, M.D., of Boston, as guest speaker at the Heart luncheon of Friday noon, March 14.

• The **Michigan Clinical Institute** gratefully acknowledges the cooperation of the **Michigan Tuberculosis Association** in sponsoring Jay A. Myers, M.D., Minneapolis, Minnesota, guest speaker who appears on Thursday, March 13, 1952, at 2:40 p.m.

• **Michigan Medical Service** contributed 2,000 "Doodle Diaries" to be used by MCI registrants as notebooks. Thanks are extended to Michigan Medical Service.

• **Norvin C. Kiefer, M.D.,** Washington, D. C., Director, Health and Special Weapons Defense Division, FCDA, is guest speaker at the Medical Civil Defense meeting an Wednesday evening, March 12, 1952, 8:30 p.m. in the Grand Ballroom, Sheraton-Cadillac Hotel. Doctor Kiefer's address is being sponsored by the Wayne County Medical Society, the Michigan Clinical Institute, and the Michigan State Medical Society and is entitled: "The Physician in Civil Defense."

PROGRAM

Wednesday, March 12, 1952

A.M.

7:30 REGISTRATION—Fifth Floor

8:30—EXHIBITS OPEN—Fourth Floor

FIRST ASSEMBLY

Grand Ballroom, Sheraton-Cadillac Hotel

B. T. Montgomery, M.D., Sault Ste. Marie, Chairman

8:50 WELCOME

Otto O. Beck, M.D., Birmingham
President, Michigan State Medical Society

Arch Walls, M.D., Detroit
President, Wayne County Medical Society

9:00 "Office Treatment of the Urological Patient"

Reader J. Hubbell, M.D., Kalamazoo
Chief of Surgical Section, Bronson Methodist Hospital, Kalamazoo



R. J. Hubbell, M.D.

9:20 "Management Common Fractures of the Lower Extremity"

Robert J. Bannow, M.D., Pontiac
Chief, Orthopedic Surgery Department, St. Joseph Mercy Hospital, Pontiac; Staff, St. Joseph Mercy Hospital and Pontiac General Hospital; Diplomate, American Board Orthopedic Surgery and Member American Academy of Orthopedic Surgeons



R. J. Bannon, M.D.

9:40 "Conservative Treatment of Low Back Pain"

Charles H. Frantz, M.D., Grand Rapids
Consultant Blodgett Memorial Hospital and Mary Free Bed Convalescent and Orthopedic Center



C. H. Frantz, M.D.

10:00 INTERMISSION TO VIEW EXHIBITS

11:00 "Present Status of the Treatment of Burns"

Truman G. Blocker, Jr., M.D., Galveston, Texas
Professor of Plastic and Maxillofacial Surgery, University of Texas Medical Branch; Medical Administrator, University Branch Hospitals; Consultant, Surgeon General's Office; Branch Section Chief, Veterans Administration, Member of Burn Subcommittee, National Research Council



T. G. Blocker, Jr., M.D.

11:20 "Abdominal Emergencies"

Clarence E. Umphrey, M.D., Detroit
Surgeon, Florence Crittenton Hospital



C. E. Umphrey, M.D.

11:40 "The Surgery of Traumatism with Special Reference to the Injuries of the Abdominal Contents"

Edward J. McCormick, M.D., Toledo, Ohio
Visiting Surgeon Toledo and Flower Hospitals; Member Executive Committee and Chairman Advisory Committee, St. Vincent's Hospital



E. J. McCormick, M.D.

M

12:00 End of First Assembly

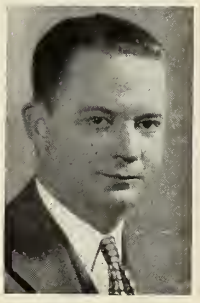
P.M.

12:15—Luncheon, English Room, Sheraton-Cadillac Hotel

Wilfrid Haughey, M.D., Battle Creek, *Chairman*

1:15 "Dynamic Therapeutics in Chronic Disease"

Howard A. Rusk, M.D., New York City
Professor and Chairman, Department of Physical Medicine and Rehabilitation, New York University College of Medicine; Chairman Health Resources Advisory Committee, Office of Defense Mobilization



H. A. Rusk, M.D.



H. A. Ott, M.D.



N. F. Miller, M.D.



F. S. Leeder, M.D.



W. C. C. Cole, M.D.



N. Westlund, M.D.



M. R. Westerberg, M.D.



C. G. Jennings, M.D.



R. D. Rabinovitch, M.D.

SECOND ASSEMBLY

Grand Ballroom, Sheraton-Cadillac Hotel

H. A. Towsley, M.D., Ann Arbor, *Chairman*

P.M.

2:00 **"Prenatal Care"**

Harold A. Ott, M.D., Detroit
Member, Active Staff, Obstetrics and Gynecology, Florence Crittenton Hospital; Consultant, Obstetrics and Gynecology, Herman Keifer Hospital; Acting Medical Director, Florence Crittenton Hospital; Instructor, Obstetrics and Gynecology, Wayne University College of Medicine.

2:20 **"Postpartum Care"**

Norman F. Miller, M.D., Ann Arbor
Professor and Head of Department of Obstetrics and Gynecology, University of Michigan

2:40—"A Modern Immunization Program"

Frederick S. Leeder, M.D., Lansing
Director, Division of Disease Control Records and Statistics, Michigan Department of Health

3:00 **INTERMISSION TO VIEW EXHIBITS**

4:00 **"Blood Dyscrasias of the Newborn"**

Wyman C. C. Cole, M.D., Detroit
Chief, Pediatric Service, Woman's Hospital; Senior Attending, Pediatrics, Harper Hospital

4:20 **Panel on (a) Deviated Child; (b) Problems of Newborn; (c) Convulsive Status of Childhood**

Moderator:

Norman Westlund, M.D., Saginaw
Chairman, Section of Neuropsychiatry Saginaw General Hospital

Neurologist:

Martha R. Westerberg, M.D., Ann Arbor
Assistant Professor of Neurology, Department of Neurology, University of Michigan; Director Saginaw Valley Children's Center

Psychiatrist:

Ralph D. Rabinovitch, M.D., Ann Arbor
Chief of Children's Service, Neuropsychiatric Institute, University of Michigan; Associate Professor of Psychiatry, University of Michigan

Pediatrician:

Charles G. Jennings, M.D., Detroit
Assistant Pediatrician, Children's Hospital; Voluntary Assistant in Pediatrics, Harper Hospital; Pediatrician, Jennings Memorial Hospital; Consulting Pediatrician, Merrill-Palmer School, Detroit; Instructor in Clinical Pediatrics, Wayne University College of Medicine

5:00 **End of Second Assembly**

Wednesday Evening—March 12, 1952

Grand Ballroom, Sheraton-Cadillac Hotel

P.M.

8:30 MEDICAL CIVIL DEFENSE MEETING

The evening meeting of Wednesday, March 12, will be devoted to the medical phases of civil defense.

SPEAKER

"The Physician in Civil Defense"

NORVIN C. KIEFER, M.D., Washington, D. C., Director Health and Special Weapons Defense Division, F.C.D.A.

Sponsors: Wayne County Medical Society, Michigan Clinical Institute and the Michigan State Medical Society

All M.C.I. registrants, their wives and guests are cordially invited

Thursday, March 13, 1952

Sheraton-Cadillac Hotel

A.M.

8:30 REGISTRATION—Fifth Floor

EXHIBITS OPEN—Fourth Floor

THIRD ASSEMBLY

Grand Ballroom, Sheraton-Cadillac Hotel

LOUIS JAFFE, M.D., Detroit, *Chairman*

9:00 "Treatment of Contact Dermatitis"

JAMES R. ROGIN, M.D., Detroit

Assistant Professor of Dermatology and Syphilology, Wayne University College of Medicine



J. R. ROGIN, M.D.

9:20 "Symptomatic Treatment of Hay Fever and Asthma"

OSCAR SWINEFORD, JR., M.D., Charlottesville, Virginia

Professor of Internal Medicine in charge of Allergy, Arthritis Division, University of Virginia, Department of Medicine



O. SWINEFORD, JR., M.D.

10:00 INTERMISSION TO VIEW EXHIBITS

11:00 "Medical Management of Peptic Ulcer"

S. G. MEYERS, M.D., Detroit

Associate Professor of Clinical Medicine, Wayne University College of Medicine; Attending Physician, Receiving Hospital, Harper Hospital, North End Clinic



S. G. MEYERS, M.D.

11:20 "Practical Considerations in the Management of Diabetes"

GARFIELD G. DUNCAN, M.D., Philadelphia

Director of Medical Division, Pennsylvania Hospital and Benjamin Franklin Clinic; Clinical Professor of Medicine, Jefferson Medical College



G. G. DUNCAN, M.D.

11:40 "Medical Treatment of Phlebitis"

FRANK D. JOHNSON, M.D., Flint

Attending Physician, Bellevue Hospital; University Hospital, New York University; Bellevue Medical Center



F. D. JOHNSON, M.D.

M

12:00 End of Third Assembly



R. S. Sykes, D.D.S.
Sponsor, Sykes Lecture



L. V. Ackerman, M.D.



C. F. List, M.D.



F. H. Bethell, M.D.



W. B. Cooksey, M.D.



J. A. Myers, M.D.



J. L. Dill, M.D.



I. B. Taylor, M.D.

P.M.

12:15 **LUNCHEON, English Room, Sheraton-Cadillac Hotel**

E. F. Sladek, M.D., Traverse City, *Chairman*

1:15 **THE R. S. SYKES LECTURE**

"The Clinical Pathologic Evaluation of Benign and Borderline Epithelial Tumors of the Large Bowel"

Lauren V. Ackerman, M.D., St. Louis, Missouri

Professor of Surgical Pathology and Pathology, Washington University School of Medicine, St. Louis, Mo., Surgeon-Pathologist to Barnes Hospital and Affiliated Hospitals; Consulting Pathologist to Homer Phillips Hospital, St. Louis and Ellis Fischel State Cancer Hospital

FOURTH ASSEMBLY

Grand Ballroom, Sheraton-Cadillac Hotel

W. Z. Rundles, M.D., Flint, Chairman

P.M.

2:00 **"Chemotherapy in Malignant Diseases"**

Frank H. Bethell, M.D., Ann Arbor

Professor of Internal Medicine, Assistant Director, Thomas Simpson Memorial Institute for Medical Research; Principal Investigator Atomic Energy Commission Laboratory for Study of Biological Effects of Irradiation, University of Michigan; Consultant in Hematology, Percy Jones Hospital, Battle Creek

2:20 **"Neuralgia"**

Carl F. List, M.D., Grand Rapids

Former Assistant, Professor of Neurosurgery, University of Michigan

2:40 **"Refinements in Diagnosis of Early Tuberculosis"**

Jay A. Myers, M.D., Minneapolis, Minnesota*

Medical Director Lymanhurst School, Minneapolis; Chief of Tuberculosis Service, Minneapolis General Hospital; Chief of University of Minnesota Chest Clinic

3:00 **INTERMISSION TO VIEW EXHIBITS**

4:00 **"Health Requirements of the Aging Population"**

Warren B. Cooksey, M.D., Detroit

Assistant Professor Clinical Medicine, Wayne University; Chief of Staff, Chief of Medicine, Florence Crittenton Hospital; Attending Physician, Harper Hospital; Governor's Commission on Problems of the Aged

4:20 **"The Uses of Local Anesthesia"**

Ivan B. Taylor, M.D., Detroit

Clinical Professor of Anesthesia, Wayne University College of Medicine; Consultant in Anesthesia, Veterans Administration, Dearborn

4:40 **"Causes and Treatment of Vertigo"**

J. Lewis Dill, M.D., Detroit

Surgeon in Charge, Division of Otolaryngology, Henry Ford Hospital, Detroit

5:00 **End of Fourth Assembly**

**Sponsored by Michigan Tuberculosis Association*

Friday, March 14, 1952

Sheraton-Cadillac Hotel

A.M.

8:30 **REGISTRATION—Fifth Floor**
EXHIBITS OPEN—Fourth Floor



F. D. Johnston, M.D.



Conrad Lam, M.D.

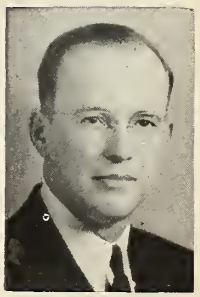
FIFTH ASSEMBLY

Grand Ballroom, Sheraton-Cadillac Hotel

P. S. Barker, M.D., Ann Arbor, *Chairman*
F. J. Smith, M.D., Detroit, *Co-Chairman*

9:00 **"The Proper Place of the Electrocardiogram in Clinical Practice"**

Franklin D. Johnston, M.D., Ann Arbor**
Professor of Internal Medicine, University of Michigan



G. B. Myers, M.D.

9:20 **"The Surgical Treatment of Mitral Stenosis"**

Conrad Lam, M.D., Detroit**
Associate Surgeon, Department of Thoracic Surgery, Henry Ford Hospital, Detroit

9:40 **"Modern Treatment of Congestive Heart Failure"**

Gordon B. Myers, M.D., Detroit**
Professor of Internal Medicine, Wayne University College of Medicine; Head of Department of Medicine, City of Detroit Receiving Hospital



M. S. Hecht, M.D.

10:00 **INTERMISSION TO VIEW EXHIBITS**

11:00 **"Current Therapy of Rheumatic Fever in Children"**

Manes S. Hecht, M.D., Detroit**
Director of Research, Children's Hospital



S. W. Hoobler, M.D.

11:20 **"Drug Therapy of Hypertension"**

Sibley W. Hoobler, M.D., Ann Arbor**
Assistant Professor of Internal Medicine in charge of Cardiovascular Unit, University of Michigan

11:40 **Panel Discussion: "The Flicker Photometer"**

Myrton S. Chambers, M.D., Flint**
Director of Departments of Internal Medicine and Electrocardiography, Hurley Hospital; Chief of Section of Cardiovascular Diseases, Hurley Hospital Cardiologist, McClaren General Hospital; President Genesee County Medical Society

Franklin D. Johnston, M.D., Ann Arbor**



M. S. Chambers, M.D.

**Sponsored by Michigan Heart Association*



D. Donald, M.D.



S. A. Levine, M.D.



L. T. Iseri, M.D.



C. F. Wilkinson, Jr., M.D.



R. L. Schaefer, M.D.



R. O. Muether, M.D.



F. M. Hanger, M.D.



R. H. Freyberg, M.D.

M

12:15 **HEART LUNCHEON, English Room, Sheraton-Cadillac Hotel****

Douglas Donald, M.D., Detroit, *Chairman*

1. Annual Meeting and Election of Officers of Michigan Heart Association
2. "The Importance of the History and Physical Examination in the Diagnosis of Heart Disease"

Samuel A. Levine, M.D., Boston, Mass.**
Physician, Peter Bent Brigham Hospital, Boston; Clinical Professor of Medicine, Howard Medical School, Boston

SIXTH ASSEMBLY

Grand Ballroom, Sheraton-Cadillac Hotel

D. B. Wiley, M.D., Utica, *Chairman*

P.M.

2:00 **"Treatment of the Nephrotic Syndrome"**
Lloyd T. Iseri, M.D., Detroit
Assistant Professor and Research Associate, Wayne University College of Medicine

2:20 **"Arteriosclerosis"**
Charles F. Wilkinson, Jr., M.D., New York City
Professor and Chairman, Department of Medicine, New York University Postgraduate Medical School; Director, Medical Service and Attending Physician, University Hospital, New York City; Director, Fourth Medical (N.Y.U.) Division; Visiting Physician, Bellevue Hospital, New York City

2:40 **"Obesity"**
Robert L. Schaefer, M.D., Detroit, Internist

3:00 **FINAL INTERMISSION TO VIEW EXHIBITS (30 minutes only)**

3:30 **"Differential Diagnosis of Jaundice"**
Raymond O. Muether, M.D., St. Louis, Missouri
Associate Professor of Internal Medicine, St. Louis University School of Medicine; Director of Clinical Laboratories, St. Louis University Group of Hospitals; Editor, Missouri State Medical Journal; Member of the Council of St. Louis Medical Society

4:00 **"Current Evaluation of Cortisone and Corticotropin for Rheumatic Disease"**
Richard H. Freyberg, M.D., New York City
Associate Professor of Clinical Medicine, Cornell University Medical College

4:30 **"Cirrhosis of the Liver"**
Franklin M. Hanger, M.D., New York City
Professor of Medicine, Columbia University; Attending Physician, Presbyterian Hospital, New York

5:00 **End of Sixth Assembly and of the Institute**

* * *

For list of exhibitors at the Institute, see Page 81.

***Sponsored by Michigan Heart Association*

BEAUMONT MEMORIAL

(Continued from Page 72)

gan State Medical Society, 606 Townsend Street, Lansing 15, Michigan.

This is the first time the Michigan State Medical Society has undertaken such an enterprise. We believe in preserving this shrine we are rendering a service to posterity. We believe most of our members will be interested. We are assured that this shrine will be permanently preserved when it is finished, because it will be part of the Mackinac Island State Park and that commission guarantees continued care and supervision.

BIOCHEMISTRY OF MENTAL PATIENTS

WAYNE University recently has undertaken a research project designed to investigate the biochemistry of mental patients. The program is sponsored by the McGregor Fund and the Michigan Department of Mental Health.

This first paper on the effect of electric shock on brain cortex *in vitro* is submitted as a preliminary to experiments which are already under way on the study of mental and hormonal changes in excited and depressed subjects. There are many physical factors in mental disease which have not been adequately considered. Much more fundamental work in psychiatry along biochemical lines seems indicated.

The article in this issue of THE JOURNAL has been written with the hope that it will be of interest to the physician. Our special concern is the Michigan program on mental health.

IT'S A FACT

Medical science can help you to live longer in the same way a good mechanic can keep your car running. The mechanic can do nothing for your car if you keep it on the road and ignore danger signals.

Your doctor can do nothing for you unless you ask his help. The time your doctor can give you the greatest help (and at less cost) is before you get sick.

* * *

The ratio of total hospital costs remains at 1 per cent of the national income, a proportion which has been maintained as long as national estimates have been available for study.—*Michigan Health Council Bulletin*, November, 1951.

1952 MICHIGAN CLINICAL INSTITUTE

Technical Exhibitors

Booth. No.

A. S. Aloe Co., St. Louis, Mo.....44
Americana Corp., Chicago, Ill.....34
Ames Co., Inc., Elkhart, Ind.....10
Ayerst, McKenna & Harrison, Ltd., New York, N. Y.....37

Baker Laboratories, Cleveland, Ohio.....45
Bilhuber-Knoll Corp., Orange, N. J. 54
Borden Co., New York, N. Y.....50
Brown & Williamson Tobacco Corp., Louisville, Ky..... 15, 39

California Pharmacal Co., Los Angeles, Calif.....14
Camel Cigarettes, New York, N. Y.....31, 32
Ciba Pharmaceutical Products, Inc., Summit, N. J.....64
Coca-Cola Co., Atlanta, Ga.....65, 66
Commercial Solvents Corporation..... 62
Cottrell-Clarke, Inc., Detroit, Mich.....28
CSC Pharmaceuticals, New York, N. Y..... 62

Davis & Geck, Inc., Brooklyn, N. Y.....63
Doho Chemical Corp., New York, N. Y..... 8
Doris Appel Medical Sculptures, Lynn, Mass.....27

Ferguson Mfg. Co., Grand Rapids, Mich.....43

Gerber Products Co., Fremont, Mich.....30

Hack Shoe Co., Detroit, Mich..... 3
Hanovia Chemical & Mfg. Co., Newark, N. J.....48
J. F. Hartz Co., Detroit, Mich.....40
Holland-Rantos, Inc., New York, N. Y.....24

G. A. Ingram Co., Detroit, Mich.....67, 68

A. Kuhlman & Co., Detroit, Mich..... 1

Lanteen Medical Labs., Inc., Evanston, Ill.....38
Lea & Febiger, Philadelphia, Pa.....70
Lederle Labs., New York, N. Y.....49
Liebel-Flarsheim Co., Cincinnati, Ohio.....4, 5
Eli Lilly & Co., Indianapolis, Ind.....55
J. B. Lippincott Co., Philadelphia, Pa.....22

M & R Dietetic Labs., Inc., Columbus, Ohio.....11
Maico Detroit Co., Detroit, Mich.....69
Mallard Inc., Detroit, Mich.....35
Marion Phillips Maternity Preparations, Rochester, N. Y. 16
Mead Johnson & Co., Evansville, Ind.....71, 72
Medco Products Co., Tulsa, Okla.....18
Medical Aids Inc., Chicago, Ill.....23
Medical Protective Co., Fort Wayne, Ind.....41
Medical Supply Corp. of Detroit, Detroit, Mich.....56
Merck & Co., Inc., Rahway, N. J.....21
Meyer Chemical Co., Inc., Detroit, Mich.....42
C. V. Mosby Co., St. Louis, Mo.....52

National Drug Co., Philadelphia, Pa..... 9
Wm. R. Niedelson Co., Detroit, Mich.....74

Ortho Pharmaceutical Corp., Raritan, N. J.....47

Parke, Davis & Co., Detroit, Mich.....6, 7
Philip Morris & Co., Ltd., New York, N. Y.....12

A. H. Robins Co., Inc., Richmond, Va.....33

Sanborn Co., Cambridge, Mass.....19
Sandoz Chemical Works, Inc., New York, N. Y.....29
W. B. Saunders Co., Philadelphia, Pa..... 2
Schering Corp., Bloomfield, N. J.....20
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Michigan State Medical Society

Eighty-sixth Annual Session

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* Discussed in Executive Session.

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Michigan State Medical Society

Eighty-sixth Annual Session

DIGEST OF PROCEEDINGS OF THE HOUSE OF DELEGATES

MONDAY MORNING SESSION

September 24, 1951

The first session of the House of Delegates of the Michigan State Medical Society, held at the Pantlind Hotel, Grand Rapids, Michigan, September 24-25, 1951, was convened at 9:45 a.m., R. H. Baker, M.D., Pontiac, Speaker, presiding.

I. Record of Attendance

Office	*Officer*	*Meetings* 1st	2nd	3rd	4th	5th
Speaker	R. H. Baker	x	x	x	x	x
Vice Speaker	J. E. Livesay	x	x	x	x	x
Secretary	L. Fernald Foster	x	x	x	x	x
Immediate Past President	W. E. Barstow	x	x	x	x	x

County	*Delegate*					
1. Allegan	L. F. Brown	x	x	x	x	x
2. Alpena-Alcona-Presque Isle	E. S. Parmenter	x	x	x	x	x
3. Barry	A. B. Gwinn	x	x	x	x	x
4. Bay-Arenac-Iosco	O. J. Johnson	x	x	x	x	x
	W. S. Stinson	x	x	–	x	x
5. Berrien	D. W. Thorup	x	x	x	x	x
6. Branch	H. J. Meier	x	x	x	x	x
7. Calhoun	H. C. Hansen	x	x	x	x	x
	S. T. Lowe	x	x	x	x	x
8. Cass	S. L. Loupee	x	x	x	x	x
9. Chippewa-Mackinac	B. T. Montgomery	x	x	x	x	x
10. Clinton	F. W. Smtih	x	x	x	x	x
11. Delta-Schoolcraft	A. H. Miller	–	–	–	x	x
12. Dickinson-Iron	D. R. Smith	x	x	x	x	x
13. Eaton	G. C. Stucky	x	x	x	x	x
14. Genesee	F. W. Baske	x	x	x	x	x
	L. M. Bogart	–	x	x	x	x
	C. W. Colwell	x	x	x	x	x
	F. D. Johnson	x	x	x	x	x
15. Gogebic	H. A. Pinkerton	Not Represented				
16. Grand Traverse-Leelanau-Benzie	D. G. Pike	x	x	x	x	x
17. Gratiot-Isabella-Clare	M. G. Becker	x	x	x	x	x
18. Hillsdale	L. W. Day	x	x	x	x	x
19. Houghton-Baraga-Keweenaw	P. S. Sloan	x	x	x	x	x
20. Huron	C. W. Oakes	x	x	x	x	x
21. Ingham	Kenneth Johnson	x	x	x	x	x
	O. B. McGillicuddy	x	x	x	x	x
	F. L. Troost	x	x	x	x	x
	H. W. Wiley	x	x	x	x	–
22. Ionia-Montcalm	W. L. Bird	x	x	x	x	x
23. Jackson	G. L. Otis	x	x	x	x	x
	J. W. Rice	x	x	x	x	x
24. Kalamazoo	Fred Ryan	x	x	x	x	x
	W. A. Scott	x	x	x	x	x
	R. W. Shook	x	x	x	x	x
25. Kent	L. C. Carpenter	x	x	x	x	x
	G. W. DeBoer	x	x	–	x	–
	J. W. Logie	x	x	x	x	x
	W. B. Mitchell	x	x	x	x	x
	A. A. Van Solkema	x	x	x	x	x
	A. V. Wenger	x	x	x	x	x
26. Lapeer	D. J. O'Brien	x	x	x	x	–
	C. R. Zolliker	–	–	–	–	x
27. Lenawee	R. E. Dustin	x	x	x	x	x
28. Livingston	H. C. Hill	x	x	–	x	x
29. Luce	M. A. Surrell	Not Represented				
30. Macomb	O. D. Stryker	x	x	x	x	x
31. Manistee	E. C. Hansen	x	x	x	x	x
32. Marquette-Alger	A. S. Narotzky	x	x	x	x	x
33. Mason	E. B. Boldyreff	x	x	x	x	x
34. Mecosta-Osceola-Lake	Paul Ivkovich	x	x	x	x	x
35. Menominee	J. R. Heidenreich	x	x	x	x	x
36. Midland	H. L. Gordon	x	–	x	x	–
37. Monroe	J. P. Flanders	x	x	x	x	x
38. Muskegon	R. D. Risk	x	x	x	x	x
	N. W. Scholle	x	x	x	x	x
39. Newaygo	J. P. Klein	x	x	x	x	x
40. North Central	S. A. Stealy	x	x	x	x	x
41. Northern Mich.	J. R. Rodger	x	x	x	x	x
42. Oakland	E. B. Cudney	x	x	x	x	x
	O. R. Mackenzie	x	x	x	x	x
	J. M. Markley	x	x	x	x	x
	E. C. Rupp	x	x	x	–	–
	P. E. Sutton	–	–	–	x	x
43. Oceana	M. G. Wood	Not Represented				
44. Ontonagon	W. F. Strong	x	x	x	–	–
45. Ottawa	D. C. Bloemendaal	x	x	x	x	x
46. Saginaw	F. E. Luger	x	x	x	x	x
	J. E. Manning	x	x	x	x	–
	J. P. Markey	x	x	x	x	x
47. Sanilac	James Cripps	Not Represented				
48. Shiawassee	C. L. Weston	x	x	x	x	x
49. St. Clair	J. F. Beer	x	x	x	x	x
50. St. Joseph	R. A. Springer	x	x	x	x	x
51. Tuscola	L. L. Savage	x	–	x	x	x
52. Van Buren	W. R. Young	x	x	x	x	x
53. Washtenaw	P. S. Barker	x	x	–	x	x
	O. K. Engelke	x	x	x	x	x
	B. M. Harris	x	x	x	x	x
	H. A. Miller	x	x	x	x	–
54. Wayne	R. W. Teed	x	x	x	x	x
	Sidney Adler	x	x	x	x	x
	Raphael Altman	x	x	x	x	x
	K. B. Babcock	x	x	x	x	x
	W. W. Babcock	x	x	x	x	x
	L. J. Bailey	x	x	x	x	x
	W. L. Brosius	x	x	x	x	x
	C. L. Candler	x	x	x	x	x
	George Chabut	x	x	x	x	x
	M. A. Darling	x	x	x	x	x
	H. F. Dibble	x	x	x	x	x
	H. B. Fenech	x	x	x	x	x
	E. H. Fenton	–	x	x	x	x
	R. F. Fenton	x	x	x	x	x
	C. K. Hasley	x	x	x	x	x
	L. T. Henderson	x	x	x	x	x
	Louis Jaffe	x	x	x	x	x
	R. A. Johnson	x	x	x	x	x
	D. H. Kaump	x	x	x	x	–
	E. D. King	x	x	x	x	x
	E. G. Krieg	x	x	x	x	x
	H. J. Kullman	x	x	x	x	x
	L. R. Leader	x	x	x	x	x
	M. L. Lichter	x	x	x	x	x
	J. J. Lightbody	x	x	x	x	x
	E. C. Long	x	x	x	x	x
	I. G. Molner	x	x	x	–	x
	L. J. Morand	x	x	x	x	x
	R. L. Novy	x	x	x	x	x
	E. A. Osius	x	x	x	x	–
	C. I. Owen	x	x	x	x	x
	G. C. Penberthy	x	x	x	x	x
	A. H. Price	x	x	x	x	x
	W. S. Reveno	x	x	x	x	–
	J. H. Schlemer	x	x	x	x	x
	E. D. Spalding	x	x	x	x	x
	D. I. Sugar	x	x	x	x	x
	K. L. Swift	x	x	x	x	x
	E. C. Texter	x	x	x	x	x
	R. V. Walker	x	x	x	x	x
	Arch Walls	x	x	x	x	x
	P. J. Waltz	x	–	x	x	x
	F. A. Weiser	x	x	x	x	x
	J. A. Witter	x	x	x	x	x
	D. A. Young	x	x	x	–	–
55. Wexford-Missaukee	R. V. Daugherty	x	x	x	x	x

THE SPEAKER: The Press Committee is composed of Dr. Livesay, Dr. Bromme, Dr. Dibble, Dr. Foster and myself. It is our responsibility to release press news to the public. Please do not give any information to the press, either on or off the record. If you have backgrounds or examples which would be of value, give them to the Press Committee, which will have its headquarters in Parlor D of this hotel. The Press Relations Committee will be in the press room at all times.

XI. Special Members

One more item, in regard to special memberships: If you have special memberships to request, it is not necessary for you to present them in a separate resolution. Turn over your list and credentials, or your resolution if you have one, to the Secretary. Leave it at the desk, and it will be turned over to the chairman of the Special Memberships Committee, Dr. Darling. He will present the entire list by resolution in due time.

In Memoriam

There is one other item I wish to bring up, namely, to ask you to take note of the fact that 100 of the membership of the Michigan State Medical Society have died during the past year. I have their names, and they are on record. The names are available if you wish to see them.

Among them I wish to name two in particular, who have given outstanding service to our Society. One is Dr. James H. Dempster. I will simply state that for thirteen years Dr. Dempster was Editor of our JOURNAL. Many of you knew him and respected and loved him for the fine work he did.

The other member, who will be remembered by many in the House, was Henry J. Pyle, of Grand Rapids, who was Speaker of this House from 1929 to 1933.

W. B. MITCHELL (Kent): If you please, Mr. Speaker, I would like to present a resolution at this time.

THE SPEAKER: I will accept your resolution at this time, Dr. Mitchell.

XII—a. RESOLUTION RE H. J. PYLE, M.D., DECEASED

W. B. MITCHELL: This concerns Dr. Henry J. Pyle, who was Speaker of the House of Delegates:

"Whereas, the late Henry J. Pyle, M.D., served faithfully as the Speaker of the House of Delegates from 1929 to 1933 inclusively; be it

"RESOLVED: That the Kent County Medical Society request that the House of Delegates of the Michigan State Medical Society rise for a moment of silence in respect for its former Speaker; be it further

"RESOLVED: That a copy of this resolution be placed upon the minutes of the House of Delegates, and a copy be sent to his family."

I move the adoption of this resolution, Mr. Speaker.

(The motion was severally seconded, was put to a vote, and was carried unanimously.)

THE SPEAKER: We will honor all those members who passed away during the year by rising for a moment of silence.

(Silent standing tribute.)

II. Speaker's Address

By R. H. Baker, M.D., Pontiac

As your Speaker, this is my moment to express my own thoughts, and not worry about a second or parliamentary practice. This morning I am in a reminiscent mood.

It was my pleasure and privilege this month to hear one of our distinguished members, Dr. Frederick A. Coller, address my County Medical Society on "The Progress of Surgery." Medical history has always been a hobby with Dr. Coller. He noted the early high spots in surgical development, such as the use of ether, the concept of antiseptic surgery, the advent of x-ray and radium. Prior to 1920 surgery made no great advances except as assisted by these agents. Then a new era began to dawn. Anesthetic agents and techniques were greatly improved. The era of the sulfas and the antibiotics is now full blown. We have new and more exact concepts of physiology and biochemistry. With this new knowledge, surgery has extended into many new and previously untouched fields.

I give this outline of his remarks to see if it stirs in you any memories of the past and any dreams of the future. As I listened to Dr. Coller I could think back to my father's generation. My father entered the practice of medicine in 1882. He had the first student-owned microscope in the University of Michigan Medical School. He had two years of undergraduate medical training to obtain his M.D. degree. He witnessed antiseptic surgery under carbolic spray, in the old amphitheater. He had the first x-ray machine in Bay County, and this was truly primitive and with no safeguards for patient or operator.

You will pardon the personal references, for his was an era in the progress of medicine with which he succeeded in keeping pace. As all true physicians should, he took an active part in the activities of organized medicine, finally succeeding to the State presidency in 1919. His presidential address keynoted a warning to the profession against what was then called "state medicine."

As I review this personal medical history, I am reminded of the history of our State Society's activities in the years that I have known them. Just twenty years ago it was my privilege and duty as local chairman to arrange, in Pontiac, the annual meeting of the State Medical Society, with an attendance of perhaps 300 or 400 members. That meeting was so primitive in its arrangements that it is laughable to recall, and our scientific speakers were then largely Michigan men. Think how we have grown in organization and importance in twenty years!

Our House of Delegates now requires five sessions and two days for its deliberations. Our three-day scientific sessions are ranked as first among state conventions by many of our nationally prominent speakers. Recently we have added our spring Michigan Clinical Institute, utilizing many speakers from our own number. Our technical exhibits are excellent and space is at a premium.

And what of our organization and the responsibilities before you gentlemen? Our Society now attains efficiency with a central office recently housed in our own building, an Executive Secretary with a capable staff, and a legal counselor who guides us through the intricacies of potential legal complications. More recently we have added a Public Relations Director, and a program of activity calling for expenditures far in excess of any thought of twenty years ago.

Thirty-eight committees and subcommittees on multiple phases of medical activity and interest, and Public Relations now report annually the activities and careful thought of hundreds of our members. Thirty-three additional standing and special committees assist The Council and House of Delegates. Many of these are of very recent origin. I boast not of size and numbers, but take pride, with you, in the extent of our active interest in all phases of our medical relations and our responsibilities to American society.

With the changing demands of a nation, the Michigan State Medical Society is meeting not only its medical needs but through active participation is providing postgraduate training, is promoting good citizenship, is seeking to provide good medical and hospital insurance, good health laws, and expansion of medical and nursing service to the public.

We have encouraged and are proud of the work of our medical Auxiliary. We have stimulated greater interest in rural health. These are but some of the cogs in the expanding wheel of progress, kept in motion by the Michigan State Medical Society. Our public relations

department, with its active program of education, has been to our credit. You shall shortly be given an opportunity to hear of its future plans and view its latest educational film.

Gentlemen, do not fail to review the committee reports in your Handbook. These embody the thought and action of organized medicine in Michigan since we met one year ago. Listen carefully to the recommendations of your Council. Some of these will call for resolution and action by the House of Delegates. Additional amendment to the Bylaws is indicated.

One point I wish this House to decide pertains to associate memberships in relation to representation by delegates, as found in the Bylaws, page 13, Chapter 5, Section 3(b), and page 18, Chapter 8, Section 1.

I am reminded of a statement attributed to Patrick Henry, the young Virginia orator of the Revolution: "I have but one lamp by which my feet are guided, and that is the lamp of experience. I know of but one way of judging the future, and that is by the past."

I charge you, as delegates to this 86th annual session of the Michigan State Medical Society, in your deliberations to be always mindful of the great heritage and traditions of American medicine, of our progress and freedom in a system of private enterprise. Review our past and plan our future wisely!

My report as Speaker will be referred to the Reference Committee on Officers' Reports.

III. "Formula for Freedom"

THE VICE SPEAKER: Gentlemen, the Formula for Freedom program has been recommended by the Public Relations Committee and adopted by the Council of the Michigan State Medical Society. As has any prescription, the Formula for Freedom has certain basic elements. These important ingredients are (a) "Know Yourself"; (b) "Know How to Live," and (c) "Know Your Government." Each calls for action on your part as leaders of the medical profession in Michigan. Action at this session will be required in the form of certain resolutions which are to be introduced. Action following this session will begin immediately, and will continue through the year 1952.

Today we bring you three representatives of the public. Each is an authority in his own field. Each will give you his concept of one element of the Formula for Freedom in order to present the philosophy and thinking behind this program.

Our President will then summarize the program and will give specific suggestions for action, after which we will hear his Presidential Address.

I present our first speaker, Alfred C. Haake, Ph.D., of Park Ridge, Illinois, brought to us today through the courtesy of General Motors Corporation. Dr. Haake will speak on the subject, "Know Yourself."

Know Yourself by Alfred C. Haake, Park Ridge, Illinois, was published in the December issue.

THE VICE SPEAKER: Our next speaker is William T. Reeves, Jr., Dean of St. Marks Cathedral, Grand Rapids. His subject is *Know How to Live.*

Rev. Mr. Reeve's address appears elsewhere in this issue.

THE VICE SPEAKER: Our third speaker will talk on the topic, "Know Your Government." Gentlemen, it is a pleasure to present to you the Auditor General of the State of Michigan, Mr. John Martin.

Know Your Government by Hon. John B. Martin, Grand Rapids, will be published in the February issue.

THE VICE SPEAKER: And now, the President of the Michigan State Medical Society, Dr. Umphrey.

A summation of the Formula for Freedom was presented by President C. E. Umphrey, M.D., Detroit. Doctor Umphrey's address will be published in the March JMSMS.

THE SPEAKER: Thank you, gentlemen, for your careful attention to this special order of business.

It is now our pleasure and privilege to listen to the President's Address. Dr. C. E. Umphrey will address us.

IV. The President's Address

By C. E. Umphrey, M.D., Detroit

The previous speakers, Mr. John B. Martin, Auditor General of the State of Michigan, Reverend William T. Reeves, Dean of St. Mark's Cathedral, and Dr. Alfred C. Haake have come to us through the efforts of our Public Relations Department. They have keynoted most forcefully the basic principles of our public relations program for the coming year. They, like former President Hoover, in a recent address, have stressed "old virtues" we must revive if American freedom is long to endure.

We must respect the old virtue of religious faith.

There are the old virtues of integrity and whole truth.

There are the old virtues of incorruptible service and honor in public office.

There are the old virtues of economy in government, of self-reliance, thrift and individual liberty.

There are the old virtues of patriotism, real love for one's country, and a willingness to sacrifice for it.

These old ideas are very inexpensive, but they could even help us win hot or cold wars.

We believe this nation cannot long exist as the bulwark of freedom unless these old virtues are our guides in public life.

During the past year we have tried to work out a theory that would best aid our nation in a recovery from impending chaos. The medical profession realizes that such a state of confusion exists in our politics, finances, religions and foreign relations that it makes our problems almost insurmountable. How often we hear the questions asked, "What's the use? Who can combat machine politics? Why can't we stop organized crime?" All too often the conclusion is drawn, "It doesn't pay to be an honest citizen."

History is replete with examples that would prove the fallacy of such thinking. Wherever a reformation was instituted, you would find a small, compact, intelligent, loyal group of citizens leading the way. We believe our medical profession of the State of Michigan constitutes such an organization.

Our CAP (Cooperation with the American People) Commission meets our needs more completely than most of us realize. There is just one obstacle to its success: The CAP can never succeed unless each doctor of medicine will devote 10 per cent of his time to the project of spreading factual information. We must know those who seek to represent us on the political front. They should be specially trained and educated, but above all they must be honest. All political aspirants must be free of faction control. We must further know which proposed legislation is good and which is bad. We must become acquainted with and offer every aid to our legislators. Good government is our project.

Where will we get this information? We have a right to look to our national and state organizations. It will be forthcoming. With these facts will come the plea to study, restudy and file for future reference. This effort is most essential if we are to re-establish the rights of the individual as opposed to socialism. If we are convinced of the invincibility of the good we can do, then our efforts in the next four or five years will be recorded in the pages of history as one of the great reconstructive movements. Our posterity will be the benefactors.

In addition to the reconstructive plans listed above, our State leads in many phases of organizational work. We have promoted medical education and facilities for increasing the number of medical graduates in Michigan. A badly needed headquarters building has been purchased, which should prove of inestimable worth in completing our ever-expanding program and a financial asset as well.

We have had many contacts with labor. We have supported the voluntary health plans. Much aid has been given the armed services in obtaining trained medical personnel. The Michigan State Medical Society has aided financially and helped direct the Michigan Health Council to its new place in the over-all plans of medical care. Much time has been devoted to the Basic Science Act as well as to the laws of medical registration. The inroads of cultism have been blocked with few exceptions, and the high standards of medical care have been maintained.

Very little has been said about the splendid accomplishments of the various committees. Many of you I have personally thanked, and to all of those who have served I bring not only my personal gratitude but the appreciation of all your officers for a job well done.

We are proud of our executive office. Mr. Hugh Brennaman and his staff have worked day and night with no thought of their own personal sacrifices. Promoting Americanism has assumed the proportion of a crusade with them. This is true of the entire personnel of our central office.

Mr. William Burns, our Executive Director, and Dr. L. Fernald Foster, our Secretary, have caused every other state medical society to look on us with envy.

It has been my pleasure to observe our delegates to the American Medical Association for the past three years. They have dispatched the business assigned them with careful thoroughness, and should become a powerful influence in the national organization.

Both the retiring President of the American Medical Association, Dr. Elmer L. Henderson, and the incoming President, Dr. John W. Cline, expressed their personal appreciation for the services rendered by the Michigan delegates.

Finally, I would like to mention our President-elect, Dr. Otto Beck. Dr. Beck has given the Michigan State Medical Society more of his time and abilities over the past twenty years than any of us will ever realize or fully appreciate. Because of preparation and disposition he is a natural leader for us. It is with pleasure that I anticipate his induction into office, and I wish to assure him that my sincere efforts will always be available and at the disposal of the Michigan State Medical Society.

In a parting admonition may I restate our objective: To reawaken spiritually the incentive for individual freedom on which this country was founded. The most direct route to this objective is the education of your patient and mine, who will exercise the franchise to vote.

THE SPEAKER: Dr. Umphrey's address will be referred to the Reference Committee on Officers' Reports.

The next item of business is the address of our President-elect, Dr. Otto O. Beck.

V. President-elect's Address

By Otto O. Beck, M.D., Birmingham

Only a few years ago this House of Delegates instructed The Council to establish a public relations program. This was an entirely new idea for organized medicine. There was no place to go for help and guidance, for no other state medical society nor the American Medical Association at that time had attempted anything of such a nature. Consequently, we were groping in the dark much of the time. Among the many projects attempted there were some that were of doubtful value; but out of it all there developed a program of such importance that it must remain as a permanent function of the Society.

The Michigan Medical Service was established by us as a means of providing medical care for the low income group. It has become a great counterforce to the threat of a federally-controlled medical care plan. The presentation of the medical viewpoint on this expanded field of voluntary medical care coverage has been an important function of the public relations program.

How well we have succeeded is difficult to estimate. We believe that at the present time there is very little likelihood that the Congress will even consider such a proposal. The medical profession is now better organized and more united in its determination to remain free, and to care for the sick in the best manner that scientific medicine provides. This public relations program has gained supporters among hundreds of lay organizations in the common fight, and we are continually gaining more support.

We have not succeeded in educating the public as well as we would have desired, but one thing is certain —that it has been forcefully brought to the attention of the members of this Society that the only real and lasting benefit is dependent upon the conduct of each individual physician. The idea of giving service to his fellow man as the paramount consideration is gaining ground among the doctors of this State.

Unfortunately, the problems of medicine are not now the paramount issues confronting us today. At present, we are engaged in a war in order to stop the spread of communism. At the same time our liberty and freedom are threatened from within our own borders.

Our government is filled with incompetent office-holders whose main ambition is to promote their own welfare. To them honesty is not a virtue to be followed in the strict meaning of the word. Corruption is rarely punished and is often condoned. Information released by our government is often slanted. Spending has become a virtue. Saving for one's future security is discouraged. Communists have infiltrated themselves into high places, and their discovery is even defended. Above all else, the worst of all evils is that a large segment of our population has become so amoral as to condone the present existing state of affairs.

Only a few decades ago the discovery of evil in high places brought forth such a fierce condemnation from the populace that political careers were wrecked. Now falsehood, theft, bribery, graft, corruption, and even treason, if not actually condoned, at least do not stir up a wave of righteous indignation among the masses.

The exposure of crime by way of television evidently was considered as fine entertainment, for no popular demand has been made for the punishment of evildoers. One can only deduce from the foregoing facts that a large segment of the population has become amoral, otherwise how could it support and condone the present state of affairs?

I have had personal experience with communism, for I lived and worked for seven months in Soviet Russia. I lived with the Russian people and learned to know them. I loved them for their fine qualities. I saw their anguish, their fears, their suffering, and their hunger for freedom.

I also associated with communists, and from them I learned about communism and of their determination to communize the whole world. They are not in a hurry. One of their first steps in their wicked scheme is to demoralize a nation. They follow closely that old proverb, "What the gods wish to destroy, they first corrupt."

Last year your public relations program was directed toward good citizenship. In this endeavor the medical profession produced a rebirth of patriotism. It is of the utmost importance that this program be continued and expanded. It is vitally necessary that somewhere a leadership be developed to bring this nation back to the old principles on which it was established.

No other group is more ideally suited to do this than the medical profession. A great stratum of our society is hoping and yearning for someone to lead them. It is a challenge which we should gladly accept, for no greater patriotic endeavor could be performed than to fight for the continuation of our freedom and the maintenance of those principles of righteousness upon which this nation was founded.

I close this brief message with a statement made a few years ago by Herbert Hoover, who said:

"Here in America today is the only remaining sanctuary of freedom, the last oasis of civilization, and the last reserve of moral and economic strength. If we are wise, these values can be made to serve all mankind."

THE SPEAKER: The address of the President-elect will be referred to the Reference Committee on Officers' Reports.

The next item of business will be the annual and supplemental reports of The Council. Dr. R. J. Hubbell, Chairman.

VI. Annual Reports of the Council

SUPPLEMENTAL REPORTS OF THE COUNCIL

R. J. HUBBELL, M.D. (Kalamazoo): The annual report of The Council is printed in the Handbook on page 51. It will be referred to the proper reference committee. I shall read the supplemental report of The Council as of September 24, 1951:

1. *Membership*—As of September 5, 1951, the membership of the Michigan State Medical Society totaled 5,101, including 421 special members who are relieved from paying dues and assessments.

2. *Finances*—The Constitution of the Michigan State Medical Society charges The Council with administration of the funds of the Society, and the Treasurer with the responsibility for safekeeping of the Society's invested funds.

Following the mandate of the Constitution, The Council has caused an "annual audit to be made of the funds of the Society by a certified public accountant." The complete report of Ernst & Ernst for the year 1950 was published in the March 1951 issue of THE JOURNAL of the Michigan State Medical Society, beginning at page 314. On pages 316 and 317 of the same number of THE JOURNAL is a copy of the MSMS budgets for the year 1951. The audit of the accounts is and always has been available for inspection by any member of the Michigan State Medical Society who may call at the Executive Offices, 606 Townsend Street, Lansing 15.

The report of our staff accountant for the first eight months of this year (from January 1 to September 1, 1951) of income and expense is as follows:

INCOME AND EXPENSE

Account	On Hand 1/1/51	Income to 9/1/51	Expenses to 9/1/51	Balance on hand 9/1/51
General Fund	$ 58,268.41	$111,812.60	$ 56,804.71	$113,276.30
Annual Session	— 0 —	22,610.00	3,439.65	19,170.35
P.G. Institute (1951)	— 0 —	11,510.00	8,816.94	2,693.06
Clinical Institute (1952)	— 0 —	— 0 —	291.92	291.92 (Adv. Exp.)
THE JOURNAL	— 0 —	39,367.88	31,731.38	7,636.50
Public Education	59,600.98	94,193.50	62,136.58	91,657.90
Rheumatic Fever	23,467.55	19,348.15	14,365.21	28,450.49
TOTALS	$141,336.94	$298,842.13	$177,586.39	$262,592.68

ESTIMATED OVER-ALL BUDGET FOR 1952

Estimated Income:		
1952 Dues (4,400 members at $45)		$198,000.00
Allocated $20 to General Fund	$88,000.00	
Allocated $1.50 to THE JOURNAL	6,600.00	
Allocated $20 to Public Education	88,000.00	
Allocated $1.50 to Surplus	6,600.00	
Allocated $2 to Building Fund	8,800.00	
Estimated Balance 1/1/52 General Fund		66,674.31
Estimated Balance 1/1/52 Public Education		61,063.20
THE JOURNAL—Advertising Sales, Reprints & Cuts		55,000.00
Annual Session—1952		17,000.00
Michigan Clinical Institute—1952		9,000.00
Rheumatic Fever Program ($20,736.40 plus cash on hand 1/1/52 of $21,267.90)		42,004.30
Interest and Miscellaneous Income		100.00 448,841.81
Estimated Expenses:		
Administrative and General Expense		40,000.00
Society Expense		20,000.00
Committee Expense (Incl. Mich. Health Council)		30,000.00
Public Education Expense		106,240.00
JOURNAL Expense		55,000.00
Annual Session Expense		17,000.00
Michigan Clinical Institute Expense		9,000.00
Rheumatic Fever Expense		30,825.00
Contingencies and Surplus:		
Allocated to Rheumatic Fever	$15,000.00	
Allocated to Surplus Account ($6,600 x 2 years)	13,200.00	
Allocated to Building Fund ($8,800 x 2 years)	17,600.00	
Allocated to General Fund Surplus	54,000.00	
Allocated to Public Education Surplus	40,976.81	
		$448,841.81

Detailed Description of Bonds Redeemed for Cash

Report of Treasurer A. S. Brunk, M.D., Detroit, August 1, 1951:

United States Savings Bonds, Series "G"

The purchase price of Series "G" Bonds is $100 per $100 Bond, and earns 2.5 per cent interest, paid semi-annually if held until maturity date, which is twelve years from date of purchase. If bonds are surrendered for redemption prior to maturity date, the interest rate is less than 2.5 per cent, and the rate depends upon the number of years they are held; therefore, if redeemed prior to maturity date, a refund is demanded by the government of a portion of interest previously paid at the rate of 2.5 per cent, and to collect the refund it is simply deducted from the face value of the bond at date of redemption. The bond, therefore, prior to maturity, is not redeemed at face value, or the amount which was originally paid for the bond.

The total amount of bonds purchased on a given date are made up of many bonds of lesser denominations. We therefore use the term "Group of Bonds" in our description of bonds, which were purchased on the same date, and total a given amount.

SERIES "G" BONDS (Redeemed August 1, 1951)

Group of Bonds (Principal Amount)	Actual Cost	Date Purchased	Interest Received to 8/1/51	Redemption Value After Deduction of Int. Refund 8/1/51	Redemption Value Plus Interest Received
$17,600.00	$17,600.00	2/1/45	$2,860.00	$16,860.80	$19,720.80
5,000.00	5,000.00	6/1/44	875.00	4,805.00	5,680.00
5,000.00	5,000.00	6/1/45	750.00	4,775.00	5,525.00
1,000.00	1,000.00	12/1/45	137.50	952.00	1,089.50
$28,600.00	$28,600.00		$4,622.50	$27,392.80	$32,015.30
TOTAL REDEMPTION VALUE (after deduction of interest refund)					27,392.80
TOTAL INTEREST RECEIVED (for the period bonds were held)					4,622.50
				TOTAL:	$32,015.30

United States Savings Bonds, Series "F"

The purchase price of Series "F" bonds is $75.00 per $100 Bonds. They bear no interest, but increase in value from year to year until maturity date, which is twelve years from date of purchase, and are then worth $100. However, the increase in value per year is not as great, if redeemed prior to maturity, as it is per year if held until maturity date.

SERIES "F" BONDS (Redeemed 8/1/51)

Group of Bonds (Principal Amount)	Actual Cost	Date Purchased	Increase in Value of Bonds (From date of purchase to 8/1/51	Redemption Value (Cost Plus Increase in Value) 8/1/51
$ 2,500.00	$ 1,850.00	5/1/41	$472.50	$ 2,322.50
700.00	518.00	7/1/41	132.30	650.30
12,400.00	9,176.00	12/1/49	62.00	9,238.00
6,000.00	4,440.00	6/1/50	12.00	4,452.00
500.00	370.00	9/1/41	87.00	457.00
$22,100.00	$16,354.00		$765.80	$17,119.80

TOTAL REDEMPTION VALUE (after increase in value to 8/1/51) 17,119.80

TOTAL MONEY RECEIVED FOR ALL BONDS REDEEMED 8/1/51 (which includes interest received on "G" Bonds, and interest in value of "F" bonds) $49,135.10

TOTAL ACTUAL COST OF ALL BONDS DESCRIBED ABOVE.... 44,954.00

PROFIT EARNED ON ABOVE BONDS DURING PERIOD HELD $ 4,181.10

All interest received on "G" Bonds, with the exception of cash balance now in the Detroit Bank, minus expenses incurred for safekeeping of bonds, has been invested from time to time by purchasing additional bonds, which purchases have been reported from year to year in the Treasurer's Annual Report.

Since the above interest has been invested in additional bonds, the available cash from the above transaction, which has been directed by The Council to be used for the purchase of a "Home Office" is the redemption value of bonds redeemed August 1, 1951—$44,512.60—less Detroit Bank service fee for handling the above transaction, which is $3.95, leaving a net total of $44,508.65, which amount has been transferred to the general fund of the Michigan State Medical Society.

More detailed financial reports, including the Public Relations Account from January 1, 1951, to September 1, 1951, have been presented today (in mimeographed form) to all members of the House of Delegates.

3. *Michigan Medical Service.*—An up-to-date report on this Corporation, including finances, will be presented to you at the meeting of Michigan Medical Service membership tomorrow, September 25, at 2 p.m., in the Ballroom, Pantlind Hotel, Grand Rapids. All MSMS delegates are members of the Michigan Medical Service Corporation and are expected to attend this important annual meeting.

The Council is of the opinion that much good for Michigan Medical Service and for the people it serves will result from the creation of an MSMS Liaison Committee to Michigan Medical Service—a permanent Committee of five persons, each having a three-year tenure, with one retiring annually (and no one serving longer than two terms). Such a Committee should hold frequent meetings with the officers and administrative staff of Michigan Medical Service to discuss problems and ambitions for better service to the people and to the medical profession, and to bring to the MMS personnel the viewpoint of the purveyors of medical service. Michigan Medical Service is a fiscal agent of Michigan's medical practitioners to supply prepaid medical service to the people. Problems facing it (other than fiscal) are medical problems, and only medical practitioners can help and assist MMS in solving them.

A recommendation on this subject follows.

4. *Gogebic County Circuit Court decision re Ironwood's Grand View Hospital* (chiropractor vs hospital trustees).—On August 6, Judge Thomas J. Landers handed down a decision that chiropractors have not the legal right to practice in hospitals. This decision was in agreement with the opinions of our MSMS legal counsel (J. Joseph Herbert) and Dean E. Blythe Stason of the University of Michigan, but in direct variance to portions of recent opinions on this subject issued by the present Attorney General and his immediate predecessor. The Gogebic County prosecutor requested leave of the Supreme Court to have this decision reviewed, which was denied. Legal counsel Herbert will present to the House of Delegates the details of another suit, in chancery, just begun. (See Annual Report of The Council—Contact with Governmental Agencies, Item 11.)

5. *Atomic Energy.*—Special commendation is due the MSMS Committee on Atomic and Allied Procedures for splendid work performed during the past year, especially in its pioneering task of developing the Atomic Number of THE JOURNAL MSMS (March, 1951).

A recommendation on this subject follows.

6. *Study of Medical Practice Act.*—The report of MSMS representatives to the Joint Committee on Study of Medical Practice Act (joint with representatives of Michigan State Board of Registration in Medicine) is published in the Handbook for Delegates. Since December 19, 1945, MSMS has recommended that changes be made so that second-year interns and residents be permitted to continue their education in hospitals without being licensed to practice medicine in Michigan.

On October 14, 1947, the Michigan State Board of Registration in Medicine changed its administrative rules to permit postgraduate students to take up to three years' training in licensed hospitals, without a license to practice. However, in February, 1948, the Attorney General gave an opinion that the Board did not have authority to grant this permission.

The matter needs clarification by the Michigan legislature. The report of the MSMS representatives to the Joint Committee on Study of Medical Practice Act indicated that the State Board of Registration in Medicine will favor the MSMS viewpoint (which in essence is aimed to provide more medical practitioners in Michigan) if MSMS will approve an annual registration fee on all M.D.s as desired by the State Board.

The Council refers this important matter to the House of Delegates, without recommendation.

7. *Basic Science Law.*—The report of the Special Committee on Study of Basic Science Law appears in the Handbook for Delegates. It is the opinion of The Council that the Basic Science Law is a good law, but that its administration needs major improvement. This should be accomplished by rules and regulations. Opening the Act to legislative tinkering is both unnecessary and dangerous.

A recommendation on this subject follows.

8. *Beaumont Memorial.*—The Early House on Mackinac Island (where Beaumont first cared for his famous patient, Alexis St. Martin) should be restored to its original status and made a public museum as a shrine to Dr. Beaumont. This can be accomplished only by MSMS, aided tangibly by its Woman's Auxiliary. President-elect Otto O. Beck, M.D., has been delegated to outline this project to the House of Delegates at this session. The Council respectfully requests your interest and favorable consideration.

9. *American Medical Education Foundation.*—The Council urges every MSMS member to support this very constructive program, one of the most important ever undertaken by the medical profession. The doctors' financial contribution to the AMEF will prove conclusively that aid to medical education need not come from federal sources, and that our medical schools can remain free of governmental domination (socialized education). The physicians of America contributed more than 56 per cent of the initial grant of $1,132,500 made in July to the seventy-nine medical schools in the United States. The AMEF goal this year is $1,000,000. Medicine has been good to our Michigan profession, so each practitioner should be urged to show his appreciation and do his share in this voluntary undertaking.

A recommendation on this subject follows.

10. *Michigan's Foremost Family Physician for 1951.*—Selection of one of our Michigan general practitioners as nominee for the AMA Gold Medal Award is now

the privilege of the House of Delegates, according to a formula worked out by The Council, which, out of a field of eleven, narrowed the choice to the following three: Charles L. Bennett, M.D., Kalamazoo; Arch Walls, M.D., Detroit; Clayton Willison, M.D., Sault Ste. Marie.

11(a). *"Formula for Freedom."*—Entering upon a crucial period in the determination of America's future domestic and foreign policy, as well as upon correlated factors in respect to medicine's future, The Council has determined upon a program entitled "Formula for Freedom." This program is considered to be the most effective means of bringing all facets of activity of organized medicine into focus so that greatest public relations progress may be obtained. This ambitious but necessary project has been outlined to the House of Delegates at this session.

(b) *New MSMS Film.*—"To Save Your Life," striking at the untruth that doctors of medicine seek to keep down the number of doctors trained, and attempting to clarify the position of doctors in respect to the type, quality and cost of education involved in becoming a doctor of medicine, a recruiting film entitled, "To Save Your Life" has been prepared by the Public Relations Committee. The film will be distributed for showing in schools as a part of school guidance programs; also through television and service groups to the general public, in order to clarify what should be expected in respect to quality of medical service and its reasonable cost. This is a low budget film on 16 mm. in color and sound. Its premiere is before the House of Delegates at this session.

12. *List of Non-Members.*—Pursuant to the House of Delegates' instructions of 1948, The Council (through the Secretary) will submit a list of former members whose 1951 dues are not paid as of September 1, 1951. To insure accuracy, this list was submitted to and certified as correct by county and district medical society secretaries.

13. *Michigan Rheumatic Fever Control Program.*—This voluntary program, organized and maintained by MSMS with financial help from the Michigan Heart Association and the Michigan Society for Crippled Children and Adults, Inc., is your program which is being most carefully watched by governmental agencies which are willing to see it fail in order to prove that the medical profession cannot run its own business without federal help. Because of enthusiastic medical participation, some rheumatic fever centers in this State are models of efficiency and activity, working for the good of the community and bringing renown to the M.D.s of the area. All centers must reach this goal of perfection—achieved only through the active participation of all the practitioners of the area. Only 100 per cent unselfish cooperation will make successful the Michigan rheumatic fever control program, an MSMS project—another Michigan first.

A recommendation on this subject follows.

14. *Seventeen specialty societies,* alumni and fraternity groups are honoring MSMS by holding meetings coincident with our annual session in Grand Rapids this year. The Council appreciates this cooperation, and expresses its sincere thanks to these organizations and ancillary groups. It hopes that they will repeat their meetings on the occasion of all future MSMS annual sessions, and that this action will be emulated by other groups in the medical and health field which, by holding concurrent meetings, will be able to take advantage of the large registration at our conventions.

15. *New MSMS "Home"*—The Executive Office staff moved into the new MSMS home at 606 Townsend Street, Lansing, on July 27, 1951. All members of the MSMS House of Delegates are cordially invited to visit the Society headquarters any time they are in the capital city.

Recommendations

We respectfully invite to your attention the eight recommendations in the original report of The Council, printed in the Handbook on pages 70 and 71. They read as follows:

1. That MSMS representatives be instructed to continue their yearly visit to Washington, D. C., on the occasion of Michigan Day sponsored by the United States Chamber of Commerce.

2. That the unwise concentration of power in the health field, as recommended in Staff Report No. 8 (Michigan Health Agencies) to the Michigan Joint Legislative Committee on Reorganization of State Government, be invited by county medical society officers to the attention of all their members, to the end that this brain trust proposal is killed and a more sensible approach in administration of the State's health agencies is achieved.

3. That continued active, tangible cooperation with the American Medical Association be maintained by every MSMS member during these parlous times. Strength comes from unity and work.

4. That doctors of medicine throughout the State, especially in the smaller cities, be urged to stagger their half-holidays, and that county medical societies be advised that the problem of all doctors taking the same weekly half-holiday still exists and all efforts should be made to solve the matter through contacts and publicity to county medical society members.

5. That the 1951 House of Delegates reconsider its amendment to Chapter V, Section 5, re emeritus members, and rescind its action so that the present provisions re emeritus membership (practice for fifty years and membership in MSMS for twenty-five consecutive years) be continued. Emeritus membership is the highest honor in the hands of the MSMS, and its qualifications should be correspondingly high. (This matter has been referred to the Committee on Constitution and By-laws.)

6. That consideration be given to amending the MSMS By-laws re-election of alternate delegates (Chapter VIII, Section 10-d) in order to eliminate the annual confusion in the House of Delegates when this item of business is presented. (This matter has been referred to the Committee on Constitution and By-laws).

7. That consideration be given to amending the By-laws (Chapter VIII, Section 9) so that the Vice Speaker of the House of Delegates is a member of The Council and of its Executive Committee, with power to vote. The Vice Speaker is now invited to all meetings of The Council and of its Executive Committee, but is not entitled to vote. (This matter has been referred to the Committee on Constitution and By-laws.)

8. That, if necessary, the MSMS House of Delegates recommend to county medical societies (upon advice of its Committee on Constitution and By-laws) that county medical society by-laws be amended to delete any sentence similar to the following: "By virtue of the Charter granted by this Society, all active members of this Society are automatically members of the Michigan State Medical Society and of the American Medical Association," inasmuch as the AMA now charges dues and not all members of the county and state medical societies have paid said dues and are members of the AMA. If this situation applied statewide, the House of Delegates may wish to recommend such a change in the by-laws of Michigan's component county medical societies, keeping in mind that the Constitution and By-laws of the AMA transcends those of the MSMS and of any of its component county medical societies. (This matter has been referred to the Committee on Constitution and By-laws.)

The Council respectfully submits five additional recommendations:

9. That the MSMS House of Delegates recommend to the members of Michigan Medical Service, for consideration at their meeting of September 25, 1951, that the members request MSMS to appoint a permanent liai-

son committee of five persons to advise and aid Michigan Medical Service in all medical matters (other than fiscal) so that the viewpoint of the purveyors of service is obtained, resulting in better and better service to the people.

10. That the Committee on Atomic and Allied Procedures be continued, and that this phase of MSMS activity be carried on with increasing vigor, as the subject is more important now than ever before. Further, that another number of JMSMS be dedicated in 1952 to Atomic Medicine in which treatment is stressed.

11. That the House of Delegates veto any plans to amend or scuttle the Michigan Basic Science Act, but that it respectfully urge the Chief Executive of the State of Michigan to liberalize the administration of this law by the appointment to the Board of more practical members, to the end that young M.D.s are encouraged to come to Michigan for postgraduate work, resulting in more practitioners of medicine remaining in this State.

12. That the plan of organization in behalf of the American Medical Education Foundation, as recommended by the AMA, be placed into effect in Michigan at once; and further, that the House of Delegates urge every MSMS member to realize the importance of contributing as generously as his means will permit to a cause which promotes the voluntary way and makes unnecessary the intrusion of the federal government into medical education.

13. That the House of Delegates urge every county medical society in areas served by rheumatic fever centers to immediately inaugurate a chain of responsibility as recommended by the State Society, so that all practitioners of the area are apprised of their duty in preserving the voluntary Michigan Rheumatic Fever Control Program through active participation and unselfish cooperation. To neglect this opportunity means that some of our own members are aiding the enemy, who holds up all such failure as reason for the early socialization of medicine.

Respectfully submitted,
R. J. Hubbell, M.D., *Chairman*
William Bromme, M.D., *Vice Chairman*
L. W. Hull, M.D.
R. S. Breakey, M.D.
G. W. Slagle, M.D.
J. D. Miller, M.D.
R. C. Pochert, M.D.
H. B. Zemmer, M.D.
L. C. Harvie, M.D.
G. B. Saltonstall, M.D.
F. H. Drummond, M.D.
C. A. Paukstis, M.D.
A. H. Miller, M.D.
J. D. Miller, M.D.
W. S. Jones, M.D.
J. S. DeTar, M.D.
D. B. Wiley, M.D.
W. D. Barrett, M.D.
W. B. Harm, M.D.
R. H. Baker, M.D.
C. E. Umphrey, M.D.
Otto O. Beck, M.D.
L. Fernald Foster, M.D.
A. S. Brunk, M.D.
W. E. Barstow, M.D.

The Speaker: Thank you, Dr. Hubbell. This report will be referred to the Reference Committee on Reports of The Council.

At The Council's request, remarks on The Grandview Hospital situation are in order. Mr. Herbert will report.

Mr. J. Joseph Herbert: Mr. Speaker and gentlemen, most of you have probably had some information concerning the situation in the far western reaches of the northern peninsula, at a little hospital called the Grand View Hospital in Ironwood, a county hospital organized under Act 350.

Some time ago, due to a peculiar local situation, the prosecuting attorney requested an opinion of the Attorney General concerning the rules of the hospital and the right of healers, other than doctors of medicine, to practice in the hospital. The rules of the hospital, which are in the usual form, provide for a medical staff, and that staff is composed of doctors of medicine.

The question asked by the prosecutor of the Attorney General was whether osteopaths and chiropractors would be and are permitted to practice in that hospital, despite the rules adopted by the trustees of that hospital.

Two opinions came down from the Attorney General's office, written by an assistant attorney general no longer with the Department, to the effect that under this law a chiropractor or an osteopath could not be excluded from practices in the hospital. You have probably read or heard something of that opinion.

There are some of us who are not in accord with that opinion. Be that as it may, some time later an occasion arose for the prosecutor to bring a criminal action against the hospital, the board of trustees and its administrator, who is a lay administrator and not a doctor of medicine.

The Council of the Michigan State Society has been in very close touch with that situation, and has remained in touch with it. The defendants in that criminal action were brought before a justice for examination, and they were bound over for trial before the Circuit Court of Gogebic County. Subsequently, the attorney for the board made a motion to quash the information. They had a hearing and argued before Judge Thomas Landers, of that Circuit; and Judge Thomas Landers, in a well-considered and fairly lengthy opinion, granted the motion to quash, and threw the case out of court.

Following that, the prosecutor endeavored to get the Supreme Court of our State to review the Judge's decision. An application was made, a hearing was heard on the application to review, and the Supreme Court denied the application to review; and so that case was ended.

That was both fortunate and unfortunate, because had the Supreme Court concluded to review it, perhaps we would have had a decision by the Supreme Court as to the meaning and application of Act 350, the County Hospital Act, and specifically whether or not such hospitals must admit to the staff of the hospital cultists of various kinds.

Even before the Supreme Court had denied the right to review, the prosecutor in the name of Gogebic County brought a civil suit, a suit in chancery in the circuit court there, to restrain the hospital board, the hospital itself and its administrator from enforcing its rules, and praying for an injunction to prevent the hospital from excluding persons not on the medical staff of the hospital.

It might be interpolated at this point that the brother of the prosecutor is a doctor of medicine in that community, who has had some difficulty with the hospital, who is not a member of the staff and allegedly has refused to abide by the rules of the hospital with regard to hospital records, histories and other procedures that the rules require all staff members to follow. So, in effect, this is a fairly personal matter with the prosecutor there.

That suit is now pending. It has not yet been heard. An answer to the bill of complaint has been filed. The suit promises to have this question finally answered, because the parties to this suit would have the right to take an appeal as a matter of right and without discretion on the part of any authority. So the chances are that eventually this matter will reach the Supreme Court, and the question specifically as to what is meant in this Act 350 by "school of medicine," whether the expression "school of medicine" is a generic one or a specific one, as referring to doctor of medicine, or whether it might include all types of healers, and so on, will eventually be reported on.

I can say with some degree of certainty that this ques-

tion probably will be settled, and it is more than of local interest. The hospital Act, Act 350, the County Hospital Act, is one that has been used quite extensively throughout the State, and there are quite a number of hospitals organized under that Act.

Also, it may be drawn to your attention that the opinion of the Attorney General also included hospitals under what is known as the Joint Hospital Authority Act, enacted in 1945, which is a similar statute, authorizing a number of government units, townships, cities or counties, to build, maintain and operate hospitals, very similar to Act 350. It extends that category of hospitals, too, and probably extends to other publicly supported hospitals, although there is no direct opinion of the Attorney General's office on that.

It may be said that, except as to private or so-called voluntary hospitals, which are not operated under these laws of the State, this decision will be of great importance.

THE SPEAKER: Thank you, Mr. Herbert.

VII. Report of Delegates to AMA

The next order of business is the report of the delegates to the American Medical Association. I will call on Dr. Christian, who will present the report.

L. G. CHRISTIAN, M.D. (Ingham): The 100th session of the American Medical Association in Atlantic City had a registration of 28,396 persons—12,229 physicians and 16,167 guests and others. This compared with a total registration of 23,777, including 10,241 physicians, in San Francisco last year.

It was a grand meeting, successful in every way, and those who worked hard in putting on the "big show" had a right to be particularly pleased.

In his report to the House of Delegates, Dr. Elmer L. Henderson, the retiring President, said the medical profession had met the threat of socialized medicine with an accelerated, positive program designed to advance the health of the nation. Then he listed fifteen long-term projects—a positive program to promote the national health through scientific activities, to foster and maintain high standards of medical practice, and to solve health problems in a manner most conducive to the public welfare.

Dr. John W. Cline, the new President, said in his inaugural address, which was broadcast to the nation over the Mutual and ABC networks, that talk dealt almost exclusively with the American Medical Association, its aims and objectives. Every doctor who heard him could not help but feel proud that he was part of such a truly American institution, democratic in organization and dedicated to high purposes.

The new President-elect of the American Medical Association is Dr. Louis H. Bauer, Hempstead, New York, who has been Chairman of the Board of Trustees. Dr. Bauer, who has served the AMA long and well in many capacities, made an eloquent address to the House, after it applauded the announcement of his election.

He said medicine had averted the greatest threat against its freedom, but he warned doctors everywhere that they could not relax.

"Now is the time for constructive action," he said. "Our voluntary insurance program has made tremendous strides, but it is not yet the complete answer. It must be expanded to fill in coverage which still exists. The whole profession must be brought enthusiastically behind the program."

Dr. Bauer pointed out that doctors and medical societies no longer can be purely scientific in their viewpoints, but that they must have an interest in the economics of medicine and in the methods of distribution of medical care.

Dr. Dwight H. Murray, Napa, California, is succeeding Dr. Bauer as Chairman of the Board of Trustees. He has been especially active for some time in legislative matters affecting the profession and medical care generally.

Dr. David B. Allman, Atlantic City, was elected a member of the Board of Trustees to fill three years of Dr. Bauer's unexpired term. Dr. Walter B. Martin, Norfolk, Virginia, was re-elected to the Board for five years.

Dr. Oscar B. Hunter, Washington, D. C., was elected Vice President.

Other officers, all re-elected, are: Dr. J. J. Moore, Chicago, Treasurer; Dr. F. F. Borzell, Philadelphia, Speaker of the House; Dr. James R. Reuling, Bayside, New York, Vice Speaker, and Dr. George F. Lull, Secretary.

San Francisco was chosen as the site for the 1954 annual session. The 1953 session will be held in New York, and the 1952 meeting will be in Chicago.

During the session the Board of Trustees announced that the 1954 clinical session would be held in Miami. The specific dates have not been selected. The 1951 clinical session will be held in Los Angeles, the 1952 session in Denver, and the 1953 meeting in St. Louis.

Dr. Henderson, commenting on the retention of the Whitaker and Baxter firm, said: "Clem Whitaker and Leone Baxter originally planned to terminate their services at the end of this year, but the House wanted to retain them because of the excellent job done in the educational campaign of the AMA. The Board of Trustees was happy to accede to the wishes of the House of Delegates."

The main subject of discussion at the 100th session of the AMA House of Delegates was not socialized medicine but problems dealing with medical education and hospitals. Dr. Henderson, retiring President, gave the keynote of the session in his opening address. He announced that the medical profession has met the socialistic trend and can now concentrate on its basic long-range objectives.

Other problems discussed by the House of Delegates were membership, public relations, military and civil defense, and many miscellaneous items.

Medical Education and Hospitals

Eleven out of approximately fifty resolutions introduced dealt with some phase of medical education and hospitals, hospital standardization, distribution of interns, financial aid to medical schools, production of physicians, preceptorships, and multiplicity of meetings. The House took the following action on these problems:

1. *Hospital Standardization.*—Approved the report of the Reference Committee on Joint Commission on Accreditation of Hospitals.

This report provides for a Joint Commission on Accreditation of Hospitals, composed of three representatives of the American College of Surgeons, six from the American Hospital Association and six representatives from the AMA. This commission will formulate standards, determine type and scope of inspection, maintain records and award all certificates of accreditation. It will be financed by the organizations in proportion to their representatives.

In giving its approval, the House of Delegates expressed the belief that greater voting power should be given the medical profession to insure medical control of professional problems. The House pointed out the desirability of general practice representation on the commission and the need for an advisory committee to the commission composed of the various specialty groups, and suggested that this advisory committee be permitted to observe the deliberation of the commission. The House of Delegates instructed the Board of Trustees or its representatives on the commission to be governed at all times by the principles adopted by the House on hospital relations. Attention was also called to the invitation received by the Board of Trustees from the Hospital Association for a preliminary discussion of hospital-physician relations.

2. *Financial Aid to Medical Schools.*—(a) Stressed the importance of supporting the drive for private medical education through the American Medical Education Foundation, and expressed the thanks to the Woman's Auxiliary for its contribution of $10,000 to the fund and the American College of Radiology for its donation of $2,000. Emphasized that contributions may be allocated to a designated medical school.

(b) Endorsed the principle of one-time federal grant in aid for construction, equipment and renovation of medical schools, but no part of these funds for operative expense or salary.

3. *Interns.*—Commended the action of the Board of Trustees in appointing an advisory commission to the Council on Medical Education and Hospitals, to study the discrepancy between internships offered and the number available, and urged that this much-needed evaluation be made as soon as possible.

Approved the New Jersey plan of hospitals accepting students from foreign schools to teach these students the best American democracy, and recommended that this plan be publicized so that other states may utilize it.

4. *Production of Physicians.*—Instructed the Board of Trustees to continue its efforts to publicize the report of the Council on Medical Education and Hospitals regarding the supply of physicians to refute the implication that the AMA limits the number of students.

This report states that in the last ten years the number of medical students increased almost 5,000, which is equivalent to fifteen new medical schools, that the freshman class is 23 per cent larger than in 1940, and that the present rate of expansion of medical schools will be producing 30 per cent more physicians than in 1940.

5. *Preceptorships.*—Recommended that the Council on Medical Education continue the study of preceptorships and invite representatives from the student medical associations to sit in on these meetings. It was pointed out that fourteen schools have adopted the preceptorship system.

6. *Meetings.*—After studying a resolution recommending that present rules be changed to permit combining staff meetings and clinical conferences with county medical society meetings, it was recommended that the Council on Medical Education and Hospitals study the whole problem of multiplicity of meetings.

7. *Radium.*—Referred to the Council on Medical Education and Hospitals a set of desirable standards to permit physicians to apply radium in hospitals, and recommended these be distributed to hospitals.

Membership

1. The Board of Trustees announced the following exemptions from AMA dues:

(a) Members who have retired from practice and who are exempt from local dues.

(b) Members over seventy years of age.

(c) Members for whom payment constitutes a financial hardship and who are excused from local and state dues.

(d) Interns and residents, but not for more than five years after graduation from medical schools (exception—time in service).

(e) Members in service.

2. After studying several resolutions on dues, the House of Delegates:

(a) Approved the principle of single membership and exemption of dues for all emeritus and retired members, and instructed the By-laws Committee to implement these principles.

(b) Requested the Board of Trustees to re-evaluate the position of the AMA regarding delinquent dues.

Public Relations

Dr. Henderson, Chairman of the Co-ordinating Committee, announced that on the recommendation of Whitaker and Baxter the national education campaign will be terminated at the end of the year, but have directed the Board to keep them on. He reviewed the two and one-half year campaign, and pointed out a few results: 11,000 national, state and local organizations have gone on record as being opposed to socialized medicine; in the election last fall, about 90 per cent of the candidates who favored socialized medicine were defeated.

The House of Delegates:

Voted their appreciation to Whitaker and Baxter, and expressed the hope that their services would be available if necessary.

Approved the plans for the AMA Public Relations Department. These plans include the appointment of a committee of prominent laymen to present to the Board of Trustees the viewpoint of the general public.

Expressed its unalterable opposition to communism, nazism, fascism, state socialism, and any other form of collectivism that violates the age-old principle of individual responsibility.

Empowered the special committee appointed to augment the 12-point program to formulate a statement of policy to guide the AMA and constituent societies.

Requested the AMA to take immediate steps to fully inform and educate the public as to the facts pertaining to hospitals and the AMA, and principles governing same.

Urged a thorough investigation be made of the entire school system, particularly teachers and authors of textbooks who advocate the overthrow of the American system of free enterprise.

Military and Civil Defense

On the problems of procurement of blood, the delegates approved the following specific recommendations from the Committee on Blood Banks:

1. Physicians and their families be urged to donate blood for civil defense.

2. Development of blood bank committees by the state and county societies.

3. That Congress be reminded of the urgent need for appropriation of funds for plasma and equipment for the collection and distribution of blood plasma.

4. That physicians using blood recognize their responsibility for replacement from families and friends.

The House directed the Council on Emergency Medical Care to submit suggestions to the Board of Trustees for meeting the medical responsibilities arising out of the Universal Military Training Act.

Items considered by the reference committee varied from the problem of merchandise profit to income tax deductions and insurance forms.

On these problems the House of Delegates voted:

That an effort be made to get the Commissioner of Internal Revenue to reverse the 1921 ruling that expenses for postgraduate work are personal expenses and nondeductible, and that, if not successful, to bring it before the United States Tax Court.

Urged the Board of Trustees to continue its efforts to establish a procedure whereby physicians and members of professional groups may set aside income for pension funds that will be taxable on receipt.

Reaffirmed the following resolution: "It is entirely within the definition of medical ethics for its members to engage in lectures, demonstrations, the preparation of pamphlets and other measures suitable for the dissemination of information to prevent blindness, and directed to any non-medical group." This resolution was brought back to the House by the Judicial Council because of its broad implications.

Objected to the proposed revision of Section VI of the By-laws, "Patents, commissions, rebates and secret remedies," which would modify profits on appliances, medicines, et cetera, to "excessive profits."

Recommended that all curative workshops, rehabilitation centers, and other organizations of similar nature, which provide services in physical therapy or occupa-

tional therapy, be under the direct supervision of a properly qualified physician.

Authorized the appointment of a Committee on Nervous and Mental Diseases.

Recommended that changes be made in the By-laws to provide that the Past President of the AMA will be a member of the House of Delegates for five years.

Announced that the Council on Medical Service has developed certain simplified insurance forms that are available to the membership.

Recommended that advertising agencies make an effort to correlate their advertising program with established medical principles for the best interest of the public.

Urged that the National Specialty Boards facilitate participation in emergency medical service calls by physicians, regardless of type of practice.

* * *

Mr. Speaker, may I have the privilege of addressing the House of Delegates for a few minutes in order that I may sing my "swan song"? Despite the legend, swans do sometimes sing.

THE SPEAKER: You may, Dr. Christian.

L. G. CHRISTIAN, M.D. (Ingham): This House of Delegates in 1937 elected me as your delegate to the House of Delegates of the AMA, and has re-elected me each two years since. For your confidence, I wish to thank you. I would like to review briefly some of the activities that your delegates were engaged in during my term of office:

Dr. Henry A. Luce, a grand gentleman and medical statesman, was chairman of our delegation. I think it is just and proper to enumerate for you Dr. Luce's activities:

In 1934, at the Cleveland meeting, Dr. Luce drew the first resolution on voluntary prepayment medical care. This was met with a great deal of opposition and stand-patism, but it caused the AMA to bend a little after they set up their ten-point program.

He continued to hammer at the AMA at each session, and finally, when Michigan Medical Service was inaugurated, they began to see the light; and today this is their bulwark, voluntary prepayment medical care, against compulsory health insurance or socialized medicine that is being sponsored by the administration and that branch of the Democratic Party headed by Ewing and the President.

Dr. Luce also sponsored a plan to set up an information office in Washington, in order that the doctors could know what medical legislation was being offered to the Congress, and have time to act before it had been passed. This created quite a furor and stern opposition, but we finally were able to establish a Council on Medical Care, with an information bureau at the national capital.

This has since been made an independent bureau. Dr. Luce also did something about the economics of medicine in this fight. One of his great contributions was the offering of and fighting through the resolution to establish a Section on General Practice in the Scientific Assembly. The support of this State Medical Society and several others caused a trial period in which the general practitioner was thrown into the Section on Miscellaneous Business. The response was so great that the Board of Trustees saw the value of this program, and it caused the AMA finally to learn that the general practitioners are the "grass roots doctors" and the backbone of American medicine.

Dr. Luce was the voice of Michigan, and all who heard his masterful voice, "MR. SPEAKER LUCE, OF MICHIGAN!" paid the strictest attention to what he had to say. They all admired and respected him, but his ideas and the ideas of this State Medical Society were usually three to five years ahead of their thinking.

Dr. Luce was the general of our delegation, and Dr. Thomas Gruber was the chief of staff. Claude Keyport, Tony Reeder and I were the foot soldiers. Sometimes we were called "gumshoes." Dr. Gruber was an unusual man, a hospital superintendent, who often said he never had a private patient in all his life; yet the patient-physician relationship was one of his strongest convictions, whether the patient be in the home, the doctor's office or in the hospital.

Dr. Gruber believed that he should be treated by a physician in private practice of medicine. Dr. Gruber became a power in the House of Delegates. He was respected, honored and loved by those who knew him intimately. Tony Reeder and Claude Keyport did their job well, and I enjoyed their companionship and their loyalty to the principles enunciated by this House of Delegates, the Council of the State Medical Society, and its officers.

Your present delegation, Wy Barrett, your Chairman, Bill Hyland, Bob Novy, Herb Huron and Ralph Johnson, are an able and enthusiastic, loyal, hard-working group. I have watched them work on the floor of the House, in the committee rooms and in their contact with other delegates, and I can assure you that no state has a better balanced crew.

To my successor: I offer my congratulations at being able to work with these men.

Now the "swan is singing": I wish to express my appreciation for your confidence in electing me year after year. To The Council and officers, both past and present, I wish to thank them for their entire cooperation, advice and guidance. It has been a great experience, one that I shall always treasure, and it has acquainted me with the unselfish devotion of our present medical leaders in the welfare of the individual doctors throughout the nation in preserving the free practice of medicine.

(The audience arose and applauded.)

THE SPEAKER: I will refer this report to the Reference Committee on Officers' Reports.

XII—b. RE L. G. CHRISTIAN, M.D., FOR SERVICE AS AMA DELEGATE

R. A. JOHNSON, M.D. (Wayne): Mr. Speaker, I arise to a point of personal privilege, and to present a resolution that is self-explanatory:

"Whereas, Leo Gregory Christian has served this Society faithfully and well as delegate to the American Medical Association for fourteen years, and

"Whereas, he has announced his decision not to be a candidate again, and

"Whereas, his able and sincere contribution can never be fully acknowledged; therefore, be it

"RESOLVED: That we adopt this resolution as a mark of our esteem, respect and recognition for his faithful service to this House, to the Michigan State Medical Society, and to every doctor of medicine in Michigan."

I move that this resolution be adopted, Mr. Speaker.

(The motion was severally seconded, and was carried unanimously.)

VIII. Report of Woman's Auxiliary to MSMS

THE SPEAKER: The next order of business is new on our agenda, but it is very important this year because it is the 25th anniversary of our Woman's Auxiliary. We take some pride in having started—I don't know whether we or they started—but I could tell you a story about 25th anniversaries, except that our time is limited, and it would have to be deleted from the record anyway.

I take pleasure in calling upon Mrs. O. D. Stryker, who will give the annual report of the Woman's Auxiliary.

MRS. OSCAR D. STRYKER: For the first time in the history of the Michigan State Medical Society the distaff side of this organization—its Woman's Auxiliary—has been invited to have its annual report read to the House of Delegates by the Auxiliary President. We feel hon-

ored to have been so invited, and appreciate this recognition of our efforts in your behalf.

Twenty-five years ago our founders organized the Auxiliary for social purposes and to prepare for any assistance the Medical Society might request. At that time no one could foresee that in these short years this organization would be standing side by side with the doctors, fighting for the very existence of their profession. With the guidance of the leaders in the Medical Society we were able to meet the challenge to aid in the struggle to keep American medicine free.

The people I really would like to talk to probably are not here today—those doctors who tolerate, belittle, ignore, show hostility, or who say, "I do not want my wife to belong to that organization."

I believe most of you have discovered that women do influence thinking, and that we can be of service to you. I sometimes wonder if these men are against the Auxiliary because they are indifferent members of organized medicine and fear that if their wives become informed auxiliary members they would question their complacency and willingness to let others fight for them.

You are all probably familiar with the definition of an ambitious wife—"The prod behind the drone." Basically, the motives of each Auxiliary member are to help her husband and thereby to help the medical profession. Why should it matter if sometimes our objective is reached by unmasculine ways?

The job of women everywhere is to do the jobs the men do not get done. Most citizens, especially those interested in community affairs, recognize the force of women's groups. The Auxiliary is the only organization, outside of the Medical Society itself, which is working exclusively in the interests of your profession, to keep it free from strangling controls, to help it in good public relations, and to assist in obtaining proper legislation to protect its standards.

Who is better qualified to work in the interests of the medical profession than the doctor's wife? We try always to remember that we are an Auxiliary to a parent organization. We feel it is our duty to acquaint ourselves not only with the background and philosophy but also with the recent decisions and actions of our parent organization.

Public relations projects have always been given first place on our program. I believe our Auxiliary is an effective weapon in the public relations program of the Medical Society. Our first project last fall was the continuance of your Good Citizenship Campaign. Every Auxiliary contributed time and effort to this work, and many reported physicians and their wives and families registered and voting 100 per cent. Much literature was distributed, surveys and checks made by telephone, radio programs arranged, and cars driven to the polls on election day.

The Auxiliary's efforts in the field of legislation are helping to lessen the work of the Medical Society's committees. The women realize the importance of keeping informed on legislative matters, and of continuing our fight against compulsory health insurance.

Many meetings have been held, speakers provided, and literature distributed to inform the public on these issues. Letters to congressmen from lay, and professional groups in all of the counties stressed the importance of defeating the trend toward socialism in this country. Work is also continuing in obtaining resolutions from important groups.

Realizing that nursing care for tomorrow means work on nurse recruitment today, we have urged every Auxiliary to take part in this activity. To aid in this we made an outline for work on nurse recruitment on the county level, which was sent out to every auxiliary in our state, and by request to many other state auxiliaries.

Almost every auxiliary provided schools with information on nursing education or held recruitment programs in the schools. Fourteen nurse scholarships are given in all, and many other auxiliaries contribute money toward scholarships. We cooperated with the nursing organizations on both the state and county levels, and sponsored many Future Nurses Clubs. Our work in this vital task of nurse recruitment is of paramount importance and interest to the public.

Our participation in health programs and community activities develops lay confidence in us, and gives assurance that we are not prompted by selfish motives in working to defeat compulsory health insurance. A survey of county reports shows that our auxiliaries have contributed time, funds and individual effort to twenty-eight civic and health projects. Funds and the services of members also were given to many philanthropic agencies, including hospitals, sanatoriums and orphanages.

For ten years, the Auxiliary has co-sponsored a radio speech contest on tuberculosis, in cooperation with the Michigan Tuberculosis Association. This is our foremost health education project, and grows in importance every year with increased cooperation in its promotion by the auxiliaries.

The six state winners have their expenses paid to Lansing, and broadcast their essays over the Michigan State College Radio Station. Prizes also are awarded the winners on the county level by some of the auxiliaries, and in some instances to the teachers of the winning pupils. It was my pleasant duty to present the medals of award to the winners in Lansing last December.

The *News Bulletin*, our four-page publication, is issued quarterly to every Auxiliary member and member-at-large. This is financed by the Michigan State Medical Society and edited by your President-elect and the Public Relations Council of the State Society. We are most grateful for this assistance.

Subscriptions to *Today's Health* and the *National Bulletin* were urged at every opportunity but the results are still far short of the expectations of the respective chairmen. Many paid subscriptions of *Today's Health* were given by the auxiliaries to schools, libraries, hospitals, and city and county officials. We also collected, packed and shipped over three tons of supplies to the Medical and Surgical Relief Committee.

The auxiliaries have also assisted with Blue Cross and Blue Shield enrollment campaigns, and arranged programs on medical care insurance. The results of these efforts have been reflected in the favorable reactions of the public to the medical insurance principle.

The State Auxiliary now has forty-three component auxiliaries, twelve counties with members-at-large, and only Barry County with no Auxiliary members. This year we found ourselves half again as large, and with several hundred more members than in any previous year.

Such growth called for many changes in the basic structure of our meetings, as well as in other procedures. Knowing that suggestions from below are much more acceptable than edicts from above, a questionnaire was made up and sent out to every member of the Executive Board in November. The result was very gratifying, as not only did 96 per cent respond, but opinions and criticisms were expressed which never would have been voiced from the floor.

In accordance with the suggestions made by the majority, we have effected several changes, and more will be in force during the year ahead. We hope they will make for a more efficient handling of Auxiliary business.

Our National Auxiliary is over 50,000 strong. Such a great number of active, intelligent women, united in a common cause, is a force to be listened to and reckoned with among women's organizations.

Our State Auxiliary has 2,377 members, not even half of those eligible to join. In comparing our rosters I find that only two-thirds of the wives of the delegates and alternates of this group are members. We feel we have made a worthwhile contribution in behalf of

medicine—but think how much more could be accomplished if every physician's wife was an Auxiliary member and an active one!

Such a report as this is supposed to include an account of the President's activities. I shall make it brief. In attending meetings on Auxiliary business, the President traveled 8,219 miles and was accompanied on most of this by the President-elect: Six district meetings, twenty-four county meetings, eleven other meetings relative to the Auxiliary. The Wisconsin State Auxiliary convention in Milwaukee; the Midyear Conference of State Presidents, in Chicago; the Public Relations Conference of the MSMS in Detroit, and the National Auxiliary convention in Atlantic City were attended. The President presided at five post-convention Board meetings, two Executive Board meetings, one Executive Committee meeting, and will preside at all of the meetings of this convention except one.

Letters have been answered as soon as possible. It was an arduous task but a pleasant one. It is to be hoped that some way will be found to lighten this work for my successor. Four hundred thirty-seven letters were written and nineteen packets of material sent out. This does not include the work done by my corresponding secretary.

We are indebted to Mrs. Albert Callery for the fine history of our twenty-five years as an Auxiliary, which appeared in the April issue of THE JOURNAL of the MSMS. I recommend that each county auxiliary cut it out and keep it in their files.

In this report it has been impossible to cover all of the activities carried on by the individual counties. I can only say that I feel the Auxiliary has this year demonstrated the purposes for which we are organized—the promotion of friendship among physicians and their families, the interpretations of the aims and ideals of organized medicine to the laity, and to all organizations which look to the advancement of health education.

Many women accept the privilege of being the wife of a doctor without accepting the responsibilities which accompany it. We should all remember everything we have comes from the practice of medicine.

Auxiliary work should be a labor of love, and so demands the best portion of our powers and all of our wisdom offered as a steward giving back that which he has been permitted to use.

I am very proud of all the committees of the Auxiliary, both county and state, and can only say "Thank you," and remind them that their rewards are in the satisfaction of a job well done. To every state officer, district director, state chairman, county president, and active Auxiliary member, I extend my sincere gratitude for faithful cooperation and devotion to service which has made this year such a wonderful one for me and a progressive one for the Auxiliary.

I would also like to take this opportunity to thank most sincerely the Michigan State Medical Society, its President, Dr. Clarence Umphrey, the members of The Council, the staff of the Public Relations Council, and the Executive Office, Dr. Arthur Rothman, Chairman of the Advisory Committee, as well as all the members of that committee for their continued support and assistance.

I wish also to express my heartfelt gratitude to one who patiently endured much inconvenience and discomfort to enable me to travel so much in the past two years, who never failed in giving me encouragement and cooperation, and whose lifelong devotion to organized medicine was the inspiration for me to accept this task—my physician husband.

I wish to remind you members of the House of Delegates that the Auxiliary stands ready to do any task you ask, faithfully and loyally.

Looking to the future, we continue to ask of you:

Recognition of the Auxiliary as an ally.

Appreciation of the Auxiliary program.

Cooperation in periodic joint meetings.

Faith in our ability to do the work that needs to be done.

THE SPEAKER: Thank you, Mrs. Stryker. This report will be referred to the Reference Committee on Officers' Reports.

We will move now to the next item, resolutions.

XII—c. MATTERS FOR MEDIATION COMMITTEE

E. D. SPALDING, M.D. (Wayne): Mr. Speaker, I have a resolution to present:

"WHEREAS, it has never been the policy of the medical profession to set specific fees for professional services, but rather to rely on the principle of a fair fee in each individual instance, taking into account the services rendered, the responsibility incurred, the professional skill required, the custom in that locality, and especially the economic status, and ability of the recipient to pay, and

"WHEREAS, there has of late developed an increasing violation of these principles among a small but willful minority of the profession, and

"WHEREAS, by persistently so doing this small minority is seriously undermining the good will and respect of the general public for the profession as a whole, which through the long past it has been the latter's constant endeavor to develop and maintain; therefore, be it

"RESOLVED: That the House of Delegates of the Michigan State Medical Society strongly denounce such practices as are bringing the profession into disrepute; and be it further

"RESOLVED: That all constituent county societies are hereby directed to bring all such willful and persistent practices to the attention of their respective Committees of Mediation of such matters, for prompt, appropriate and drastic action; and to serve notice that if the perpetration of such practices as reflect on the good name of medicine are persisted in, it will result in the forfeiture of their membership."

THE SPEAKER: This resolution will be referred to the Reference Committee on Legislation and Public Relations.

XII—d. ANNUAL CONTRIBUTION AMEF

R. W. TEED, M.D. (Washtenaw):

"WHEREAS, medical school officials estimate that there is an annual deficit of about $10,000,000 in medical school operation in this country, and needed construction at a cost in excess of $300,000,000, and

"WHEREAS, many deans and other medical school officials have sought federal aid in this emergency, and

"WHEREAS, the American Medical Association has been promoting free enterprise as the ideal system for this, country and

"WHEREAS, most doctors of medicine now practicing paid only 20 per cent to 25 per cent of the actual cost of their education, there being a total deficit of some $8,000 to $10,000 per student paid either by private endowment or public aid; therefore, be it

"RESOLVED: That this House of Delegates support the program of the American Medical Education Foundation by urging every physician in Michigan to contribute at least $100 per annum to this Foundation for a period of ten years, thus repaying some 10 per cent of the cost of his education; and be it further

"RESOLVED: That business organizations, philanthropic trusts, and other individuals interested in private enterprise be invited to contribute to the work of the Foundation; and be it further

"RESOLVED: That attention be called to the fact that this contribution can be earmarked for use by either the University of Michigan Medical School or Wayne University College of Medicine if you so specify."

THE SPEAKER: This will be referred to the Reference Committee on Resolutions.

XII—f. FAVORING LITTLE HOOVER COMMISSION'S RECOMMENDATION RE HEALTH

R. V. Walker, M.D. (Wayne): I have a resolution to offer concerning a reorganization of the Michigan Department of Health under which all health agencies of the State would be integrated:

"Whereas, there is a great and obvious need for integration of all the various health agencies of the State of Michigan, and

"Whereas, the Health Department of the State, if properly reorganized, would be the logical coordinating body, and

"Whereas, the Michigan Hoover Commission has recommended that such a reorganization of the Health Department be made; therefore, be it

"Resolved: That this House of Delegates of the Michigan State Medical Society endorse in general the recommendation of the Michigan Hoover Commission for the reorganization of the State Health Department, under which all health agencies of the State would be integrated; and be it further

"Resolved: That there be appointed a committee of the Michigan State Medical Society to study this problem and draft a bill embodying a plan similar to that already successfully in operation in California and New York; and be it further

"Resolved: That in this plan the State Board of Health be selected from among a group of properly qualified individuals, who in turn would select a Commissioner of Health responsible to them."

The Speaker: This resolution will be referred to both the Reference Committee on Legislation and Public Relations and to the Reference Committee on Preventive Medicine and Public Health.

XII—i. COMPREHENSIVE PHYSICAL EXAMINATION

W. S. Reveno, M.D. (Wayne): This resolution refers to the matter of a comprehensive physical examination:

"Whereas, a basic tenet in medical care under the American system is that the individual is primarily responsible for his own health, and

"Whereas, there are many worthy health organizations conducting campaigns emphasizing a particular disease or a special body condition, and

"Whereas, the work of these organizations would have greatest value if their special subjects were combined under a single slogan with adequate supplementary slogans to give emphasis to their special subject, and

"Whereas, if such combined effort is carried out, the proper emphasis on the complete individual can be made to the public under a 'Know Yourself' campaign, such as is provided for in the 'Formula for Freedom' program, and

"Whereas, a comprehensive physical examination is an essential requirement for an individual in order to properly understand his personal health requirements; therefore, be it

"RESOLVED: That the Michigan State Medical Society support the effort to encourage individuals to have comprehensive physical examinations at proper intervals; that the Society develop a concept of what should be included in an efficient and adequate comprehensive physical examination; and be it further

"RESOLVED: That the Michigan State Medical Society work with the Michigan Health Council and other medical and health organizations to the end that their efforts for a comprehensive physical examination are coordinated so that the responsibility of the individual for his own health will receive greatest emphasis to the public."

The Speaker: This will be referred to the Reference Committee on Resolutions.

XIII—a. AMENDMENTS TO BY-LAWS CHAP. 8, SEC. 1—EXCLUDING ASSOCIATE MEMBERS IN COUNT

D. G. Pike, M.D. (Grand Traverse-Leelanau-Benzie):

"Whereas, the Bylaws of the Michigan State Medical Society leave some doubt as to the intent in regard to allocation of delegates, and

"Whereas, some inequities could result from various interpretations of the Bylaws; therefore, be it

"RESOLVED: That Chapter 8, Section 1 be amended to read as follows:

"Composition: The House of Delegates shall be composed of members elected by component county societies. Reports having been properly filed with the Secretary of the Society, each component county society shall be entitled to send to the House of Delegates each year one delegate for each fifty members and one delegate for each major fraction thereof. The term 'members' as used in this Section shall apply to active, life, emeritus and retired members only. Any component county society having less than fifty members shall be entitled to send one delegate."

The Speaker: This will be referred to the Reference Committee on Constitution and Bylaws.

XIII—b. BYLAWS—CHAP. 8, SEC. 1—INCLUDING ASSOCIATE MEMBERS IN COUNT

B. M. Harris, M.D. (Washtenaw): Mr. Speaker, this resolution concerns associate members:

"Whereas, the Constitution and Bylaws of the Michigan State Medical Society provide for representation in the House of Delegates in the rating of one delegate for each fifty members, and

"Whereas, the great majority of associate members are interns and residents, and

"Whereas, interns and residents are being groomed for active membership, the very purpose of associate membership being this preparation and indoctrination of young physicians, and

"Whereas, it would be manifestly undemocratic to carry such young members on our Society rolls without representation in the governing body thereof; be it therefore

"Resolved: That Section 1, Chapter 8 of the Bylaws be amended to read:

"Composition: The House of Delegates shall be composed of members elected by the component county societies. Reports having been properly filed with the Secretary of this Society, each component county society shall be entitled to send to the House of Delegates each year one delegate for each fifty active and associate members, and one delegate for each major fraction thereof."

The Speaker: This will be referred to the Reference Committee on Constitution and Bylaws.

XII—e. AMEF CONTRIBUTIONS MAY BE EARMARKED FOR SPECIFIC MEDICAL SCHOOLS

R. A. Johnson, M.D. (Wayne):

"Whereas, the American Medical Association is urging each doctor to contribute $100 to a national medical educational fund, and

"Whereas, the Michigan State Medical Society has approved such contributions, and

"Whereas, the alumni of the Wayne University School of Medicine are earmarking their contributions for Wayne University, and

"Whereas, both the Michigan schools of medicine need funds very badly for many projects, and

"Whereas, the Michigan State Medical Society and the American Medical Association will get credit for such funds as are raised locally and earmarked for local use; therefore, be it

"Resolved: That all doctors of medicine in Michigan be urged to contribute to the educational fund, and that such contributions may be earmarked for the Wayne

University College of Medicine or the University of Michigan College of Medicine, or some other urgent phase of medical education in the State, which is acceptable to the American Medical Education Foundation."

THE SPEAKER: This will be referred to the Reference Committee on Resolutions.

XII—g. OBJECTING TO LITTLE HOOVER COMMISSION'S RECOMMENDATION RE HEALTH

J. M. MARKLEY, M.D. (Oakland):

"WHEREAS, a staff report (No. 8) to the Michigan Joint Legislative Committee on Reorganization of State Government, entitled 'Michigan's Health Agencies' recommends that an 'Office of Health Affairs' be established, controlling the Department of Health, Hospital Survey and Construction Program, Crippled Children's Commission, State tuberculosis hospitals, State mental health program (including all State mental hospitals) and several other important functions, and

"WHEREAS, this tremendous over-all power would be placed in the hands of a State Council of Health of seven persons, to contain not more than three physicians (not necessarily M.D.'s), and

"WHEREAS, such a power grab would illogically scramble such preventive health functions as those of the State Health Department with such curative medical care responsibilities as those of the Crippled Children's Commission and be in effect a long initial step toward socialized medicine; therefore, be it

"RESOLVED: That this proposal of concentration of power in the health field be condemned and be vigorously opposed by the MSMS and every member thereof as an unworkable and unwise scheme; and be it further

"RESOLVED: That MSMS, its component county and district societies, and all members utilize every effort so that State agencies having to do with curative medical care (such as the Michigan Crippled Children's Commission) are maintained as independent departments as presently constituted."

THE SPEAKER: This will be referred to both the Reference Committee on Legislation and Public Relations and the Reference Committee on Preventive Medicine and Public Health.

XII—j. MORAL DEGENERATION IN GOVERNMENT

J. P. KLEIN, M.D. (Newaygo): This is a resolution regarding the health effects of moral degeneration of government:

"WHEREAS, the doctor of medicine is intimately acquainted with the health of his patients and with reasons why his patients are in need of medical care, and

"WHEREAS, it has become obvious in recent years that an increasing number of patients are in need of medical care for reasons primarily due to moral and ethical laxity, and

"WHEREAS, such moral and ethical laxity is due to the example of moral disintegration set by persons and powers who are influential in our government, as well as policies of government which have encouraged unhealthy mental and moral conditions, and

"WHEREAS, such moral degeneration is not only directly injurious to the health of the individual, and thus to society, but also predisposes a lowering of patriotic morale and undermining of the private enterprise system which is based on personal initiative and moral integrity, and

"WHEREAS, the people have, under the Bill of Rights and their voting franchise, a means of changing such undesirable conditions of government, and

"WHEREAS, the Michigan State Medical Society has a medical, moral and patriotic duty to point to conditions which are deleterious to the health of the people; therefore, be it

"RESOLVED: That the Michigan State Medical Society publicly point to the moral degeneration of the government and the resultant health effects of such condition; and be it further

"RESOLVED: That the Michigan State Medical Society urge upon the people of the State of Michigan that they take recourse to correct these conditions, as provided under the Constitutions of the United States of America and the State of Michigan."

THE SPEAKER: This resolution will be referred to the Reference Committee on Legislation and Public Relations.

XII—k. FLUORIDATION OF WATER

J. R. HEIDENREICH, M.D. (Menominee):

"WHEREAS, lengthy tests in many cities in the United States present conclusive and acceptable evidence that the ingestion of small amounts of fluorides during the period of tooth enamel formation produces a harder, more caries-resistant enamel, thereby substantially and safely reducing the incidence of dental caries, and

"WHEREAS, the fluoridation of water is a most effective approach to improving health through the prevention of dental decay, and is economically advantageous to the public as well as the individual, and

"WHEREAS, the fluoridation of public water supplies is approved and recommended by the American Public Health Association, United States Public Health Service, American Dental Association, Michigan State Dental Society, as in the interest of better health, and

"WHEREAS, many Michigan communities still have not applied this health safeguard to their water supplies for the benefit of their citizens; now, therefore, be it

"RESOLVED: That the House of Delegates of the Michigan State Medical Society endorse the process of fluoridation and encourage all physicians to seek the adoption of a program of fluoridation in every Michigan community having a public water supply that is deficient in fluoride; and be it further

"RESOLVED: That a copy of this resolution be sent to every county medical society, the State Health Officer, and every local health officer in Michigan."

THE SPEAKER: This will be referred to the Reference Committee on Hygiene and Public Health.

XII—l. CONGRATULATIONS TO TRUSTEES OF GRAND VIEW HOSPITAL, IRONWOOD

O. R. MACKENZIE, M.D. (Oakland):

"WHEREAS, the Board of Trustees of Grand View Hospital, Ironwood, have taken commendable action by insisting that their patients receive proper and adequate care by medically trained personnel; therefore, be it

"RESOLVED: That this House of Delegates, by adopting this resolution, go on record as commending the Board of Trustees for their valiant stand taken in the best interests of the public they serve; and be it further

"RESOLVED: That a suitably embossed copy of this resolution be sent to the hospital."

THE SPEAKER: This resolution will be referred to the Reference Committee on Resolutions.

XII—m. DUES COLLECTION EXPENSE

G. W. DE BOER, M.D. (Kent):

"WHEREAS, the American Medical Association makes a reimbursement of 1 per cent for collection of national dues, and

"WHEREAS, the collection of State dues is an entirely comparable matter and is of considerable secretarial expense to the county societies; therefore, be it

"RESOLVED: That the county societies of the Michigan State Medical Society be reimbursed 1 per cent for the collection of State dues."

THE SPEAKER: The chair will refer that to the Reference Committee on Resolutions.

The Chair declares this session recessed until two o'clock this afternoon.

(The meeting recessed at 1 p.m.)

MONDAY AFTERNOON SESSION

September 24, 1951

The meeting was reconvened at 2 p.m., R. H. Baker, M.D., Speaker of the House, presiding.

THE SPEAKER: I will ask Dr. Arch Walls, chairman of The Cinema Committee, to introduce the new MSMS motion picture.

IX. New MSMS Color/Sound Picture "To Save Your Life"

ARCH WALLS, M.D. (Wayne): I recall two years ago when I stood here and made a very feeble attempt to explain to you what we intended to do in the cinema project. It was very feeble, because I was on the spot. I didn't know we were going to drag out of the corners of everywhere a film of refugees, and whatnot. I heard many comments after that was shown, and if that is what you are going to expect, you don't want any part of it.

Today I feel much happier about the situation with regard to the cinema and public relations. I feel that today the cinema is one of the greatest media we have, and one of the cheapest. After I give you some of these facts it will prove to you that it is one of the cheapest forms by which we can show to the public what we are trying to do in the field of public relations.

So far, 299 theaters in the State of Michigan have shown or carried the film, "Lucky Junior." That film has been shown to over 1,500,000 people. That is not an approximation or guess—it is a count of paid admissions to those particular theaters.

Two hundred fifty-nine theaters in the State of Michigan also have shown "To Your Health," which was another film we made last year. That also has been shown to almost one million people.

Today, I am very happy to tell you about another film of which we are very proud. We feel it is worth $40,000 for public relations, but fortunately it comes to you gentlemen and the Michigan State Medical Society at a cost of around $4,000. This film is in color, and its purpose is to show the sacrifice of a medical student preparing to become a doctor, to show to the public that perhaps we have the right to charge for an examination or operation, or whatnot, as we do.

This film will take thirty minutes to run, and in the future this film will be shown to public organizations such as parent-teacher associations, organizations of Kiwanis Clubs, and others. It is not going to be shown in theaters at the present time because it is too long. It will be shown on television, which we hope will reach over five million people during the next year.

We feel highly grateful in regard to what our public relations staff has done at our State office. Our committee has done a few hours of work on it, but it has been very enjoyable work, and I hope you will all appreciate it and will give us your comments later. You may write them on a slip of paper. Any constructive criticism you have to offer will be very much appreciated, because we hope to make more films this next year, and with your guidance and suggestions we can improve them.

I think we're ready to roll.

(The motion picture, "To Save Your Life," was shown.) (*Applause*)

THE SPEAKER: The chairman of this committee asks that if you have any comments, favorable or otherwise, you give them to the committee. Mr. Doane is around somewhere, and you may wish to meet him. Dr. Walls or Hugh Brenneman will be pleased to receive your comments.

X. Selection of Michigan's Foremost Family Physician

THE SPEAKER: I will ask Dr. Foster, the Secretary, to read the backgrounds concerning the nominations for Michigan's Foremost Family Physician.

The Secretary read the three biographies.

THE SPEAKER: Gentlemen, you have heard these biographical sketches presented. It is now your duty to vote by ballot. I will appoint three tellers to step forward and receive the ballots, distribute them, and then collect them after you have voted. You will record the name of one man as your choice.

I will appoint Dr. Stealy of Grayling, Dr. Sloan of Hancock, and Dr. Logie of Grand Rapids to act as tellers.

The names are Drs. Charles Bennett, Arch Walls and Clayton Willison.

The members of the House thereupon voted.

THE SPEAKER: I have the report of the tellers on the election of the foremost family physician. In all, 112 ballots were cast. Dr. Clayton Willison, of Sault Ste. Marie, received sixty-nine votes. He is duly declared elected to this honor. (*Applause*)

(The Vice Speaker assumed the Chair.)

THE VICE SPEAKER: We proceed now with a matter of routine business.

XIV. Reports of Standing Committees

XIV—a. POSTGRADUATE MEDICAL EDUCATION COMMITTEE

The Committee on Postgraduate Medical Education has its report on page 75 of the Handbook. It is an excellent report. Is there any further report from that Committee? If not, it will be referred to the Reference Committee on Standing Committees.

XIV—b. COMMITTEE ON PREVENTIVE MEDICINE

The Preventive Medicine Committee has its report on page 80. Is there any addition to the report as printed? If not, it will be referred to the Reference Committee on Standing Committees.

XIV—c. COMMITTEE ON RHEUMATIC FEVER CONTROL

The report of the Rheumatic Fever Control Committee will be found on page 82.

XIV—d. COMMITTEE ON CANCER CONTROL

The Cancer Control Committee and its subcommittees appear on page 84.

XIV—e. COMMITTEE ON MATERNAL HEALTH

The Maternal Health Committee report is on page 87.

XIV—f. VENEREAL DISEASE CONTROL

The Venereal Disease Control Committee's report is on page 89.

XIV—g. TUBERCULOSIS CONTROL

Tuberculosis Control Committee, page 91.

XIV—h. INDUSTRIAL HEALTH

Industrial Health Committee, page 92.

XIV—i. MENTAL HYGIENE

Mental Hygiene Committee, page 94.

XIV—j. CHILD WELFARE

The Child Welfare Committee report is on page 96, and the report of its Subcommittee of Ophthalmologists is on page 97.

XIV—k. IODIZED SALT

The Iodized Salt Committee report is on page 99.

XIV—l. GERIATRICS COMMITTEE

The Geriatrics Committee and its subcommittee on Diabetes Control on pages 100 and 101.

Are there any additions to these reports? If not, these reports will be referred to the Reference Committee on Standing Committees.

XIV—m. INFECTIOUS DIARRHEA

The Committe on Infectious Diarrhea is on page 102.

XIV—n. DISTRIBUTION OF MEDICAL CARE

The Committee on Distribution of Medical Care is on page 103. Is there any addition to these reports? If not, they will be referred to the Reference Committee on Standing Committees.

XIV—o. PUBLIC RELATIONS

The report of the Committee on Public Relations and its subcommittees appears on page 104. I would like to single out this report as one of the most important for you to read. It details the work of the Public Relations Committee, and is one of the most vigorous activities of your Medical Society, and also one of the costliest. I would advise you to read it and find out what that Committee is doing.

This report will be referred to the Reference Committee on Standing Committees.

XIV—p. ETHICS COMMITTEE

The report of the Committee on Ethics appears on page 112. Is there an additional report? If not, this will be referred to the Reference Committee on Standing Committees.

XIV—q. LEGISLATIVE COMMITTEE

The report of the Legislative Committee is on page 112. It is an excellent report. This also is one of the very active committees, and it has given a detailed report of what has happened during the year. I advise you to read it very carefully. Is there an additional report? If not, this report will be referred to the Reference Committee on Standing Committees.

XV. Reports of Special Committees

XV—a. COMMITTEE ON SCIENTIFIC RADIO

The next item is the Scientific Radio Committee. Their report appears on page 120 of the Handbook. Is there an additional report? If not, it will be referred to the Reference Committee on Reports of Special Committees.

XV—b. WOMAN'S AUXILIARY

The report of the Advisory Committee to the Woman's Auxiliary appears on page 121. It will be referred to the Reference Committee on Special Committees.

XV—c. LIAISON WITH MEDICAL ASSISTANTS

The report of the Liaison Committee with State Medical Assistants' Society appears on page 122. It will be referred to the Reference Committee on Reports of Special Committees.

XV—d. NATIONAL FOUNDATION

The report of the Advisory Committee to the National Foundation for Infantile Paralysis is on page 122. This will be referred to the Reference Committee on Reports of Special Committees.

XV—e. INCREASE IN MEDICAL STUDENTS

The report of the Committee on Increase of Medical Students Graduated from Michigan Medical Schools appears on page 123.

E. F. Sladek, M.D. (Grand Traverse-Leelanau-Benzie): This subject of the increase in medical students has been of considerable discussion in this House for the past few years, and we finally, by fine co-operation and particularly through the efforts of our Legislative Committee and the special committee appointed by the Governor, have produced one and, if building materials are available within one year we will have the equivalent of another medical school for Michigan.

In other words, the increase in medical students in both universities will be commensurate with the development of another medical school. That is a tremendous saving, by just adding facilities to existing facilities.

I want to thank the members of the House and all the members of the Michigan State Medical Society who helped to put over the legislative appropriation for the expansion of the medical schools.

The Vice Speaker: This report will be referred to the Reference Committee on Reports of Special Committees.

XV—f. BEAUMONT MEMORIAL

I am informed that Dr. Hirschman has some information on the Beaumont Memorial Committee.

L. J. Hirschman, M.D. (Traverse City): I guess I am the only surviving member of the Committee. I made a little survey of Mackinac Island the first part of July, and visited the old quarters where the Beaumont episode took place. It is in a disgraceful condition. It certainly should be rehabilitated, and I believe some activities should be instituted to raise some funds and get busy.

The Michigan State Medical Society, in conjunction with the Upper Peninsula Medical Society, erected a beautiful monument to Beaumont, which I also inspected. I was there at its dedication some fifty years ago. It is in very good condition. If we could do as good a job in rehabilitating the old fur headquarters as we did with the monument, I think it would reflect credit on the State of Michigan and our profession.

I would suggest that The Council take some action to find ways and means of appropriating a little money to make a survey as to what it would cost to put the building in condition. Maybe the State Society, along with individual contributions, could really make a shrine of the old building. It certainly is up to us to do something about it.

The Vice Speaker: Thank you, Dr. Hirschman.

I wonder if Dr. Beck would like to comment at this time on what action The Council has taken.

Otto O. Beck, M.D. (Birmingham): Mr. Vice Speaker, you heard the resolution introduced this morning with reference to the restoration of the building known as the Early House on Mackinac Island. Dr. Hirschman has just commented on that subject, Dr. Hirschman being a member of the committee which was appointed some years ago by Dr. Corbus, of this Society, to further that project.

The Executive Committee of The Council requested that I bring this House a short sketch of the history of the building, plus some of the important work done by Dr. Beaumont.

The Early House now is a three-story residence, situated below the Fort, on the corner of the first street down from the hill. It is a residence, but 100 or more years ago that house was the store and warehouse of the American Fur Company, and it was in that store that the shot was fired which injured Alexis St. Martin. The shot and the resulting wound set the stage for the tremendous discovery made by Dr. Beaumont.

A word about Dr. Beaumont: He was born on November 21, 1785, at Lebanon, Connecticut. He had the usual public school education of that time. He taught school. In 1810 he decided to study medicine, and he associated himself with one Dr. Benjamin Candler, of St. Albans, Vermont, who at that time was the leading practitioner of that community. He studied under Dr.

Candler for two years and then was licensed to practice medicine in 1812.

The year 1812, as you will recall, was a war year. Beaumont joined the army and saw service with the United States forces. Following the war of 1812 he entered private practice. He carried on private practice for only three years, when he was commissioned as assistant surgeon to the U. S. Army by President Monroe in 1820.

His first post was Mackinac Island. He proceeded from New York to Mackinac Island by coach, by boat through the canal, and then by the first steamer on the Great Lakes, to Mackinac Island. At that time Mackinac Island had a population of 500 people, but since it was a trading post of the American Fur Company the population in the summer swelled to about 5,000 people—traders, trappers, foresters, employes of the American Fur Company, who journeyed to Mackinac Island to sell their catches of furs and to buy articles of apparel necessary for the coming winter. In the summer the Island was a scene of great holiday festivities for these people who had been confined in the woods of Michigan, Minnesota and Wisconsin as well as the entire Northwest Territory. They were there to have a good time.

Then, on June 6, 1822, there was gathered in the store of the American Fur Company, which is now known as the Early House, a great number of men who were trading, horsing around and having a good time, when accidentally a gun loaded with buckshot went off two or three feet distant from Alexis St. Martin, then a boy of eighteen.

The blast hit St. Martin on the left side of the chest, and he fell to the floor in dire straits. Dr. Beaumont was the Fort surgeon. He was immediately called, and proceeded from the Fort to the store, where he found St. Martin in very critical condition, and stated that the boy would not live thirty-six hours. He left instructions about what to do for the lad, and said he would return again in a little while.

Two or three hours later Beaumont returned, and to his surprise he found the boy in pretty good condition. He dressed the wound, pulled out some shot, some wadding, some clothing, pieces of rib; the sixth rib was entirely blasted away. The fifth rib was fractured. There was a wound about the size of a man's hand. Out of this wound protruded the lower lobe of the left lung, about the size of a turkey egg, and below the protrusion of the lung the stomach protruded, which was perforated. The contents of the food St. Martin had eaten that morning were flowing out of the stomach.

St. Martin was moved to the Fort on the hill, to the hospital, and there Beaumont cared for him daily. St. Martin gradually improved in health.

In the spring of 1823 the Mackinac Island authorities decided that they did not care to spend any more money for the care of St. Martin, who was a pauper, friendless, with no family; consequently, they decided to send him to his home in Canada, 2,000 miles away, in an open boat. Dr. Beaumont objected very strenuously, but was unsuccessful in changing their opinion.

Thereupon, Dr. Beaumont took the boy to his own home, out of sympathy and compassion, fed him, clothed him, lodged him, and furnished him with the comforts of life. He dressed the wound twice daily. He did all this on a salary of $40 a month, beside supporting his own family.

The idea of experimentation on the stomach did not occur to Dr. Beaumont until about three years later. He found that with Alexis lying on his right side he could look into the boy's stomach and see the action taking place. He could pour in liquids with a funnel, put in food with a spoon, attach meat and sundry food articles to a string suspended in the stomach, and later withdraw them and note the action of the stomach upon the food introduced.

These experiments were carried on more or less intensively for a period of time, and then at intervals when St. Martin objected to further experiments. These experiments were conducted at Mackinac Island and at Fort Crawford, Washington, D. C., and at Plattsburg, New York, depending upon where the surgeon of the Army of the United States sent Beaumont.

In all, Dr. Beaumont did 238 experiments, and in all he made fifty-one deductions on the function and physiology of the stomach. Dr. Vaughan had this to say: "He made such an exact study of the physical and chemical nature of gastric juice that with the exception of the discovery of pepsin, the closest research of modern times has added but little to the work done by him."

In 1833 Dr. Beaumont published his book, "Experiments and Observations on the Gastric Juice and the Physiology of Digestion." Honors were conferred upon him. In certain circles his work was recognized as being of tremendous importance. But, as so often occurs, sometimes those who contribute so tremendously during their lifetime do not have their contributions recognized until after they have died.

While Dr. Beaumont was living, he was made an honorary member of the Michigan Territorial Medical Society, a forerunner of this Society. He was an honor member of the Connecticut Medical Society, and the honorary degree of Doctor of Medicine was conferred upon him by Columbia College of Washington, D. C.

As Dr. Hirschman stated, the Upper Peninsula Medical Society, in conjunction with the Michigan State Medical Society, in 1900 erected a monument to Dr. Beaumont on Mackinac Island. That monument was re-dedicated in 1930, and Dr. Burton R. Corbus of this Society made the re-dedication address.

Dr. Beaumont died in St. Louis in 1853 at sixty-six years of age. He had been transferred there by the Surgeon General of the Army, to care for the Jefferson Barracks personnel near St. Louis, and then he moved into St. Louis, where he then established a private practice and became professor of surgery at the new University Medical School.

Concerning the restoration of this building: About twelve years ago The Council of the Michigan State Medical Society first became aware that the building was available. After a number of years we obtained funds in the amount of $10,000 from the Parke, Davis Company to purchase the building. The building was purchased. It is owned by the State of Michigan and is under the care of the Mackinac State Island Park Commission.

After obtaining the building and making it available, there is now the question of its restoration. It is not in the original condition. The Island Park Commission, a year or two ago, asked a person from the University of Michigan to go up there and make quite an extensive survey. This was done. People all over the world were written in an attempt to find out just what the building had been like in 1820. Many photographs and copies of letters and documents of one sort or another were gathered together even from some European countries, and from the documents obtained we are told now that they know just about exactly what the building was like in 1820 when the accident occurred.

We understand it was a one-and-one-half story building, the basement being of stone, and the upper structure of logs. The building can be restored by using logs from trees on the Island, and replacing stones that need replacing. We are told that the cost of the restoration of this building will be something like $50,000 to $60,000.

True, that is a considerable amount of money, and it is not an easy task to raise that much; but when you consider the membership of this Society—5,000 people—it would not take much more than an average of $10 per member to restore that building to its original structure.

Of course, in all such endeavors to raise money there is such a thing as a 100 per cent contribution.

If the building is restored, and the members of The

Council hope it will be, it will be a fine monument to medicine. It will be a fine thing for the doctors of Michigan. They will be able to take considerable pride in restoring this medical landmark—a landmark which led to the then greatest discovery known to man—the physiology of the stomach.

I would imagine after its restoration there would be a sign placed in front of the building, as there is now, but possibly with the inscription that the building had been restored by the doctors of Michigan. If you have ever been to the Island you know something about the thousands and thousands of people who go there every summer. They look over the city and the Fort and other historic places.

The money to restore the building possibly could be raised easily if we went outside the medical profession, because there are some people who are very intensely interested in seeing it restored. Personally, I would take tremendous pride in the fact that the doctors of this State had done the job themselves.

THE VICE SPEAKER: Thank you, Dr. Beck, for this information. I will now turn the Chair back to the Speaker.

XVI. Committees of the Council

(The Speaker resumed the Chair.)

THE SPEAKER: There is one committee report that the House asked for last year, namely, that of the Committee of Seven to Study the Basic Science Act. That report is printed in the Handbook. However, I think it might be well to call on Dr. J. D. Miller, Chairman of that Committee, to read the Committee's report and make any comment he wishes at this time. That report will go to the proper reference committee.

XVI—a. LIAISON COMMITTEE MICHIGAN HOSPITAL ASSOCIATION
XVI—b. LIAISON COMMITTEE STATE PHARMACEUTICAL ASSOCIATION

J. D. MILLER, M.D. (Kent): Under reports of committees of The Council, first is the Liaison Committee with the Michigan Hospital Association. While this report is for information, it was thought by the chairman and also discussed with other members of the Committee, who agreed, that it could well be consolidated with the so-called Permanent Conference Committee, which is a liaison committee with the Michigan Hospital Association and the Michigan Nursing Center Association, the reason being that you go to one meeting and then have to go to another, and do the same thing all over again at the meeting when all three groups are represented.

In the annual report of the Liaison Committee with the Michigan State Pharmaceutical Association, no formal meetings were held and no formal report made. I just want to mention that the Chairman of the Committee has been able to furnish a great deal of information to the Pharmaceutical Association on legislative and other problems that have come through our sources, and from them we received a great deal of help in the way of handling some of these legislative problems, both local and national. That, of course, is not a part of the formal report of the Committee.

XVI—c. COMMITTEE OF SEVEN ON BASIC SCIENCE

This is the annual report of the Committee of Seven to Study the Basic Science Act, 1950-1951:

This Committee met February 15, 1951 and June 4, 1951 at Detroit, Michigan. After due consideration it was the consensus of this Committee that the Basic Science Act is fundamentally a good Act. It was also the opinion of this Committee that one change in the present Act should be made, and that some additions to the Act might improve the Act and the administration of the Act to the benefit of the people of the State of Michigan.

This Committee, therefore, recommends the following:

1. That the Act be amended so as to omit the examination in "public health and hygiene."

(The reason for this is that it is the stumbling block which keeps the Basic Science Board in the State of Michigan from having reciprocity with a great many other states—nineteen, to be exact—because their listings are not under that exact wording).

2. That legislation be recommended providing that the records of the Board of Examiners in the Basic Sciences be deposited with the Secretary of State and be made available for public inspection.

(As this Board is now administered, it is absolutely impossible to find out how many people took the examinations, who took the examinations, who passed and who didn't, who were admitted by reciprocity, and who were not. That failure in the administration of the Act leaves this large loophole by which many irregular practitioners are now admitted to the State of Michigan).

3. That legislation be recommended providing that nobody who has satisfactorily passed an examination in the basic sciences shall be required to submit a second time to an examination in the same basic sciences for the purpose of determining his fitness to practice medicine and surgery in the State of Michigan.

(That, of course, is a big point, as we realize, and cannot be carried out under the present laws).

4. That legislation be recommended that will permit interns and residents to train in Michigan hospitals without the necessity of passing the basic science examination.

5. That legislation be recommended providing that whenever a member of the Board of Examiners in the Basic Sciences shall have served two consecutive terms, he shall not be eligible for reappointment until the expiration of ten years after the end of his second term.

Respectfully submitted,

J. D. MILLER, M.D., *Chairman*
W. B. HARM, M.D.
J. JOSEPH HERBERT, LL.B.
J. E. LIVESAY, M.D.
J. H. SCHLEMER, M.D.
E. D. SPALDING, M.D.
D. B. WILEY, M.D.

* * *

The term of office, if I remember it correctly, is six years. This fifth item means that a man can serve twelve years, and then he would have to wait ten years before he could be reappointed. I think the thought behind that is obvious.

THE SPEAKER: The Chair will refer this report to the Reference Committee on Reports of The Council.

XIII—c. CONSTITUTION. ART. X, SEC. 2 RE TREASURER BEING MEMBER OF EXECUTIVE COMMITTEE

C. L. CANDLER, M.D. (Wayne):

"Whereas, matters relative to the financial structure of the State Society are constantly being discussed by the Executive Committee of The Council, it would be desirable to have the Treasurer of the State Medical Society as a member of the Executive Committee of The Council; therefore, be it

"RESOLVED: That Article X, Section 2 of the Constitution be changed by adding, after the word 'Secretary,' the word 'Treasurer'."

THE SPEAKER: This resolution will be referred to the Reference Committee on Constitution and Bylaws.

XII—n. TEACHING CIVIL DEFENSE IN MEDICAL SCHOOLS

M. L. LICHTER, M.D. (Wayne):

"WHEREAS, the United States is faced with the problem of civil defense, and

"WHEREAS, it is the moral responsibility of the medical profession to participate fully in such an endeavor, and

"WHEREAS, this problem will be present as long as strong aggressor nations continue to exist, and

"WHEREAS, the education of doctors of medicine in the medical problems involved in atomic, bacteriologic and chemical warfare, as they affect the civilian population, is of paramount importance in the fulfillment of the profession's responsibilities; therefore, be it

"RESOLVED: That the House of Delegates direct the State Committee on Emergency Medical Service to confer with the deans of the two medical schools of the State of Michigan, recommending some modification of their curricula in regard to this problem."

THE SPEAKER: This will be referred to the Reference Committee on Emergency Medical Service.

XII—o. TEACHING OF ETHICS IN MEDICAL SCHOOLS

WARREN BABCOCK, M.D. (Wayne):

"WHEREAS, the greatest good in medical public relations is determined by the action of the medical profession in their treatment of individual patients, and

"WHEREAS, a small selfish minority can undermine the good of the majority, and

"WHEREAS, misunderstanding of medical ethics is common among the profession and is often used as an excuse by this minority group, and

"WHEREAS, courses in medical ethics are given in many of the medical schools of this country; therefore, be it

"RESOLVED: That the House of Delegates direct the State Committee on Medical Ethics to confer with the deans of the two medical schools of the State of Michigan, recommending some modification of their curricula in regard to this problem."

THE SPEAKER: This resolution will be referred to the Reference Committee on Resolutions.

Are there any other resolutions?

XII—h. RE ACT 59 OF P. A. 1937

H. W. WILEY, M.D. (Ingham) presented this resolution which was referred to the Reference Committee on Reports of The Council and subsequently considered in Executive Session.

THE SPEAKER: I understand we have not cleared reports of special committees of The Council, as printed in the Handbook.

XVI—d TO m INCLUSIVE

On page 4 of the Handbook you will see a list of committees of The Council, their reports appearing on pages 125 through 137 of the Handbook. I will consider those reports having been read as printed. They will be referred to the Reference Committee on Reports of The Council. We shall now recess until 8 p.m. this evening. The reference committees will go into session at once.

(The meeting recessed at 4 p.m.)

MONDAY EVENING SESSION

September 24, 1951

The meeting was reconvened at 8:30 p.m., R. H. Baker, M.D., Speaker of the House, presiding.

XII—p. BEAUMONT MEMORIAL RESTORATION RESOLUTION

E. B. CUDNEY, M.D. (Oakland): This is a resolution concerning the Beaumont Memorial on Mackinac Island:

"WHEREAS, Dr. William Beaumont began his pioneering work in physiology at Mackinac Island, Michigan, in 1822, and

"WHEREAS, the first observation of his famous patient, Alexis St. Martin, was made by Dr. Beaumont in the American Fur Company's trading post, now known as the Early House on Mackinac Island, and

"WHEREAS, through the generosity of Parke, Davis & Company, Detroit, the Early House was acquired several years ago by the Mackinac Island State Park Commission as the first step in plans to convert this historical building into a permanent shrine to the memory of Beaumont, with maintenance to be assumed by the Park Commission, and

"WHEREAS, such a monument to the imperishable research of Beaumont would constantly remind the thousands of people who visit Mackinac Island annually that a free medicine is always a progressive one, eternally endeavoring to improve its science and its service to the public; therefore, be it

"RESOLVED: That the Michigan State Medical Society assume responsibility for developing the Beaumont Memorial on Mackinac Island, and that the House of Delegates authorize The Council and the Woman's Auxiliary to the Michigan State Medical Society to inaugurate a drive for funds among the Michigan medical profession and its friends, to complete the work of transforming the Early House into a medical landmark for posterity; and be it further

"RESOLVED: That contributions in this campaign be on a voluntary basis, with the names of all donors inscribed permanently in the Beaumont Memorial, and that the work be completed, if at all possible, in 1952, in order to commemorate the 130th anniversary of Beaumont's important discovery."

THE SPEAKER: This resolution will be referred to the Reference Committee on Miscellaneous Business.

XVIII—a. REFERENCE COMMITTEE ON OFFICERS' REPORTS

E. H. FENTON, M.D. (Wayne): Mr. Speaker, the Reference Committee on Officers' Reports considered the following reports:

(1) Speaker's Address
(2) President's Address
(3) President-elect's Address
(4) AMA Delegates' report
(5) Annual report of the Woman's Auxiliary President

1. *Speaker's Address.*—We wish to compliment Dr. Baker on his address, which reviewed medical progress and the growth of the Michigan State Medical Society, with its many added services to the public.

2. *President's Address.*—Dr. Umphrey did a splendid job in bringing before the delegation the important part the physician must play if we are to save our nation from chaos. A small, intelligent, loyal group of citizens could lead the way back to virtue in government, and the medical profession could be that group. Dr. Umphrey also paid tribute to a fine State organization, with its various personnel.

3. *President-elect's Address.*—Dr. Beck called attention to the paramount issues of the day. They are, first, a war to stop communism; secondly, corruption in high places in government. He stated that a large segment of the population has developed a loss of moral values, otherwise it could not condone such a state of affairs. Demoralization of a nation is one of the first steps to communize the world.

4. *AMA Delegates' Report.*—Dr. Christian gave a detailed report on the proceedings of the AMA House of Delegates. We salute Dr. Christian as one of our fine medical leaders, and, although he has withdrawn his name from consideration for re-election, we hope our Society can count on him in other capacities.

5. *Annual Report of Woman's Auxiliary President.*—Mrs. Stryker emphasized the many and varied means by which the Woman's Auxiliary is performing a fine service to the Society and to the country. Particularly commendable is their work in encouraging young women to go into nurse's training, and that in relation to public relations and public health service.

XVIII—b. FORMULA FOR FREEDOM

The Reference Committee would also like to state, concerning the Public Relations Department, that they did a fine job in bringing the program to us this morning.

Mr. Speaker, I move that the report of the Reference Committee on Officers' Reports be accepted as a whole.

C. L. Weston, M.D. (Shiawassee): I second the motion.

(The motion was put to a vote and was carried unanimously.)

The Speaker: Reference Committees on Reports of Special Committees.

XVIII—c. BEAUMONT MEMORIAL COMMITTEE

E. C. Texter, M.D. (Wayne): It is the recommendation of this Reference Committee that the Early House (the American Fur Company Trading Post) be restored by the Michigan State Medical Society, as recommended by President-elect Otto O. Beck, M.D., and it is hoped that it can be completed during 1951-52.

The Reference Committee discussed various methods of financing the proposed project, and it was felt, as Dr. Beck had recommended, that the financing be kept within the medical profession itself, as a medical memorial to Michigan physicians. The following two methods were suggested:

1. Direct contributions from MSMS members.
2. Special Beaumont Memorial Building Restoration Fund assessment. The Reference Committee felt that, with the present membership, a minimum of $15 would be necessary.

Mr. Speaker, I move adoption of this part of the report.

G. C. Penberthy, M.D. (Wayne): I second the motion.

(The motion was put to a vote and was carried unanimously.)

XVIII—c. SCIENTIFIC RADIO

E. C. Texter, M.D. (Wayne): The annual report of the Scientific Radio Committee: The Reference Committee recommends the approval of the report as printed in the Handbook, and wishes to commend the Committee for the remarkable job they have completed in the field of radio, and suggests they explore the field of television for future additional visual education.

I move the adoption of this part of the report.

H. J. Meier, M.D. (Branch): I second the motion.

(The motion was put to a vote and was carried unanimously.)

XVIII—c. WOMAN'S AUXILIARY

E. C. Texter, M.D. (Wayne): The annual report of the Advisory Committee to the Woman's Auxiliary: The Reference Committee recommends the approval of the report as printed in the Handbook, and that the Committee be commended for its excellent work. The Reference Committee wishes to recommend that all elected delegates and alternates be urged to have their respective wives join the Auxiliary immediately upon their return home, either joining their county chapter or becoming members-at-large.

I move the adoption of this part of the report.

H. B. Fenech, M.D. (Wayne): I second the motion.

(The motion was put to a vote and was carried unanimously.)

XVIII—c. MEDICAL ASSISTANTS

E. C. Texter, M.D. (Wayne): Annual report of the Advisory Committee to the Michigan State Medical Assistants Society: The Reference Committee recommends the approval of the report as printed in the Handbook, and suggests that even though no major tasks were necessary during the year, it is recommended that the Committee be continued and urged to enlarge its scope of activity. Also, that the annual meeting be continued with at least one member of the Advisory Committee in attendance.

I move the adoption of this part of the report.

(The motion was severally seconded, was put to a vote, and was carried unanimously.)

XVIII—c. NATIONAL FOUNDATION FOR INFANTILE PARALYSIS

E. C. Texter, M.D. (Wayne): Annual Report of the Advisory Committee to the National Foundation for Infantile Paralysis: The Reference Committee recommends the approval of items No. 1 and No. 3 as printed in the Handbook, and desires clarification of item No. 2 as printed in reference to the phrase, "Executive Committee," and that the whole item appears ambiguous.

We are asking for clarification of item No. 2, which reads: "The Committee recommends that members of the medical and public health professions rendering any service which may be paid for by the National Foundation for Infantile Paralysis should not be on the Executive Committee."

What executive committee? That is the question. We contacted Dr. Cudney, one of the members of the committee, and he was unable to clear up the question.

Mr. Speaker, I move that item No. 2 be referred to the Executive Committee of The Council for clarification.

E. D. Spalding, M.D. (Wayne): I second the motion.

(The motion was put to a vote and was carried unanimously.)

XVIII—c. INCREASE IN MEDICAL STUDENTS

E. C. Texter, M.D. (Wayne): Annual Report of the Special Committee on Increase of Students Graduated from Michigan Medical Schools: The Reference Committee approves the report as printed in the Handbook, and offers the following suggestions and recommendations:

The Committee is to be commended for its excellent work in solving a long-needed problem of increasing medical students in our two Michigan medical schools. A supplemental report, as given by E. F. Sladek, M.D., Chairman, before our House of Delegates today, wished to further commend the Committee, and stated that when the present program is carried out the increase of students graduated will be the equivalent of one new medical school without the cost of an additional medical school. As this program appears to be another "first," the Reference Committee feels that this program might well be emulated by other states having two or more medical schools, in solving our supposed shortage of physicians.

I move the adoption of this part of the report.

G. C. Penberthy, M.D. (Wayne): I second the motion.

(The motion was put to a vote and was carried unanimously.)

E. C. Texter, M.D. (Wayne): I move the adoption of the Reference Committee's report as a whole.

R. L. Novy, M.D. (Wayne): I second the motion.

(The motion was put to a vote and was carried unanimously.)

XVIII—d. REFERENCE COMMITTEE ON CONSTITUTION AND BY-LAWS

The Speaker: The Reference Committee on Constitution and By-laws.

R. A. Springer, M.D. (St. Joseph): Mr. Speaker, I would like to commend my Committee. I have had the pleasure of working on a great many committees, but I have never been on one that worked as conscientiously as the Reference Committee on Constitution and By-laws this afternoon.

XVIII—d. BYLAWS CHAPTER 8, SEC. 1—INCLUDING ASSOCIATE MEMBERS IN CONSTITUTION

R. A. Springer, M.D. (St. Joseph): The second resolution was presented by Dr. Harris:

"Whereas, the Constitution and Bylaws of the Michigan State Medical Society provide for representation in the House of Delegates in the rating of one delegate for each fifty members, and

"Whereas, the great majority of associate members are interns and residents, and

"Whereas, interns and residents are being groomed for active membership, the very purpose of associate membership being this preparation and indoctrination of young physicians, and

"Whereas, it would be manifestly undemocratic to carry such young members on our Society rolls without representation in the governing body therof; therefore, be it

RESOLVED: That Section 1, Chapter 8 of the Bylaws be amended to read:

"Composition. The House of Delegates shall be composed of members elected by the component county societies. Reports having been properly filed with the Secretary of this Society, each component county society shall be entitled to send to the House of Delegates each year one delegate for each fifty active and associate members, and one delegate for each major fraction thereof."

Your Reference Committee recommends that this resolution be not adopted. I so move.

W. B. Mitchell, M.D. (Kent): I second the motion.

(The motion was put to a vote and was carried.)

XVIII—d. CONSTITUTION ART. X, SEC. 2 TREASURER MEMBER EXECUTIVE COMMITTEE

R. A. Springer, M.D. (St. Joseph): The second resolution was presented by Dr. Candler and since it is a proposal to amend the Constitution (Art. X, Sec. 2), it is referred to the 1952 House of Delegates.

XVIII—d. COUNCIL'S RECOMMENDATIONS FOR AMENDMENT TO BYLAWS AND CONSTITUTION (a) ON EMERITUS MEMBERS QUALIFICATIONS

R. A. Springer, M.D. (St. Joseph): The Council made recommendations on page 70 in the Handbook, No. 5 referring to a By-laws amendment.

In accordance with the recommendations of The Council, your Reference Committee recommends that the action of the House of Delegates at last year's session, deleting the word "consecutive," be rescinded.

If you will turn to page 150 in the Handbook you will find that members emeritus are described the way this is intended. In other words, we are sanctioning a misprint in the Handbook. The idea is that last year "consecutive" was deleted. The Council wanted the word "consecutive" to remain in, and due to a mistake in the printing of the Handbook the word "consecutive" is there. That is the way your Reference Committee wishes to recommend it.

Mr. Speaker, I recommend the adoption of this portion of the report.

W. S. Reveno, M.D. (Wayne): I second the motion.

(The motion was put to a vote and was carried unanimously.)

The Speaker: Any other discussion? Proceed, Dr. Springer.

XVIII—d. COUNCIL'S RECOMMENDATIONS RE AMENDMENTS TO CONSTITUTION (b) VICE SPEAKER MEMBER OF EXECUTIVE COMMITTEE AND COUNCIL ART. X., SEC. 3

R. A. Springer, M.D. (St. Joseph): On page 70, item No. 7 has to do with the Vice Speaker of the House of Delegates becoming a member of The Council and the Executive Committee. On Page 143 of the Constitution—that is, page 143 in the Handbook—it states this will have to lie over for one year.

Your Reference Committee recommends that a new section, No. 3, be added to Article X of the Constitution, reading as follows: "The Vice Speaker shall be a member of The Council and the Executive Committee without vote except in the absence of the Speaker."

The Speaker: This is an amendment to the Constitution, and will have to lie over until next year. Is there any discussion before we lay it on the table until then? Proceed, Dr. Springer.

XVIII—d. COUNCIL'S RECOMMENDATIONS RE AMENDMENTS TO CONSTITUTION AND BYLAWS (c) AUTOMATIC MEMBERSHIP IN AMA

R. A. Springer, M.D. (St. Joseph): Item No. 8 on page 71 has to do with some county medical societies automatically making their members members of the AMA. That was all right before the AMA charged dues.

Your Reference Committee felt that they should recommend to the House of Delegates that the Secretary call to the attention of the county medical societies the fact that changes in the By-laws are necessary to provide for AMA dues for those who wish to become members of that organization.

REFERENCE COMMITTEE ON RESOLUTIONS

XVIII—e. HENRY J. PYLE, M.D., DECEASED

B. M. Harris, M.D. (Washtenaw): The first resolution regarded the late Henry J. Pyle, M.D., one-time Speaker of the House of Delegates.

(The resolution was re-read.)

B. M. Harris, M.D. (Washtenaw): Your Reference Committee recommends approval of this resolution as presented. I so move, Mr. Speaker.

The Speaker: We will rise for a moment of silence, in accordance with the resolution.

(Silent standing tribute.)

XVIII—e. TWO AMEF RESOLUTIONS

The next two resolutions were combined into one. One was presented by Dr. Teed, of Washtenaw, and the other by Dr. Johnson. I will read the resolution as the Reference Committee rewrote it:

"WHEREAS, medical school officials estimate that there is an annual deficit of about $10,000,000 in medical school operation in this country, and needed construction at a cost in excess of $300,000,000, and

"WHEREAS, many deans and other medical school officials have sought federal aid in this emergency, and

"WHEREAS, the American Medical Association has been promoting free enterprise as the ideal system for this country, and

"WHEREAS, most doctors of medicine now practicing paid only 20 per cent to 25 per cent of the actual cost of their education, there being a total deficit of some $8,000 to $10,000 per student paid either by private endowment or public aid; therefore, be it

"RESOLVED: That this House of Delegates support the program of the American Medical Education Foundation by urging every physician in Michigan to contribute at least $100 per annum to this Foundation for a period of ten years, thus repaying some 10 per cent of the cost of his education; and be it further

"RESOLVED: That business organizations, philanthropic trusts and other individuals interested in private enterprise be invited to contribute to the work of the Foundation; and be it further

"RESOLVED: That attention is called to the fact that this contribution can be earmarked for use by either the University of Michigan Medical School or Wayne University College of Medicine if you so specify."

Your Reference Committee recommends the adoption of this resolution. I so move, Mr. Speaker.

We combined these two resolutions into the one I have just read, and covered all the resolveds in both resolutions.

G. C. PENBERTHY, M.D. (Wayne): I second the motion.

PAUL SLOAN, M.D. (Hancock): For the sake of discussing this with our constituents back home, is that a suggestion or will that be an assessment?

THE SPEAKER: No; this is a suggestion, not an assessment. Any other discussion?

(The motion was put to a vote and was carried unanimously.)

XVIII—e. COMPREHENSIVE PHYSICAL EXAMINATION

B. M. HARRIS, M.D. (Washtenaw): The next resolution was Dr. Reveno's resolution regarding a comprehensive physical examination.

"RESOLVED: That the Michigan State Medical Society support the effort to encourage individuals to have comprehensive physical examinations at proper intervals; that the Society develop a concept of what should be included in an efficient and adequate comprehensive physical examination; and be it further

"RESOLVED: That the Michigan State Medical Society work with the Michigan Health Council and other medical and health organizations to the end that their efforts for a comprehensive physical examination are coordinated so that the responsibility of the individual for his own health will receive greatest emphasis to the public.

Your Reference Committee recommends approval of this resolution. I so move, Mr. Speaker.

J. W. LOGIE, M.D. (Kent): I second that motion.

THE SPEAKER: The question is called for. Will the "Ayes" raise their hands? Now, the "Nos." I assume those who did not vote "no" must have been neutral. We will rule that the motion is carried.

XVIII—e. CONGRATULATIONS TO GRAND VIEW HOSPITAL TRUSTEES

B. M. HARRIS, M.D. (Washtenaw): The next resolution was presented by Dr. McKenzie. The resolution congratulates the Trustees of the Grand View Hospital, Ironwood.

Your Reference Committee felt that the intent of the resolution was very commendable, but that some of the wording might perhaps be open to criticism, and therefore we have reworded the resolution as follows:

"WHEREAS, the Board of Trustees of Grand View Hospital, Ironwood, have taken commendable action by insisting that their patients receive proper and adequate care by medically trained personnel; therefore, be it

"RESOLVED: That this House of Delegates, by adopting this resolution, go on record as commending the Board of Trustees for their valiant stand taken in the best interests of the public they serve; and be it further

"RESOLVED: That a suitably embossed copy of this resolution be sent to the hospital."

I move the adoption of this substitute resolution.

L. R. LEADER, M.D. (Wayne): I second the motion.

(The motion was put to a vote and was carried unanimously.)

XVIII—e. RE DUES COLLECTION EXPENSE

B. M. HARRIS, M.D. (Washtenaw): The next resolution concerns collection expenses:

"WHEREAS, the American Medical Association makes a reimbursement of 1 per cent for collection of national dues, and

"WHEREAS, the collection of State dues is an entirely comparable matter and is of considerable secretarial expense to the county societies; therefore, be it

"RESOLVED: That the county societies of the Michigan State Medical Society be reimbursed 1 per cent for the collection of State dues."

I move the adoption of this resolution.

E. D. SPALDING, M.D. (Wayne): I second the motion.

(The motion was put to a vote and was carried.)

XVIII—e. RE TEACHING OF ETHICS IN MEDICAL SCHOOLS

B. M. HARRIS, M.D. (Washtenaw): The resolution next on the list was presented by Dr. Babcock.

(The resolution was re-read.)

B. M. HARRIS, M.D. (Washtenaw): Your Reference Committee felt that some of the phrasing could be improved upon, and we submit this substitute resolution:

"WHEREAS, a thorough understanding of medical ethics is paramount, and

"WHEREAS, the lack of this knowledge is a cause for concern by all doctors of medicine; therefore, be it

"RESOLVED: That the Ethics Committee of the Michigan State Medical Society be requested to inform themselves of the course and type of instruction in medical ethics as taught in our State medical schools."

I move the adoption of this substitute resolution.

J. A. WITTER, M.D. (Wayne): I second the motion.

(The motion was put to a vote and was carried unanimously.)

B. M. HARRIS, M.D. (Washtenaw): Mr. Speaker, I move the adoption of the report of the Reference Committee as a whole.

R. A. SPRINGER, M.D. (St. Joseph): I second the motion.

(The motion was put to a vote and was carried unanimously.)

XVIII—f. REFERENCE COMMITTEE ON REPORTS ON STANDING COMMITTEES

Dr. Loupee, will you make your report, please?

Your Reference Committee was in full attendance, and manifested distinct interest in the mass of detailed reports printed in the Handbook, and there brought to our attention.

About fifty pages of the Handbook are given over to the reports of these standing committees. Your Reference Committee had to consider all of those reports and pass upon them individually and in detail. This we have done.

In the main, these committee reports are approved by your Reference Committee and are highly commended for their content and literary style. Others are to be given special mention.

Those reports of standing committees which were studied individually and approved without further comment are as follows:

Report of the Committee on *Postgraduate Medical Education.*

Report of the *Preventive Medicine Committee,* embracing the reports on *cancer control, venereal disease control, tuberculosis control, industrial health control, iodized salt, mental hygiene, child welfare, hearing defects, the Committee on Ophthalmologists, Geriatrics, Infectious Diarrhea, Ethics Committee,* and the *Distribution of Medical Care Committee.*

All of these reports were approved as they appear in the Handbook, and are approved without comment.

The report of the *Rheumatic Fever Control Committee* draws special comment. First, rheumatic control activity is not wholly within the program of the State of Michigan. For reasons not clear to your Reference Committee, the Chairman of the Federal Health Authority is disbursing federal funds in some areas of the State, though we are well set up to meet every need within the program of our Society. It appears to your Reference Committee that socialized medicine still has a toe hold within our State. Better advertising and better public relations activity are suggested by your Reference Committee.

Second, in the *Maternal Health Committee's report,* under the topic of licensing of maternity hospitals, it should be brought up-to-date by recognizing that the legislature recently placed this function within the State Health Department. Stress upon the education of mothers is suggested for improving the status of maternal health.

Those two suggestions are added to the report of the Committee on Maternal Health.

The Subcommittee on *Diabetic Control* of the Geriatrics Committee is encouraged to carry on the expanded program.

The report of the Committee on *Public Relations* is most excellent, on which we could enlarge indefinitely; but our Reference Committee will confine itself to special comment on the report of the Woman's Auxiliary, which set the pace for enthusiastic public campaigns—for example, the C.A.P. and the Good Citizenship campaign, as outlined in the report.

Finally, the *Legislative Committee* comes in for high praise. We recommend that all doctors read this fine report, beginning on page 112 of the Handbook, and see what the Legislative Committee has been doing for them. They have accomplished great things before the Michigan legislature, and your Reference Committee wants to commend them.

I move the adoption of the report.

R. V. Walker, M.D. (Wayne): I second the motion.

(The motion was put to a vote and was carried unanimously.)

The Speaker: The report of the Reference Committee on Legislation and Public Relations.

XVIII—g. REFERENCE COMMITTEE ON LEGISLATION AND PUBLIC RELATIONS

E. A. Osius, M.D. (Wayne): Following is the report of the Reference Committee on Legislation and Public Relations: Four problems were presented to them. The first one was a resolution introduced by Dr. E. D. Spalding, of Wayne, concerning certain highly unprofessional practices. I think I had better read that resolution, if you don't mind.

XVIII—g. MATTERS FOR MEDIATION COMMITTEE

"Whereas, it has never been the policy of the medical profession to set specific fees for professional services, but rather to rely on the principle of a fair fee in each individual instance, taking into account the services rendered, the responsibility incurred, the professional skill required, the custom in that locality, but especially the economic status, and ability of the recipient to pay, and

"Whereas, there has of late developed an increasing violation of these principles among a small but willful minority of the profession, and

"Whereas, by persistently so doing this small minority is seriously undermining the good will and respect of the general public for the profession as a whole, which through the long past it has been the latter's constant endeavor to develop and maintain; therefore, be it

"Resolved: That the House of Delegates of the Michigan State Medical Society strongly denounce such practices as are bringing the profession into disrepute; and be it further

"Resolved: That all constituent county societies are hereby directed to bring all such willful and persistent practices to the attention of their respective Committees of Mediation, for prompt, appropriate and drastic action; and to serve notice that if the perpetration of such practices as reflect on the good name of medicine are persisted in, it will result in the forfeiture of their membership."

The Reference Committee discussed this at some length, also with the assistance of several visitors whom I wish to thank for their efforts, particularly Dr. Colwell, from Genesee County, whose arguments pro and con were very illuminating. The Reference Committee finally decided upon the following:

"RESOLVED: That all component county societies are hereby directed to bring all such willful and persistent impractices to the attention of their respective Committees of Mediation of such matters, for prompt and appropriate action, and to serve notice that if the perpetration of such impractices as reflect on the good name of medicine are persisted in, it may result in suspension of their membership."

Mr. Speaker, I move the adoption of this amended resolution.

E. D. Spalding, M.D. (Wayne): I second the motion.

(The motion was put to a vote and was carried unanimously.)

XVIII—g. MORAL DEGENERATION IN GOVERNMENT

E. A. Osius, M.D. (Wayne): The second matter that came up was a resolution introduced by Dr. J. P. Klein, of Newago County, regarding the health effects of moral degeneration of government.

"WHEREAS, the doctor of medicine is intimately acquainted with the health of his patients and with reasons why his patients are in need of medical care, and

"WHEREAS, it has become obvious in recent years that an increasing number of patients are in need of medical care for reasons primarily due to moral and ethical laxity, and

"WHEREAS, such moral and ethical laxity is due to the example of moral disintegration set by persons and powers influential in our government, as well as policies of government which have encouraged unhealthy mental and moral conditions, and

"WHEREAS, such moral degeneration is not only directly injurious to the health of the individual, and thus to society, but also predisposes a lowering of patriotic morale and undermining of the private enterprise system which is based on personal initiative and moral integrity, and

"WHEREAS, the people, under the Bill of Rights and their voting franchise, have a means of changing such undesirable conditions of government, and

"WHEREAS, the Michigan State Medical Society has a medical, moral and patriotic duty to point to conditions which are deleterious to the health of the people; therefore, be it

"RESOLVED: That the Michigan State Medical Society publicly points to the moral degeneration of the government and the resultant health effects of such condition; and be it further

"RESOLVED: That the Michigan State Medical Society urge upon the people of the State of Michigan that they take recourse to correct these conditions as provided under the Constitutions of the United States of America and the State of Michigan."

While the Reference Committee felt there was a great deal of worth and value in the resolution, it also

felt it was not wise at this time to approve it, and hence the Reference Committee recommends the disapproval of this resolution.

S. L. Loupee, M.D. (Cass): I second the motion.

(The motion was put to a vote and was carried unanimously.)

XVIII—g. TWO RESOLUTIONS RE LITTLE HOOVER COMMISSION RECOMMENDATIONS

E. A. Osius, M.D. (Wayne): Two resolutions were considered together, inasmuch as one was pro and the other was con. One was presented by Dr. Roger Walker, of Wayne (see page 74), and the other by Dr. J. M. Markley, of Oakland (see page 83).

These created considerable discussion. There were a lot of remarks pro and con, and quite a few visitors who added a great deal to the solution we sought. These two resolutions were considered together and were disapproved, and in their place the following resolution was suggested:

"WHEREAS, there is a great and obvious need for integration of certain health agencies of the State of Michigan, and

"WHEREAS, there is apparent need for reorganization of the Health Service of the State of Michigan; therefore, be it

"RESOLVED: That a Committee be immediately appointed by The Council of the Michigan State Medical Society to study matters covered in the Staff Report of the Michigan Joint Legislative Committee on Reorganization of State Government, Section No. 8 (Little Hoover Commission Report); and that the Committee's expenses be underwritten by the Michigan State Medical Society for travel, secretarial service, and other necessary items, and that this Committee report promptly to The Council of the Michigan State Medical Society, and that The Council of the Michigan State Medical Society be given power to act in the best interests of the people of the State of Michigan and the Michigan State Medical Society."

The urgency for this is due to the fact that the Governor recently conferred with many of the health officials, and stated that he would confer again within a matter of a week or ten days. The Reference Committee felt that urgency was an extremely essential point as far as this particular matter was concerned.

The Reference Committee moves the adoption of the substitute resolution.

R. V. Walker, M.D. (Wayne): I second the motion. Mr. Speaker, in introducing the resolution it was not my idea nor my thought that the centralization of powers should be vested in the Department of Health, even though it sounds that way. I presented it with the thought that the whole question would be studied and be brought back to The Council.

F. A. Osius, M.D. (Wayne): One of the big points is that it concentrates a great deal of power in a committee of seven individuals, of whom only three are physicians, who could be other than M.D.s, as well as four individuals who might be almost anybody or nobody, as you wish.

The Speaker: The question has been called for.

(The motion was put to a vote and was carried unanimously.)

E. A. Osius, M.D. (Wayne): Mr. Speaker, I move the adoption of the report as a whole.

G. C. Penberthy, M.D. (Wayne): I second the motion.

(The motion was put to a vote and was carried unanimously.)

XVIII—h. THE REFERENCE COMMITTEE ON HYGIENE AND PUBLIC HEALTH

O. K. Engelke, M.D. (Washtenaw): This is the report of your Reference Committee on Hygiene and Public Health. Before I get into the one resolution we worked on exclusively, I want to report to the delegates that the Legislation and Public Relations Committee and the Hygiene and Public Health Committee met jointly on the matter of the last two resolutions and the substitute resolution just passed, and concurred unanimously on the substitute resolution as proposed.

XVIII—h. FLUORIDATION OF WATER

One other resolution was turned over to the Reference Committee on Hygiene and Public Health, namely, the resolution of the Menominee County delegation regarding the fluoridation of public water supplies. Your Reference Committee on Hygiene and Public Health met with all members present, and agreed in principle with the Menominee delegation's resolution.

Is it the pleasure of the House that this resolution be read, or shall we read the new resolution, which simply effects some changes in the wording of the Menominee resolution?

The Speaker: Read the resolution reported out by the Reference Committee on Hygiene and Public Health.

O. K. Engelke, M.D. (Washtenaw): The Reference Committee recommends that the resolution on fluoridation, presented by the Menominee County Medical Society, be changed to read as follows:

"WHEREAS, controlled experiments in several cities in the United States present acceptable evidence that the ingestion of small and carefully controlled amounts of fluorides during the period of tooth enamel formation substantially reduces the incidence of dental caries, without apparent deleterious effect, and

"WHEREAS, the fluoridation of water is an effective approach to improving health through the prevention of dental decay, and is economically advantageous to the public as well as the individual, and

"WHEREAS, the fluoridation of public water supplies is endorsed by the American Public Health Association, United States Public Health Service, American Dental Association, Michigan State Dental Society, in the interest of better health, and

"WHEREAS, many Michigan communities still have not applied this health safeguard to their water supplies for the benefit of their citizens; now, therefore, be it

"RESOLVED: That the House of Delegates of the Michigan State Medical Society endorse a carefully controlled and supervised process of fluoridation of communal water supplies for the prevention of dental caries; and be it further

"RESOLVED: That a copy of this resolution be sent to every county medical society, the State Health Officer, and every local health officer in Michigan."

Mr. Speaker, I move the adoption of this resolution.

D. H. Kaump, M.D. (Wayne): I second the motion.

(The motion was put to a vote and was carried unanimously.)

The Speaker: I believe that concludes the reports of reference committees that had matters referred to them.

XVIII—i. REFERENCE COMMITTEE ON EMERGENCY MEDICAL SERVICE

J. R. Rodger, M.D. (Northern Michigan Medical Society):

Teaching Civil Defense in Medical Schools

"WHEREAS, the United States is faced with the problem of civil defense, and

"WHEREAS, it is the moral responsibility of the medical profession to participate fully in such an endeavor, and

"WHEREAS, this problem will be present as long as strong aggressor nations continue to exist, and

"WHEREAS, the education of doctors of medicine in the medical problems involved in atomic, bacteriologic and chemical warfare, as they affect the civilian popu-

lation, is of paramount importance in the fulfillment of the profession's responsibilities; therefore, be it

"RESOLVED: That the House of Delegates direct the State Committee on Emergency Medical Service to confer with the deans of the two medical schools of the State of Michigan, recommending some modification of their curricula in regard to this problem."

The Reference Committee suggests the adoption of this resolution, with no change.

I move the adoption of the resolution and the report as a whole.

L. R. Leader, M.D. (Wayne): I second the motion.

(The motion was put to a vote and was carried unanimously.)

The Speaker: We shall recess until tomorrow morning at ten o'clock.

(The meeting recessed at 10 p.m.)

TUESDAY MORNING SESSION

September 25, 1951

The meeting was reconvened at 10:15 a.m., R. H. Baker, M.D., Speaker of the House, presiding.

XVIII—d. 1950 HOUSE OF DELEGATES ACTION RE CHANGE IN COUNCILOR DISTRICTS—BYLAWS, CHAP. 9, SEC. 12

R. A. Springer, M.D. (St. Joseph): Gentlemen, these are not resolutions—they are recommendations of The Council as made to your House of Delegates, and are found on page 70 of the Handbook. They are being re-read this morning because they entail a change in the By-laws; consequently, they had to lie over for one session.

On page 69 of the Handbook, item No. 7: This refers to Kalkaska County and Clinton County. Your Reference Committee recommends that Chapter 9, Section 12 of the Bylaws be changed, transferring Clinton County from the 6th to the 2nd District. Because there have been objections to changing the Councilor District of Kalkaska County, no recommendation for change is made at this time.

I move the adoption of this portion of the report, Mr. Speaker.

M. G. Becker, M.D. (Gratiot-Isabella-Clare): I second the motion.

(The motion was put to a vote and was carried unanimously.)

XVIII—d. RE COMPOSITION OF HOUSE OF DELEGATES

R. A. Springer, M.D. (St. Joseph): Relative to Dr. Pike's resolution concerning the allocation of delegates, *your Reference Committee felt that the spirit of the resolution would be more adequately carried out by adding "voting" following "fifty" and inserting "active, life and emeritus" before "members" in Chapter 8, Section 1.*

It would therefore read in part: "Delegates selected each year one delegate for each fifty voting members, active, life and emeritus, and one delegate for each additional major fraction thereof."

I move the adoption of this portion of the report.

C. I. Owen, M.D. (Wayne): I second the motion.

(The motion was put to a vote and was carried.)

XVIII—d. ELECTION OF ALTERNATE DELEGATES

E. D. Spalding, M.D. (Wayne): In your Handbook on page 70, under "Recommendations of The Council," you will find item No. 6. It has been suggested by The Council that some clarification be made concerning Chapter 8, Section 10-d, paragraph 5 of the By-laws.

The Reference Committee has spent more time on this matter than anything else, and we still aren't quite clear in our own mind, but we thought the best thing to do would be to remove entirely from the picture of seniority of alternate delegates the question of whether a man has served before or not. It doesn't make any difference whether he has served before or not—they all go into it alike, and then you have this proposition before you:

You elect six alternate delegates, three one year and three the next year. According to the Constitution they have been elected to serve two years, so you can't elect them all in one year. Obviously, the three who were elected last year serve for two years and have one additional year to go, and they should have seniority over the three elected this year.

The only question is the introduction of the idea of seniority if a man has served as an alternate delegate before, by taking that out of the picture and treating all men alike; whether they are neophytes or re-elected probably will be solved to that extent.

If that is the wish of the House, then you will vote "Yes" on the recommendation of your Reference Committee, which is that Section 10-d, paragraph 5, on the top of page 157, the last two lines of that eight-line paragraph, where it says *"provided, however, that re-election as alternate delegate shall carry with it no additional seniority"*—if that is DELETED you will avoid the difficulty.

I so move, sir.

R. W. Teed, M.D. (Washtenaw): I second the motion.

(The motion was put to a vote and was carried unanimously.)

R. A. Springer, M.D. (St. Joseph): Mr. Speaker, I move the adoption of the report as a whole.

E. G. Krieg, M.D. (Wayne): I second the motion.

(The motion was put to a vote and was carried unanimously.)

The Speaker: There are two other reference committees left from yesterday, the report of one of whom will perhaps take some time. May I call for the report of the Reference Committee on Special Memberships.

XVIII—k. REFERENCE COMMITTEE ON SPECIAL MEMBERSHIPS

M. A. Darling, M.D. (Wayne): The Reference Committee worked long and industriously considering the names of the men presented from the various counties. The result of the work of this Committee makes ten men available for Emeritus Membership, namely:

Clinton—F. E. Luton, M. D.

Houghton-Baraga-Keweenaw—Simon Levin, M.D., and William T. King, M.D.

Kalamazoo—James W. Barnabee, M.D., and Edward D. Sage, M.D.

Kent—Aaron V. Wenger, M.D., and John W. Rigterink, M.D.

Lewanee—Esli T. Morden, M.D.

Marquette-Alger—A. L. Swinton, M.D.

Northern Michigan—Guy Clifton Conkle, M.D.

Wayne—J. C. Clippert, M.D., and George B. Hoops, M.D.

Mr. Speaker, I move the adoption of this recommendation.

(The motion was severally seconded, was put to a vote, and was carried unanimously.)

M. A. Darling, M.D. (Wayne): The Reference Committee recommends the following for Life Membership:

Branch—R. L. Wade, M.D.

Cass—S. L. Loupee, M.D.

Chippewa-Mackinac—Ira V. Yale, M.D.

Delta-Schoolcraft—A. J. Carlton, M.D.

Genesee—E. Wilbur Caster, M.D., Burton G. McGarry, M.D., and Herbert T. White, M.D.

Grand Traverse-Leelanau-Benzie — Edwin L. Thirlby, M.D.

Houghton-Baraga-Keweenaw—A. D. Aldrich, M.D.,* and Melvin D. Roberts, M.D.

Kent—James S. Brotherhood, M.D., Eugene L. Kendall, M.D., and Henry J. VandenBerg, M.D.

Macomb—H. H. Wiley, M.D.

Marquette-Alger—A. K. Bennett, M.D.

Oakland—Samuel A. Butler, M.D., George P. Raynale, M.D., Clarence T. Starker, M.D., and Milton J. Uloth, M.D.

Saginaw—Frank W. Ostrander, M.D., and Fred J. Hohn, M.D.

St. Clair—C. C. Benjamin, M.D.

Wayne—Clarence Baker, M.D., Neil J. Bentley, M.D., Edmund J. Durocher, M.D., Otto O. Fisher, M.D., Hugo A. Freund, M.D., Arthur J. Jones, M.D., Bror H. Larsson, M.D., Robert J. McClellan, M.D., Charles S. Norton, M.D., Frank L. Pierce, M.D., Harry W. Plaggemeyer, M.D., John C. Russell, M.D., John A. Sheldon, M.D., Thomas C. Starrs, M.D., Claude W. Turbett, M.D., and Robert A. C. Wollenberg, M.D.

Wexford-Missaukee—Augustus Holm, M.D.

Mr. Speaker, I move that this list of names, thirty-nine in number, be transferred to life membership.

(The motion was severally seconded, was put to a vote, and was carried unanimously.)

M. A. Darling, M.D. (Wayne): The members certified for Retired Membership are as follows:

Bay—Charles L. Hess, M.D.

Berrien—Henry J. Burrell, M. D.

Grand Traverse-Leelanau-Benzie—B. H. Van Leuven, M.D., Lewis R. Way, M.D., and Dwight Goodrich, M.D.

Houghton-Baraga-Keweenaw — Raymond Whitmore, M.D.

Kalamazoo—Howard C. Lavender, M.D.

Midland—C. V. High, M.D.

Muskegon—John L. Loomis, M.D.

Washtenaw—Frank A. Grawn, M.D., and Buenaventura Jimenez, M.D.

Wayne—Michael A. Baeff, M.D., Charles S. Ballard, M.D., Simon P. L'Esperance, M.D., and Thomas B. Marsden, M.D.

Mr. Speaker, I move the adoption of this portion of the report.

J. J. Lightbody, M.D. (Wayne): I second the motion.

(The motion was put to a vote and was carried unanimously.)

M. A. Darling, M.D. (Wayne): From the Kalamazoo Academy of Medicine we received a request for honorary membership.

Lawrence N. Upjohn, M.D., of Kalamazoo, Michigan, was graduated from the University of Michigan Medical School in 1900. After graduation he was offered a teaching position in the University, but finally accepted a position at the University of Oklahoma (which was then a Territory) as teacher of anatomy, and acting dean. He remained there two years and also carried on a private practice.

His child became ill, and he returned to Kalamazoo to begin the practice of medicine, but he started to work in the laboratory of the Upjohn Company, and has continued to be associated with them since 1904. In 1906 he was placed in charge of the eastern branch of the Upjohn Company, and returned to Kalamazoo in 1930 as President, and has been Chairman of the Board since 1943. He was honored by the Kalamazoo Academy of Medicine in 1948 as an outstanding physician and civic leader.

Mr. Speaker, I move the election of Dr. Lawrence N. Upjohn to honorary membership.

G. C. Stucky, M.D. (Eaton): I second the motion.

(The motion was put to a vote and was carried unanimously.)

M. A. Darling, M.D. (Wayne): The following are eligible for Associate Membership:

Genesee—Winston C. Baird, M.D.

Jackson—Stanley Oleksy, M.D.

Washtenaw—Frank N. Wilson, M.D.

Wayne—Paul E. Mattman, M.D., John B. Sarracino, M.D., A. E. Van Nest, M.D., Charles W. Moulton, M.D., William H. Saunders, M.D., John C. Williamson, M.D., C. H. Wright, M.D., Frank L. Ryerson, M.D., David H. Fauman, M.D., Joseph Zbikowski, M.D., and Maxim P. Melnik, M.D.

Mr. Speaker, I move the approval of this list.

C. I. Owen, M.D. (Wayne): I second the motion.

(The motion was put to a vote and was carried unanimously.)

M. A. Darling, M.D. (Wayne): Mr. Speaker, I now move the adoption of the report as a whole.

J. J. Lighebody, M.D. (Wayne): I second the motion.

(The motion was put to a vote and was carried unanimously.)

The Speaker: There are two items that I would like to ask the House's permission to introduce: (1) An address by Dr. John W. Cline, San Francisco, the President of the American Medical Association; (2) an address by Robert Collier Page, M.D., New York City, Chairman of the National Doctors' Committee for Improved Federal Medical Services.

Do I hear any objections? Hearing none, it is so ordered.

REFERENCE COMMITTEE ON MISCELLANEOUS BUSINESS

XVIII-1. BEAUMONT MEMORIAL RESTORATION RESOLUTION

R. V. Walker, M.D. (Wayne):

"WHEREAS, Dr. William Beaumont began his pioneering work in physiology at Mackinac Island, Michigan, in 1822, and

"WHEREAS, the first observation of his famous patient, Alexis St. Martin, was made by Dr. Beaumont in the American Fur Company's trading post, now known as the Early House on Mackinac Island, and

"WHEREAS, through the generosity of Parke, Davis & Company, Detroit, the Early House was acquired several years ago by the Mackinac Island State Park Commission as the first step in plans to convert this historic building into a permanent shrine to the memory of Beaumont, with maintenance to be assumed by the Park Commission, and

"WHEREAS, such a monument to the imperishable research of Beaumont would constantly remind the thousands of people who visit Mackinac Island annually that a free medicine is always a progressive one, eternally endeavoring to improve its science and its service to the public; therefore, be it

"RESOLVED: That the Michigan State Medical Society assume responsibility for developing the Beaumont Memorial on Mackinac Island, and that the House of Delegates authorize The Council and the Woman's Auxiliary to the Michigan State Medical Society to inaugurate a drive for funds among the Michigan State Medical Society members and its friends, to complete the work of transforming the Early House into a medi-

*Deceased

cal landmark for posterity; the collected funds to be deposited with the Treasurer of the Michigan State Medical Society; and be it further

"RESOLVED: That contributions in this campaign be on a voluntary basis with the names of all donors inscribed permanently in the Beaumont Memorial, and that the work be completed, if at all possible, in 1952 in order to commemorate the 130th anniversary of Beaumont's important discovery."

Mr. Speaker, I move the adoption of this resolution.

(The motion was severally seconded.)

O. O. Beck, M.D. (Birmingham): I have some additional information that I received last night and would like to pass on to you. Before I do so I would like to tell you a little more about Alexis St. Martin. I do so because after my report yesterday many delegates asked me what happened to Alex. *(Laughter.)*

Alexis St. Martin lived for thirty years after the death of Dr. Beaumont. He lived to the ripe old age of eighty-three. He lived most of his life and his latter years in abject poverty. In the latter part of his life he earned a living by chopping cordwood. He sired seventeen children.

At the time of his death Sir William Osler was living in Montreal. He heard of St. Martin's death, and he and other medical men of the area did their utmost to obtain an autopsy. Osler even offered a sum of money to the family for the stomach of St. Martin. The offer was refused. In order to protect themselves and their belief in the sacredness of St. Martin, his family kept his body for a long period of time before burial, so a sufficient amount of decomposition set in so that in their opinion, at least, it would be of no further use to science.

The additional information I received is this: As you will remember, I told you we had an estimate of the cost of the restoration of the Early House, amounting to between $50,000 and $60,000. At the meeting of The Council in July we definitely asked Mr. Doyle, the Chairman of the Island Park Commission, for definite figures on costs. He told us he would get them for us. He also received a number of letters from us, as well as calls asking for that information. It was not available. We heard nothing from Mr. Doyle until we received a telegram from him last night. His message stated that he had charts, drawings, and sketches, and so on, plus lantern slides that he would like to show us. They would be available about Thursday noon. I called him and told him he was too late.

In subsequent telephone conversation I obtained the information that the building cost now was estimated to be somewhere around $40,000. The opinion of two contractors, one from the Sault and the other from Ann Arbor, has been obtained, and it is felt that possibly it might cost somewhat less than $40,000 to restore the old building.

You all understand it is a little more difficult to restore an old building than to build a new one. It would be necessary to tear this building down and get new timbers. It will be difficult to obtain the proper timbers. The timbers that will go into the building will be hand-hewn, and will be of red cedar. I understand there is not too much red cedar available. The stone that will be used will be obtained somewhere around Rogers City; I understand the proper stone is to be found there.

The Speaker: Thank you, Dr. Beck, for this additional information. Possibly during the coming year, in your function as President, you might find time to report to us on what happened to the seventeen children sired by St. Martin. *(Laughter.)*

We have been assured that maintenance would be carried on by the Mackinac Island State Park Commission

Are you ready for the question?

(The motion was put to a vote and was carried unanimously.)

XVIII—j. REFERENCE COMMITTEE ON REPORTS OF THE COUNCIL

In Executive Session, the House of Delegates considered:

(a) Annual Reports of The Council which were approved with commendation;

(b) Resolution re Act 59 of Public Acts of 1937 which Resolution was disapproved;

(c) Report of Committee on Study of Medical Practice Act which report was approved;

(d) Report of Committee of Seven to Study Basic Science Act which report was approved, as amended.

XII—q. ALTERNATE DELEGATES TO ATTEND AMA HOUSE OF DELEGATES SESSION

E. G. Krieg, M.D. (Wayne): The import of this resolution is that at the present time only one alternate delegate is sent to the AMA House of Delegates:

"Whereas, medical organizational problems of the American Medical Association have become so many and so complex, and

"Whereas, firsthand information on these problems has not been available to all elected delegates of the Michigan State Medical Society, and

"Whereas, the proceedings of the American Medical Association can be brought more fully to the attention of the Michigan State Medical Society so as to enhance the latter's policy and action on a national level; therefore, be it

"Resolved: That all alternate delegates be sent to all official meetings of the American Medical Association House of Delegates; and be it further

"Resolved: That the expenses incurred in attending these meetings be assumed by the Michigan State Medical Society."

The Speaker: This will be referred to the Reference Committee on Resolutions.

We shall recess until eight o'clock this evening.

(The meeting recessed at 1 p.m.)

TUESDAY EVENING SESSION

September 25, 1951

The final session convened at 8:15 p.m., R. H. Baker, M.D., Speaker of the House, presiding.

The Speaker: A special order of business comes before us at this time. I would like to introduce Dr. Robert C. Page, Chairman of the nationwide Doctors' Committee for Improved Federal Medical Services, an affiliate of the Citizens' Committee for the Hoover Report, and medical director of the Standard Oil Company. Dr. Page will speak on "Doctors and the Federal Medical System."

XVII—a. ADDRESS BY DR. PAGE

(See page 41, this issue)

The Speaker: It becomes my extreme pleasure to introduce to you the President of the American Medical Association, Dr. John W. Cline of San Francisco, who will speak to us on "The Outlook for Medicine in the Immediate Future."

XVII—b. ADDRESS BY DR. CLINE

(See page 33, this issue)

XII—r. HONORARY MEMBERSHIP TO JOHN W. CLINE, M.D.

R. L. Novy, M.D. (Wayne): Mr. Speaker, I move that Dr. John W. Cline be elected an honorary member of this House of Delegates, without reference to a Reference Committee.

(The motion was severally seconded, was put to a vote, and was carried uninimously.) *(Applause.)*

XVIII—e. ALTERNATE DELEGATES TO AMA MEETINGS

B. M. Harris, M.D. (Washtenaw): We had a resolution presented this morning by Dr. Kreig:

"WHEREAS, medical organizational problems of the American Medical Association have become so many and so complex, and

"WHEREAS, firsthand information on these problems has not been available to all elected delegates of the Michigan State Medical Society, and

"WHEREAS, the proceedings of the American Medical Association can be brought more fully to the attention of the Michigan State Medical Society so as to enhance the latter's policy and action on a national level; therefore, be it

"RESOLVED: That all alternate delegates be sent to all official meetings of the American Medical Association House of Delegates; and be it further

"RESOLVED: That the expenses incurred in attending these meetings be assumed by the Michigan State Medical Society."

Your Reference Committee recommends the adoption of this resolution, and I so move.

O. K. Engelke, M.D. (Washtenaw): I second the motion.

(The motion was put to a vote and was carried unanimously.)

XVII—c. MICHIGAN'S FOREMOST FAMILY PHYSICIAN

The Speaker: At this time I wish Dr. Montgomery, of Sault Ste. Marie, would bring forward and let us have a look at Michigan's Foremost Family Physician for 1951, Dr. Willison, of Sault Ste. Marie.

(The audience arose and applauded.)

The Speaker: Would you like to say something, Dr. Willison?

Dr. Willison: I thank you all for the honor you have given me. This was rather a surprise to me. I think some of my friends are to blame for it, Dr. Miller among others.

The Speaker: After eighty-one years, nothing could be a surprise to you, Doctor. We are very much honored.

XVII—d. PRESIDENT OF STUDENT AMA

The Speaker: I would like to announce that we have with us this evening the President of the Student American Medical Association, Mr. (soon to be Dr.) Warren Mullen, of the University of Michigan. *(Applause.)* I am sorry you could not have been here right from the start, Warren. You might have had a chance to listen to our distinguished President of the American Medical Association. We hope you will go far in the direction you have already begun. We are glad to have you with us.

XIX. Election of Officers

XIX—a. COUNCILOR OF FIRST DISTRICT

H. B. Fenech, M.D. (Wayne): Mr. Speaker, I would like to place in nomination as Councilor of the First District the name of Dr. L. W. Hull.

I do not have to tell you about him, except that I do want you to know again that he has done a bang-up, fine job in this Society. The President found it advisable to make him Chairman of the Public Relations Committee, and he has done a formidable job.

With his dynamic personality and his ability to organize, he has brought together this group of his Committee, subdivided them into several groups, and has done a job of which you heard compliments by our honored President of the American Medical Association a few minutes ago.

You might say he was behind the motion picture you saw the first day of our meeting, "To Save Your Life." He has been also a member of the Finance Committee of The Council. He has served as Chairman of the Special Committee on Education, and has been a member of the Committee on Uniform Fee Schedule for Government Agencies.

For all these reasons, and because he is an individual who, as Dr. Cline said, is interested in community affairs, he holds the classification of urologist in the Detroit Rotary Club. I give you the name of Dr. Hull, an all-around man, a dynamic individual with the ability to organize and get work done. *(Applause.)*

The Speaker: Do I hear other nominations?

R. A. Springer, M.D. (St. Joseph): I move the nominations be closed.

(The motion was severally seconded, was put to a vote, and was carried unanimously.)

The Speaker: Do I hear a motion that the Secretary cast a unanimous ballot for Dr. Hull?

R. A. Springer, M.D. (St. Joseph): I so move, Mr. Speaker.

(The motion was severally seconded, was put to a vote, and was carried unanimously.)

The Speaker: Dr. L. W. Hull is duly re-elected.

XIX—b. COUNCILOR OF FOURTH DISTRICT

Next is a Councilor for the Fourth District. Dr. R. J. Hubbell is the incumbent.

D. W. Thorup, M.D. (Berrien): It is a pleasure for the delegate of the Fourth District to place in nomination the name of Ralph W. Shook, M.D., of Kalamazoo, as Councilor for that District.

The Speaker: Are there any other nominations? Do I hear a motion to close nominations?

F. C. Ryan, M.D. (Kalamazoo): I move they be closed and that the Secretary cast the unanimous ballot.

(The motion was severally seconded, was put to a vote, and was carried unanimously.)

The Speaker: Dr. Shook is declared elected as Councilor for the Fourth District.

XIX—c. COUNCILOR OF FIFTH DISTRICT

W. B. Mitchell, M.D. (Kent): I would like to place before you the name of Dr. J. D. Miller, who has served The Council for the past few years, and who has been on numerous committees and served on them well, as Councilor for the Fifth District.

The Speaker: Are there any other nominations?

G. C. Penberthy, M.D. (Wayne): I move that nominations be closed.

J. W. Logie, M.D. (Kent): Second the motion.

(The motion was put to a vote and was carried unanimously.)

The Speaker: Do I hear a motion to cast the unanimous ballot for Dr. J. D. Miller?

R. A. Springer, M.D. (St. Joseph): I so move.

R. L. Novy, M.D. (Wayne): Second the motion.

(The motion was put to a vote and was carried unanimously.)

The Speaker: Dr. J. D. Miller has been elected from the Fifth District to succeed himself.

XIX—d. COUNCILOR OF THE SIXTH DISTRICT

C. L. Weston, M.D. (Shiawassee): Mr. Speaker, it is a pleasure to nominate Dr. Harold Hiscock, of Flint, as our Councilor for the Sixth District.

The Speaker: Are there further nominations?

R. A. Springer, M.D. (St. Joseph): I move that nominations be closed and that Dr. Hiscock be elected.

(The motion was severally seconded, was put to a vote, and was carried unanimously.)

The Speaker: Dr. Hiscock is duly elected as Councilor of the Sixth District.

XIX—f. DELEGATES TO AMA

W. B. Mitchell, M.D. (Kent): Mr. Speaker, I would like to nominate Dr. William A. Hyland as delegate to the American Medical Association.

THE SPEAKER: Are there other nominations?

F. A. WEISER, M.D. (Wayne): If Dr. Cline hadn't been here I would have given his speech about Ralph Johnson. I know the man. I brought him up from a "pup." He was associate editor under me on two occasions. He was associate editor of the *Medical News* last year. This year he is editor, and if I don't nominate him, I won't be associate editor. Therefore, I place in nomination the name of Ralph Johnson as delegate to the American Medical Association.

THE SPEAKER: Are there further nominations?

J. R. RODGER, M.D. (Northern Michigan Medical Society): We have in our area a leader in medicine whom we confidently feel is eminently qualified to be a delegate to the American Medical Association. We feel this way for three reasons:

First, this man for many years has conscientiously and faithfully served the cause of organized medicine in this State. For eleven eyars he was a member of The Council. For three of those eleven years he was Chairman of The Council. In 1949 he was the President of our State Society, and 1949 was a year when many critical decisions in medicine were made.

Second, this man also has had a good deal of experience on a national level in the matter of working for organized medicine. He has been President of the National Conference on Medical Service of the American Medical Association. He has been President of the associated states' educational postgraduate committees. These offices, coupled with his frequent attendance at many national meetings, have given him a wide acquaintance and a close contact with many leaders of medicine throughout the country.

Third, he has a great resource of tactfulness and diplomacy which, coupled with a sound and quiet judgment, make him a good candidate for the office of delegate to the American Medical Association, because those are qualities which must go into the making of a valuable delegate.

Mr. Speaker, I take great pleasure in presenting to this House the name of Dr. Edward F. Sladek, of Traverse City. *(Applause)*

P. S. BARKER, M.D. (Washtenaw): Mr. Speaker, I would like to place in nomination as delegate to the American Medical Association Dr. John S. DeTar, who has long and faithfully served the cause of organized medicine.

Dr. DeTar has served as Chairman of the Public Relations Committee, as Vice Speaker and Speaker of this House of Delegates, and as Councilor for the 14th District. He was elected the foremost family physician in the State of Michigan in 1949. He is Speaker of the Congress of Delegates of the American Academy of General Practice, and a member of the Board of that organization.

He is a Board member of Michigan Medical Service and is Chairman of the Enrollment Committee of that organization. He is President of the Michigan Health Council. He has served five years on the Executive Committee of the Michigan State Medical Society, and has appeared before many lay organizations to present the stand of the Michigan State Medical Society in the battle to preserve the private practice of medicine.

He has represented the medical profession, at the request of the American Medical Association, at the National Country Life Association and the National Farm Bureau. He is well known to all in this room. He would bring to the office of delegate to the American Medical Association a special knowledge of two of the most important problems facing us today, namely, the threat of socialized medicine and the problem of the cultists, the non-M.D.s, in health services.

It is with great pleasure that I place in nomination the name of Dr. John S. DeTar as delegate to the American Medical Association.

THE SPEAKER: Dr. DeTar has been nominated. Are there any other nominations?

J. R. RODGER, M.D. (Northern Michigan Medical Society): I move that nominations be closed.

W. B. MITCHELL, M.D. (Kent): I second the motion.

(The motion was put to a vote and was carried unanimously.)

THE SPEAKER: You have four nominees for three offices. It will be necessary that you elect three out of the four by ballot.

(Balloting.)

THE SPEAKER: Gentlemen, we shall hear the report of the tellers.

O. R. MACKENZIE, M.D. (Oakland): Ninety-nine delegates voted. Johnson, 89. Hyland, 74. DeTar, 61. Sladek, 61.

THE SPEAKER: I shall read to you from the Handbook, the last paragraph on page 156 of the Constitution: "In case of a tie vote of high candidates, the winner, or winners, shall be decided by drawing lots, supervised by the Speaker of the House of Delegates, provided, however, that any candidate thus tied shall have the right to a decision by ballot if he requests same."

R. A. SPRINGER, M.D. (St. Joseph): It would be embarrassing for one of the candidates to make the motion, so in fairness to everyone concerned I think we should vote by ballot.

I so move.

THE SPEAKER: According to the Bylaws they must draw lots.

E. F. SLADEK, M.D. (Traverse City): Mr. Speaker, after a conference we have decided that we would like to have—

J. S. DETAR, M.D. (Milan): —a vote by ballot. (*Laughter*)

THE SPEAKER: A vote by ballot is requested.

(Balloting.)

THE SPEAKER: The tellers are ready to report.

O. R. MACKENZIE, M.D. (Oakland): DeTar, 52. Sladek, 47. Ninety-nine votes were cast.

THE SPEAKER: Dr. DeTar is elected.

XIX—g. ALTERNATE DELEGATES

The next item of business is nominations and election of alternate delegates to the American Medical Association. There are two incumbents. There are two others to be elected, a total of four to be elected.

I would like to point out that there are two alternate delegates holding over—Drs. Denham and Owen. I don't know what their seniority is, but according to the rules which you have already passed they would have seniority over any four elected tonight. Those you elect tonight will have their seniority determined by those receiving the four highest number of votes.

I will accept nominations first, and then I will instruct you on how to vote.

W. L. BROSIUS, M.D. (Wayne): I wish to offer for your consideration the name of a man so well known to you that he needs no eulogy. You know him for his rugged honesty, his devotion to good medicine, and you know how well he will serve you.

I nominate Dr. Warren Babcock.

R. V. WALKER, M.D. (Wayne): Gentlemen, I would like to nominate a man who also is well known. He has been very active in the House of Delegates for a good many years. If at some time he should become active in the House of Delegates of the American Medical Association he would be well heard.

He may be able to settle some of the difficulties that they run into at times, too, the same as we do. I would like to nominate Dr. Ed Spalding.

THE SPEAKER: Dr. Spalding has been nominated. Are there further nominations?

PAUL IVKOVICH, M.D. (Mecosta-Osceola-Lake): I wish to nominate Elmer Texter as an alternate delegate.

ARCH WALLS, M.D. (Wayne): I wish to place in nomination again the name of Dr. Edward Sladek as alternate.

THE SPEAKER: Are there further nominations?

R. E. DUSTIN, M.D. (Lenawee): I move that nominations be closed.

O. K. ENGELKE, M.D. (Washtenaw): I second the motion.

(The motion was put to a vote and was carried unanimously.)

THE SPEAKER: We now have four nominees—W. W. Babcock, Ed Spalding, Elmer Texter and Edward Sladek. The ballots will be distributed. Will you please number each name, 1, 2, 3 or 4, so that it will assist the tellers in creating a seniority list. You will have to vote for all four. You will list all four names, but you will put a number before each name, preferably voting the first man as No. 1. Please put the number in front of the name in order to assist the tellers. Will the tellers please pass the ballots?

F. A. WEISER, M.D. (Wayne): We took the ballots that were cast, counted the names as 1, 2, 3 and 4, and the low man actually is the high man.

In our scoring Dr. Sladek got 160; that is low. Dr. Spalding, 213. Dr. Babcock, 222. Dr. Texter, 242. F. A. WEISER, M.D. (Wayne): Let me put it this way: The first man is Dr. Sladek; second, Dr. Spalding; third, Dr. Babcock; fourth, Dr. Texter.

THE SPEAKER: The order of seniority has been declared.

(Balloting.)

THE SPEAKER: I have just been informed of the resignation on The Council of Dr. Jack DeTar. This will call for an election to fill that vacancy. Under the rules, it becomes necessary to fill the vacancy just created. Do I hear any nominations?

XIX—e. COUNCILOR OF FOURTEENTH DISTRICT

O. K. ENGELKE, M.D. (Washtenaw): Mr. Speaker, the counties in the Fourteenth District have caucused following the resignation of Dr. DeTar, and we wish to offer in nomination, as Councilor for the Fourteenth District, the name of Dr. B. M. Harris, of Ypsilanti.

R. E. DUSTIN, M.D. (Lenawee): I move that nominations be closed.

E. C. TEXTER, M.D. (Wayne): I second the motion.

(The motion was put to a vote and was carried unanimously.)

THE SPEAKER: Dr. Harris is declared elected to the unexpired term of Dr. DeTar as Councilor of the Fourteenth District.

XIX—h. PRESIDENT-ELECT

G. C. PENBERTHY, M.D. (Wayne): The hour is late, but we have a little time while awaiting the result of the voting, so I shall take a little longer in introducing or presenting a man of whom I am sure you all will approve.

Tonight, we have listened to two very constructive, outstanding talks, very stimulating addresses, which mean that the State of Michigan must continue in its position of leadership. I think the individual I am about to nominate as President-elect meets all the qualifications.

He is none other than R. J. Hubbell, a grand fellow. He is not very good at golf, but he is a leader in activities pertaining to medicine.

He was born in 1896. I will give you a little of his background because I am leading up to a point that is very dear to my heart. He married a girl from Wakefield, Michigan, in 1924. Tonight we honored a grand gentleman, Dr. Willison, who comes from the Upper Peninsula, and again I hope we will honor another gentleman who married a lady from northern Michigan. I came from Houghton, Michigan, as many of you know.

Dr. Hubbell graduated from Northwestern with a Bachelor of Scicnce degree in 1918, and became an M.D. in 1923, and interned in the Wesley Memorial Hospital. He has been in Kalamazoo more or less since 1924. He has made an outstanding contribution in that locality in the field of urological surgery. He took his postgraduate work in Philadelphia. Since 1930 he has practiced the specialty of urology.

He is a member of the American College of Surgeons and the American Board of Urology. He was appointed to The Council by none other than our good friend Dr. Corbus, of this city, in 1938, and has served faithfully since that time. He was Chairman in 1950-1951.

It is a great privilege for me, as well as a pleasure, to nominate none other than our good friend Dr. R. J. Hubbell as President-elect. (*Applause*)

THE SPEAKER: Are there any other nominations?

R. W. SHOOK, M.D. (Kalamazoo): May I second the nomination of our member.

THE SPEAKER: Thank you, Dr. Shook. Are there any other nominations?

R. W. TEED, M.D. (Washtenaw): I move that nominations be closed and that the Secretary be instructed to cast a unanimous ballot for Dr. Hubbell.

E. C. TEXTER, M.D. (Wayne): I second the motion.

(The motion was put to a vote and was carried unanimously.)

THE SPEAKER: Dr. Hubbell is declared our new President-elect. (*Applause*)

(Rising applause as Dr. Hubbell was escorted to the platform.)

THE SPEAKER: Would you like to say something, Dr. Hubbell?

R. J. HUBBELL, M.D. (Kalamazoo): Mr. Speaker and gentlemen, I would like to thank you for this honor. I certainly consider it an honor. I think the medical profession has always been very good to me, and that is especially true tonight. I am not sure that you have picked the right man, but I certainly shall try to do my best to represent the medical profession of the State of Michigan in an honorable way.

Thank you very much. (*Applause*)

XVII—e. HONORING PAST PRESIDENTS

THE SPEAKER: It has been a nice little custom that we have carried on at the final sessions for some years. I noted in the audience (and I hope they are all still here) that we have several Past Presidents with us. I can't list them in the order of the years they served us, but I hope they are here and, if so, I would like to have them step forward and be recognized, and then have a seat in the front row.

Dr. Louis Hirschman, Dr. Luce, Dr. Penberthy, Dr. Henry Cook, Dr. Urmston, Dr. Corbus, Dr. Brunk, Dr. Hyland, Dr. Ray Morrish, Dr. Sladek, Dr. Barstow, Dr. Haughey, our President for a day, please come forward. Are there any others? Will you gentlemen all arise at once and face the audience so that they can get another look at you? We are proud of you, gentlemen!

(The audience arose and applauded.)

THE SPEAKER: The Past Presidents have appointed Dr. Luce to speak for them, but he is very embarrassed tonight. (*Laughter*) Thank you, gentlemen.

Are the tellers ready? If not, we will proceed with the next item of business.

XIX—i. SPEAKER

THE VICE SPEAKER: We are now ready to proceed with the election of a Speaker of the House of Delegates. The floor is open for nominations.

P. E. SUTTON, M.D. (Oakland): I don't believe it takes a great deal of reflection on our part to look over the names of past Speakers of the House of Delegates and be convinced that we have been blessed with high quality men for practically the entire time of our existence. Within the memory of this delegate I can speak with a great deal of conviction.

Our present incumbent is no exception. I think it was demonstrated this evening with what high regard we hold him. You all know him. You all recognize

those qualities which you and I have come to believe are essential to perform the office of Speaker of this House.

Therefore, it is a great pleasure for me to present the name of Dr. Robert Baker to succeed himself as Speaker of the House of Delegates.

R. A. Springer, M.D. (St. Joseph): I move that nominations be closed and that the Secretary be instructed to cast a unanimous ballot for Dr. Baker.

E. C. Texter, M.D. (Wayne): I second that motion.

(The motion was put to a vote and was carried unanimously.)

The Vice Speaker: Dr. Baker is declared re-elected. (*Applause*)

(The Speaker resumed the Chair.)

The Speaker: I don't know whether I should make a speech now. I think we had better go on with our business. No—perhaps I could make it now.

I am very grateful for the honor that you have bestowed upon me for the third successive year. I felt terribly "green" the first year, and I don't know whether I have learned very much since. I continue to make mistakes; but you have been very kind, and I don't think we could have expedited our business as well as we have if it hadn't been for the very fine co-operation I have had from my Vice Speaker.

This is not a speech for the next candidate—it is coming from my heart. Dr. Jack Livesay has stood at my right hand so many times in questions of correct decision, rules and in keeping notes for me, and preparing all sorts of data which made things readily accessible and saved your time and saved me from embarrassment, that I am deeply grateful to him.

I am also deeply grateful to our Secretary, who many times has advised me on important matters.

I might say I am also very indebted to one of our delegates on points of parliamentary law. I cannot ignore Dr. Spalding. Dr. Spalding has been very helpful.

I am very grateful to all the staff of the central office. Nobody knows until he works in this organization how much help and steering he gets from the central office. That was one of the things I had in mind yesterday morning when I addressed you at the time we put on that little convention back in Pontiac, when Dr. Warnshuis of Grand Rapids was the Secretary. He was a very efficient gentleman. At that time our organization was small. We have grown and have had to have an Executive Director. We have a very excellent one, who has also grown with the years.

Bill Burns has a wonderful ability to handle detail and to keep things in mind and to keep them straight. Bill makes relatively few mistakes, and he usually catches them before anybody else does. He is a wonderful Executive Director. I am sure Dr. Foster will bear me out in that—that the work of the Society is certainly carried considerably on the shoulders of Bill Burns. We are wonderfully guided in our executive office by his very capable office staff of secretaries and assistants.

We now have a new man in the department, our public relations director. He, too, has been very helpful. There are a lot of things that Hugh Brenneman does for us that are not just public relations. He is the springboard for a lot of other things. He does a lot of extra work that is not necessarily called for in his immediate title and capacity. His assistants are of great help to us, too.

I must not ignore one man whom I greatly admire, who I think helped us this morning in our discussion—our legal counsel, Mr. Joe Herbert. Mr. Herbert is tremendously valuable to this organization. He puts in a great deal of time that is not strictly called for by any kind of contract we have with him. He does it because he is interested. He gives a lot of spare time to this organization, for which we are all very much indebted to him.

I must also mention our stenotypist, Mrs. Emmons. She also is very patient. She frequently recognizes the gentlemen on the floor when my mind goes blank. She has been with us long enough now so that she takes hold of her work very well. Her ears are tuned to hear various voices, and she seems to recognize you much quicker than I do. She also aids very materially in the successful recording of our deliberations, and keeps straight my errors and other things that go on in this House of Delegates. I thank her, also.

XIX—j. VICE SPEAKER

The next order of business is nominations for Vice Speaker of the House of Delegates. Do I hear nominations?

E. D. Spalding, M.D. (Wayne): Mr. Speaker, I wish to place in nomination the name of a man of whose fairness and ability we are all well aware as we see him before us each meeting. Dr. Livesay, of Genesee, as Vice Speaker.

The Speaker: Are there further nominations? If not, do I hear a motion?

R. A. Springer, M.D. (St. Joseph): I move that nominations be closed and that the Secretary be instructed to cast the unanimous ballot.

(The motion was severally seconded, was put to a vote, and was carried unanimously.)

The Speaker: Dr. Jack Livesay is again elected your Vice Speaker, and again I take pleasure in congratulating him, because his election helps you fellows a lot.

The tellers are working overtime. Come on, Jack, say a few words.

The Vice Speaker: I do have one thing that has been on my mind, which you might be interested to hear.

Since I became Vice Speaker, the Chairman of The Council has invited me to attend all the meetings of The Council and the meetings of the Executive Committee. I believe this is the first time that has been done. I think it is a very constructive move, and I heartily agree with the change proposed in the Constitution, which will come up next year.

I also heartily agree with the slight change that was made to allow the Vice Speaker a vote only in the absence of the Speaker. Whoever thought of that was very wise.

The thing I would really like to tell you is to amplify somewhat what Dr. Baker said. It is only when you start working with your Medical Society that you really find out what a tremendous volume of business is done. I was astounded.

At the recent meeting at which C. E. Wilson was honored, Dr. Beck asked him how long it took to conduct a meeting of the Board of the General Motors Corporation, and Mr. Wilson said, "Oh, approximately an hour and a half."

"Well," replied Dr. Beck, "I wonder what the difference is. It usually takes our Executive Committee twelve hours."

Gentlemen, I was astounded to find that these men start their meeting at 10:30 in the morning, recess for lunch and dinner, and are often still in session at midnight.

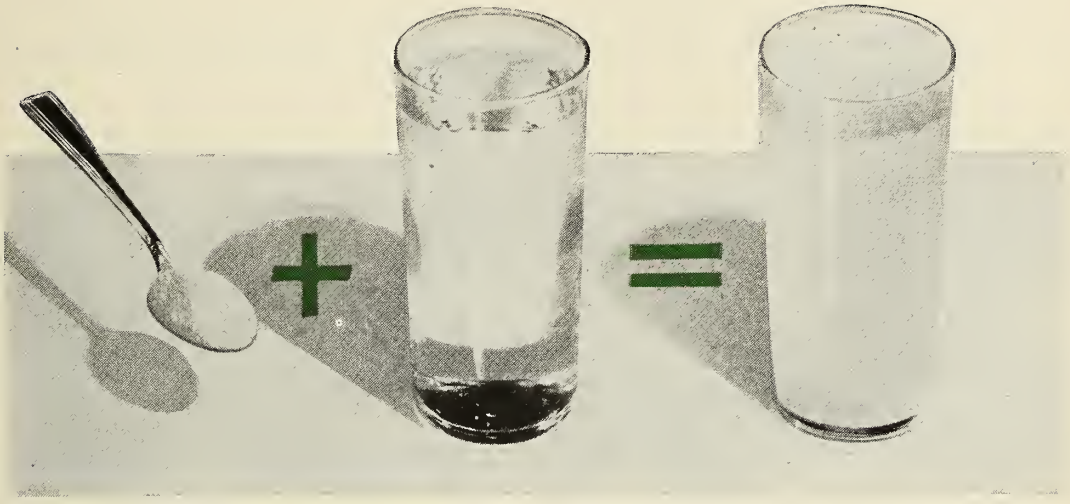
The Speaker: Thank you, Dr. Livesay. I neglected unintentionally to thank the various reference committees, who have been very helpful. A few of you we neglected this year because there were no resolutions to give to you, but those reference committees that were active were very active and very efficient.

I am very grateful to the Chairman of the Credentials Committee and the Sergeant-at-Arms and his Committee. They have done a fine job, and have handled things quickly. They carried us through an executive session. I am very grateful to them.

I shall attempt to write the chairman of each committee later this fall and ask for suggestions that may help in the appointment of reference committees in other years. We try to rotate things somewhat, and, as I said yesterday, possibly you will see fit to cut down a little on the number of committees. It isn't always easy to plan that. We try to make committees strong, and to

(Continued on Page 140)

Normohydration
FOR BOWEL REGULATION



Typically, the constipated stool is dehydrated, whereas the diarrheal stool or that induced by salines and irritants is hyperhydrated, containing free water.

When Metamucil is employed for the management of constipation, it is mixed in a full glass of cool liquid. The ingested liquid containing the mucilloid promotes normohydration.

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ACCEPTED COUNCIL ON PHARMACY AND CHEMISTRY AMERICAN MEDICAL ASSOCIATION

SEARLE RESEARCH IN THE SERVICE OF MEDICINE

Michigan's Department of Health

Albert E. Heustis, M.D., Commissioner

This Department was signally honored at the recent American Public Health Association meeting in San Francisco when two of the members of its staff were named to serve as chairmen of their sections in the national organization. Dr. Goldie Corneliuson, Chief of the Maternal and Child Health Section of the Department, was named Chairman of the Section of Maternal and Child Health of the American Public Health Association and Mrs. Alice Smith, Chief of the Section of Nutrition of this Department was named Chairman of the Section on Foods and Nutrition of the national organization.

Dr. Corneliuson was also voted president-elect of the national Association of Maternal and Child Health and Crippled Children Directors.

* * *

The services of this Department's Division of Industrial Health are discussed in a five-page, illustrated article "Michigan, a Leading Production Center, Pioneered in Occupational Health Studies," in the November, 1951 issue of the national *Industrial Health Monthly.*

* * *

Arthur G. Baker, M.D., Chief of the Section of Local Health Services has been assigned additional responsibilities as Acting Director of the Division of Health and Medical Services of the Office of Civil Defense. In his new position, Dr. Baker will assume responsibility for the development of a public health civil defense program and will also act as a co-ordinator for all civil defense programs relating to health services.

Dr. Baker's position in the Sectiion of Local Health Services, Michigan Department of Health, will remain unchanged.

* * *

Michigan Public Health, the official magazine of the Michigan Department of Health, will change format and name with the January issue—the 20-page 6x9 booklet will become a 4 to 6 page 8½x11 news-type folder with brief articles, popular heads, numerous illustrations and the name, *Michigan's Health.*

The change is being made because it is believed that busy people will read the news-type folder when the 20-page booklet might be put aside. The new bulletin, at no increase in cost, can be sent to twice the present mailing list.

* * *

George C. Stucky, M.D., Director of the Eaton County Health Department since 1938, immediate past-president of the Michigan Public Health Association, past-president of the Michigan Health Officers' Association and a member of the Governing Council of the American Public Health Association died after a two-day illness in Hayes-Beach-Green Hospital, Charlotte, Michigan, November 26.

L. W. Switzer, M.D., Director of the Manistee-Benzie District Health Department, has resigned effective December 1, 1951. Artin Bobian, sanitarian, has been appointed Acting Director.

* * *

The third annual conference of all directors of full-time local health departments to advise on the state health program has been called by the State Health Commissioner for February 6, 7 and 8.

* * *

The following information is now included in the circular which accompanies Diphtheria-Toxoid Alum Precipitated:

"Diphtheria-toxoid alum precipitated is the antigen of choice for active immunization of all age groups. Adults should first be given a Shick test and a control. If the control is positive no attempt should be made to immunize even though the Schick test is also positive, since these people have been shown to possess either active or latent immunity. Alum precipitated toxoids should always be injected intramuscularly."

* * *

All of the fluoroscopic shoe-fitting devices in use in the State have been checked during the past year for intensity of radiation which might endanger the patron and for stray radiation which would endanger the clerks by the engineers of the Division of Industrial Health. Of the 299 machines checked, only fifty-two initially met requirements for safety. However, during the year, 60 per cent were brought to a safe standards and now bear an approval placard. The public has been advised to use only those machines which bear an "approved" placard.

* * *

A plan for uniform standards in milk inspection was agreed upon by more than ninety local health department sanitarians and others who participated in a Milk Conference sponsored by this Department at Kellogg Center, Michigan State College. The health department representatives agreed upon uniform standards, uniform interpretation and uniform application which make possible reciprocity of milk inspection among health departments and obviates the necessity of duplication.

* * *

Maternity hospital inspection and licensing is discussed in the following letter sent by the Michigan Department of Health to Secretaries of County Medical Societies in areas having full-time local health departments.

November 29, 1951

To Secretaries of County Medical Societies
having local full time health departments:
Dear

One of the pieces of successful legislation endorsed by the Michigan State Medical Society was the transfer of the licensing of maternity homes and maternity sections

(Continued on Page 122)

A.P.D.——AN IMPROVED ASPIRIN COMPOUND

"D" stands for Dl-Desoxyephedrine Hydrochloride, a sympathomimetic agent. It elevates the mood of the patient. It has a marked central nervous stimulatory effect; it is effective in the sympatomatic treatment of many mild psychogenic depressive states attending old age and accompanying persistent pain such as that precipitated by the menopause, following childbirth, or prolonged post-operative recovery.

A.P.D. combines the qualities of Dl-Desoxyephedrine Hydrochloride with the well-known analgesic antipyretic actions of aspirin and Phenacetin.

Each tablet contains:

Aspirin **4 gr.**

Phenacetin **2 gr.**

Dl-Desoxyephedrine Hydrochloride **2 mg.**

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In Memoriam

Glenn C. Andersen, M.D., formerly of Kalamazoo, died August 25, 1951, at the age of forty-four.

He was graduated from the University of Illinois College of Medicine in 1935. Following four years of service in World War II, he joined the staff of the Kalamazoo State Hospital in 1946. He specialized in psychiatry and neurology and was a member of the American Psychiatric Association.

Dr. Andersen, who had been a member of the Kalamazoo Academy of Medicine since 1946, resigned from the staff of the Kalamazoo State Hospital on June 30, 1951, to accept a position of Clinical Director of the Phoenix, Arizona State Hospital.

Paul W. Bloxsom, M.D., of Grand Rapids, died August 13, 1951, at the age of fifty-nine.

For the past twenty-six years Dr. Bloxsom served the community of Grand Rapids as a general practitioner; he was coroner of Kent County for twenty years.

He obtained his medical education from the Detroit College of Medicine, from which he was graduated in 1917. The same year, Dr. Bloxsom was commissioned a lieutenant in the Navy and served throughout World War I. Following discharge from service, he interned at the Receiving Hospital, Detroit, and later practiced in Cadillac, Michigan, for five years.

Richard A. Burke, M.D., of Neguanee, died September 5, 1951, at the age of seventy-three. For the past forty-seven years he had served the community around Negaunee as a general practitioner.

Doctor Burke was graduated from the University of Illinois College of Medicine in 1904, and served his internship at St. Anthony Hospital, Joliet, Illinois, and Augustana Hospital, Chicago, Illinois.

At the time of his death, Doctor Burke was owner and operator of the Twin City Hospital in Negaunee.

He was a member of the Marquette-Alger County Medical Society and on the Board of Trustees of Morgan Heights Sanatorium. Doctor Burke served as Councilor of the Michigan State Medical Society, representing the entire Upper Peninsula for ten years.

Besides his activity in medical circles, Doctor Burke also belonged to other organizations including the Negaunee Lodge B.P.O.E. 1116 and the Negaunee Business and Professional Association.

Surving are his wife, Elizabeth, two daughters, Mrs. Margaret Bailey, Burbank, California, and Mrs. Mary Beach, Munising; one son, John, of Ishpeming; two brothers, Dr. W. T. Burke, Detroit, and John Burke, Ishpeming postmaster; three sisters, Mrs. L. C. Moore, Mrs. Loretta Berteling and Miss Ida Burke, all of whom make their residence in California. There are seven grandchildren.

Burial was in Ishpeming Cemetery, Ishpeming.

Thomas Jefferson Cox, M.D., of Ionia, died October 31, 1951, at the age of forty-six.

For the past four years he served the community of Ionia as a surgeon. Previous to that, Dr. Cox had practiced in Flint. He was graduated from the University of Texas School of Medicine in 1940.

Dr. Cox was a surgeon at Hurley Hospital, Flint, before coming to Ionia.

He was a member of the Ionia-Montcalm County Medical Society and a fellow of the American College of Surgeons.

During World War II he served in the United States Army Medical Corps for forty-four months. At the time of his separation from the Medical Corps, Doctor Cox was a Lieutenant Colonel.

Besides his activity in medical circles, Doctor Cox also belonged to the Ionia Lions and Elks.

He is survived by his wife, Helen. His immediate family, including his parents, Mr. and Mrs. George R. Cox, four sisters, and five brothers, live in Texas and New Mexico.

Michael Edward Cuncannan, M.D., of Grand Rapids, died August 22, 1951, at the age of fifty-two.

He was a general practitioner in Grand Rapids for a quarter of a century.

Dr. Cuncannan received his M.D. degree from Loyola Medical School in Chicago in 1925. He interned at the Good Samaritan Hospital in Cincinnati, Ohio. He was a member of the Kent County Medical Society, the Michigan State Medical Society and the American Medical Association.



A. William Lescohier, M.D., of Detroit, died November 17, at the age of sixty-six.

Dr. Lescohier, who retired as president of Parke-Davis & Company last April, had been an executive and a director of the 85-year-old pharmaceutical firm during its greatest period of growth. He was president from 1938. After he retired from that office he continued as a director of Parke-Davis.

Dr. Lescohier was graduated from the Detroit College of Medicine in 1909. Wayne University awarded him an honorary degree of Doctor of Science in 1937.

Dr. Lescohier became assistant director of the research and biological laboratories at Parke-Davis in 1918. In 1925 he was promoted to director of clinical investigation and in 1928 became assistant to the president. Dr. Lescohier was elected a director in 1928. The next year he was named general manager and held that position until he was elevated to president in 1938.

(Continued on Page 122)

Meat... Its Place in the Dietary Management of Nephritis

The formerly held tenet that protein intake should be restricted for all patients with impaired renal function, in order to afford the kidney physiologic "rest," is no longer valid.[1] Except for infection and some neoplastic and traumatic disorders, the treatment of renal disease is nonspecific and essentially symptomatic. The clinical problem centers largely on diet regulation, in the hope of stimulating the kidneys to improve impaired function, without unduly risking harm.

Even in the presence of azotemia, a protein intake of 60 to 80 Gm. per day has not been found harmful to the renal patient. Low protein intake, on the other hand, together with urinary loss of protein may encourage the development of asthenia, anemia, hypoproteinemia, and edema.[2] Also pertinent to the dietary management in renal disease is the experimental finding that high protein diets in normal dogs promote higher urea clearance and greater renal blood flow than do low protein diets.[3,4]

Except in anuria, a protein intake adequate to maintain nitrogen balance has been suggested.[1] Although as little as 30 to 40 Gm. of protein per day may suffice for this purpose in the fever-free patient at bed rest, few occasions arise when 1 Gm. of protein per day per kilogram of body weight may not be given safely. In the presence of significant proteinuria, unless specifically contraindicated, the dietary protein may be increased beyond that amount in order to counterbalance the urinary protein loss.

Contrary to the still prevalent ancient belief among the laity, red meats are just as harmless to the renal patient as white meats; nor is there evidence that plant proteins are more beneficial in nephritis than animal proteins. As with the normal person, the dietary protein of the patient should be of high biologic value.

Meat, because of its high content of biologically complete protein, may contribute valuably to the protein needs of the nephritic patient. The nutritional importance of meat, however, is not limited to its contained protein. Meat also contributes highly significant amounts of iron and of the vitamin B complex, including niacin, pantothenic acid, pyridoxine, riboflavin, thiamine, and the newly discovered vitamin B_{12}. Other salient features of meat in the dietary of the patient are its high palatability, its stimulation of the digestive processes, its satiety value, and its easy and practically complete digestibility.

1. Mann, G. V., and Stare, F. J.: Nutritional Needs in Illness and Disease, Handbook of Nutrition, American Medical Association, ed. 2, Philadelphia, The Blakiston Company, 1951, chap. 17, p. 351.
2. Weiss, S.: Diet and Bright's Disease, Connecticut M. J. *5*:496, 1941.
3. Jolliffe, N., and Smith, H. W.: The Excretion of Urine in the Dog: II. The Urea and Creatinine Clearance on Cracker Meal Diet, Am. J. Physiol. *99*:101, 1931.
4. Van Slyke, D. D.; Rhoads, C. P.; Hiller A., and Alving, A.: The Relationship of the Urea Clearance to the Renal Blood Flow, Am. J. Physiol. *110*:387, 1934.

The Seal of Acceptance denotes that the nutritional statements made in this advertisement are acceptable to the Council on Foods and Nutrition of the American Medical Association.

ACCEPTED COUNCIL ON FOODS AND NUTRITION AMERICAN MEDICAL ASSOCIATION

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(Continued from Page 120)

He was a member of the Wayne County Medical Society and a past president of the American Drug Manufacturers Association.

He is survived by his wife, Eva; two sons, Ralph and Donald, of Detroit; and a brother, Donald, of Madison, Wisconsin.

Robert Bruce Macduff, M.D., of Flint, died October 28, 1951, at the age of fifty-nine.

For the past thirty-two years he served the community of Flint, first as a general practitioner and later as a radiology specialist. He attended the University of Chicago and the University of Michigan Medical School. He received his medical degree in 1917. He was x-ray chief at Hurley Hospital from 1927 to 1932.

Doctor Macduff was a member of the Genesee County Medical Society, Michigan Society of Roentgenologists, and Radiology Society of North America. He was a former secretary of Genesee County Medical Society.

Besides his activity in medical circles, Dr. Macduff also belonged to other organizations including Rotary Club, Elks, and the Women's Hospital Association.

He was a veteran of World War I.

He is survived by his wife, Ellen, and one daughter, Ellen Gray, of Flint. He also leaves two brothers, Douglas, of Peekskill, New York, and Norman, of Spokane, Washington.

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The pathologist in direction is recognized by the Council on Medical Education and Hospitals of the A. M. A.

Edward A. Pillsbury, M.D., of Frankenmuth, died October 9, 1951, at the age of seventy-four. He was graduated from the University of Michigan Medical School in 1903.

For the past forty-six years he served the community of Frankenmuth as a general practitioner. Dr. Pillsbury had also practiced in Richmond, Michigan.

He was a member of the Saginaw County Medical Society and became an associate member of the American College of Physicians in 1925.

Dr. Pillsbury was honored September 1, 1949, by the residents of Frankenmuth at a "Dr. Pillsbury Day."

At the time of his death, Dr. Pillsbury was on the staff of St. Luke's, St. Mary's and Saginaw General Hospitals in Saginaw. He had been health officer of Frankenmuth township for twenty-five years.

Besides his activity in medical circles, Doctor Pillsbury also belonged to the United Spanish War Veterans, and the Germania Club of Saginaw.

During the Spanish-American War he entered the U.S. Army. His Army service was cut short when he contracted typhoid fever. He left service as a corporal.

He is survived by his wife, Kunnigunde, and two children, Gene and Mrs. Rosella Schmitt. He also leaves five grandchildren as well as five brothers and sisters.

Burial was in Oakwood Mausoleum, Saginaw, Michigan.

Joseph N. Wills, M.D., of Detroit, died in September at the age of sixty-seven.

For the past twenty-six years Doctor Wills had been a staff member of Parkside Hospital. He was graduated from the Detroit College of Medicine in 1919. Later he studied at the University of Michigan and in Scotland.

Dr. Wills, who was born in British Guiana, was an active member of the Wayne County Medical Society. He is survived by his wife, Ruby, a son, Joseph, Jr., and a brother, Alfred.

MICHIGAN'S DEPARTMENT OF HEALTH

(Continued from Page 118)

of hospitals to the Michigan Department of Health. This transfer was effective the last of September of this year.

In co-operation with the Maternal Health Committee of the Michigan State Medical Society, hospital administrators, and others directly interested, a set of rules and regulations has been developed as provided for in the law.

As you know, the Michigan Department of Health soundly subscribes to the principle of decentralization and local responsibility. Therefore, instead of attempting to build up a large central staff and do all of the work from Lansing, it is our hope that we may delegate a considerable portion of the inspectional phases of the work to existing local health departments. Such a method can be successful only with the understanding and support of your members.

A copy of the rules and regulations properly adopted is enclosed. Additional copies may be secured upon request.

Sincerely,

Albert E. Heustis, M.D.
Commissioner

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* Hamblen, E. C.: Some Aspects of Sex Endocrinology in General Practice, North Carolina M. J. 7:533 (Oct.) 1946.

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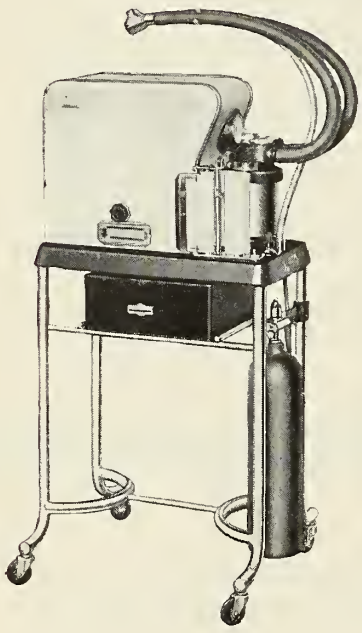
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Communications

Wm. J. Burns, Executive Director
Michigan State Medical Society
606 Townsend Street
Lansing 15, Michigan

Dear Mr. Burns:

You have asked me to forward an answer to the following question:

"Is there anything in the Wage Stabilization Law that affects doctors of medciine who hire other doctors—in other words, may a doctor of medicine increase the salary of one of his assistants, according to the wage stabilization act?"

The applicable provision of law is to be found in Paragraph (ii) of Section 402 (e) of the Defense Production Act of 1950, as amended by the Defense Production Act Amendments of 1951. The statute provides that the authority conferred by Title IV which relates, among other things, to salary stabilization shall not be exercised with respect to:

"Rates or fees charged for professional services; wages, salaries, and other compensation paid to physicians employed in a professional capacity by licensed hospitals, clinics and like medical institutions for the care of the sick or disabled * * *."

An official interpretation of this provision of the Defense Production Act by Joseph D. Cooper, Executive Director of the Office of Salary Stabilization, dated September 28, 1951, was published on October 3, 1951.

Pertinent excerpts from the official interpretation are as follows:

"Generally, physicians employed by licensed hospitals on a salary basis either to treat hospital patients, as medical specialists, or as superintendents or administrators of hospitals. All such physicians are considered employed in a professional capacity and are included in the statutory exemption. Physicians employed in the same capacities by lawfully operated clinics and like medical institutions for the care of the sick or disabled are also exempt from salary stabilization.

On the other hand, employment of a physician by another physician carrying on his practice is not exempt. The statute does not apply to this relationship."

The interpretation defines clinics as follows:

"Clinics are institutions performing medical services for the treatment of illness or bodily injury on an outpatient basis. As distinguished from hospitals, they are not equipped for in-patient care."

The expression "like medical institutions for the care of the sick or disabled" is interpreted as follows:

"These are institutions which combine medical treatment with general residential facilities, such as sanitaria for the treatment of tuberculosis patients, the mentally ill or other chronic ailments. They are generally considered hospitals by the medical professions."

Thus it will be seen both from the reading of the statute, as well as from its official interpretation, that

(Continued on Page 126)



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(Continued from Page 124)

employment of a physician by another physician carrying on his practice is not exempt from the provisions of the Act. On the other hand, if physicians are employed by a "clinic" in a professional capacity, the employment is not subject to the provisions of the Act.

In spite of the interpretive definition of a "clinic" as above quoted, the factual question as to whether a particular organization designated as a clinic will be regarded by the Office of Salary Stabilization as coming within the definition still remains. For example, the Mayo Clinic would doubtless be held clearly to come within the definition given. On the other hand, should an individual physician establish what he calls a clinic, and employ another physician to assist him in carrying on his professional work, the Office of Price Stabilization may administratively rule that the designation of such an arrangement as a clinic is not sufficient to qualify it in the exempted category.

Very truly yours,
J. Joseph Herbert
Legal Counsel

November 13, 1951.

Mr. Hugh W. Brenneman
Public Relations Counsel
Michigan State Medical Society
606 Townsend Street
Lansing 15, Michigan

Dear Mr. Brenneman:

Reference is had to the inquiry of ————, M.D., directed to the Public Relations Committee, and referred by you to me for study. The question concerns itself with the exemption of physicians from jury duty.

Fourteen years ago, by Act No. 173 of Public Acts of 1937, the legislature amended the provision of the Judicature Act dealing with exemptions from jury service. The section amended is Section 138, Chapter 11, of the Judicature Act, being Act 314 of 1915; C.L. 1929, 13740; and M.S.A. 27.263.

Prior to amendment, there were exempted from jury service:

"All officers and teachers of colleges and incorporated academies; all settled ministers of the gospel; all superintendents, engineers and conductors of any railroad; all constant ferrymen; all members of any legally organized fire department; all members of the Michigan national guard; all registered pharmacists; all practicing physicians, surgeons and dentists."

By the amendment of 1937, the above quoted passage was deleted. Some other changes were also made in the section, such as, raising the exemption age from 65 to 70. It may be seen, therefore, that for more than fourteen years, physicians and certain other classes of persons have not been exempt by statutory provision from jury service.

The following section of the Judicature Act, as amended, M.S.A. 27.264, provides in part,

(Continued on Page 128)

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(Continued from Page 126)

"The court to which any person shall be returned as a juror, shall excuse such juror from serving at such court, whenever it shall appear: * * * When for any other reason, the interests of the public, or of the individual juror, will be materially injured by such attendance, or his own health, or that of any member of his family requires his absence from such court."

It is our impression that since the amendment of the law very few, if any, physicians have served on juries because courts have been ready to excuse them from such service under the provision immediately above quoted. However, it is perfectly clear that if physicians are to enjoy absolute statutory exemption, the present law would have to be amended by the legislature.

Very truly yours,
J. Joseph Herbert
Legal Counsel

May I congratulate you on this fine Journal of the Michigan State Medical Society. I shall keep this for handy reference from time to time.

Malcolm T. McEachern, M.D.,C.M.
Director of Public Relations
American Hospital Association

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He'll have the facts at tongue-tip or, if he must refresh his memory, he'll whip out Bulletin 87 on "Medical Care Expenditures, Prices and Quantity, 1930-50," which has just reached his desk from Dr. Frank G. Dickinson, director of the Bureau of Medical Economic Research, American Medical Association.

Dr. Dickinson relies on indisputable Federal Government sources, chiefly the Department of Commerce, to support his statements. And when Doc gets through quoting Dr. Dickinson, you may be sorry you ever brought up the subject.

* * *

"Sure, the American people spent $8,000 million in 1950 for all types of medical care!" one can imagine Doc saying. "But that represents only 4.4 per cent of the $193,600 million that they spent for all goods and services in that year.

"The significant point is that, in 1930, they were spending 4.1 per cent of their total outlay and, for 20 years, the consumers' budget for medical care (by no means as high in quality as it is today) fluctuated narrowly around 4 per cent.

"Maybe 4.4 per cent of the consumers' budget represents a lot of money. But let's see . . .

"They spent, last year, 5.8 per cent for 'recreation.' And I mean for football, baseball and other spectator amusements, theater admissions, participant amusements like bowling, horse races, pinball machines, flowers and potted plants, camp fees, club dues and what not—for a total of $11,300 million as compared with $4,000 million in 1930.

"They spent 4.2 per cent for alcoholic beverages or a trifle less than for all types of medical care.

"They spent 2.3 per cent of their budget on tobacco; 1.2 per cent on barber shops, beauty parlors, baths, massages, toilet articles and cosmetics and .8 per cent on jewelry, clocks, watches and their repairs.

"Now let's take a look at that item representing all types of medical care. Let's compare the 'medical care dollar' of 1930 with that of 1950.

"Twenty years ago, the doctor got 32 cents of it; now, he receives only 28 cents, an actual decrease of 12 per cent!

"In 1930, dentists got 16 cents out of this dollar; now they get 12 cents or 26 per cent less.

"Two decades ago, 19 cents of the consumer's medical care dollar went for drugs; in 1950, only 17 cents—a drop of 12 per cent.

"A number of miscellaneous items took 19 cents in 1930 and 20 cents in 1950, an increase of 5 per cent.

"But look at the share of the consumer's medical dollar that went to hospitals—14 cents in 1930 and 23 cents in 1950. That's an increase of 66 per cent!

"If you think this is juggling figures and that 1930 might have been an exceptional year, take the 1935-39 average as a base period or point of reference. The trend is the same.

* * *

"Between this base period and 1950, the cost of all goods and services purchased by consumers rose 72 per cent, according to the U. S. Bureau of Labor Statistics' consumers' price index. On the same scale, hospital rates increased 135 per cent. But physicians' fees were up only 40 per cent and surgeons' and specialists' charges up 41 per cent.

"That's not the whole story, of course. It's immaterial how 'low' cost of an article or service may be, if the average citizen is unable to pay the price. But between the base period and 1950, average weekly earnings of production workers in manufacturing industries rose 165 per cent.

"That means that, in 1950, the individual had to work only 53 per cent as long to buy the same amount of doctors' services as he had to do in 1935-39. True, hospital charges last year were 'high'—but the patient could buy as much care, as in the base period, with only 89 per cent as much work.

"I'll skip the fact, other than to note it, that the advent of the wonder drugs and the perfection of amazingly effective surgical and therapeutic technics since 1939 has appreciably lessened the amount of physician's care and shortened the hospital stay, in order to cure the same types of illness. This means that the patient gets far more for his money than he did in the base period.

* * *

"You can get a rought index of quantity by dividing the index of expenditures for any item by the corresponding index of the price paid for that item. Divide total expenditures for bread by the average price for a loaf and you get an idea of the number of loaves purchased during the year.

"Apply this to quantity of medical care and you find the index rose from 1.0 in the base period to 2.2 in 1950. That would mean more than a 100 per cent increase in the quantity of medical care delivered but, since allowance must be made for a 17 per cent increase in population, the actual quantity increase was in the order of 85 per cent.

"If allowance is made for the fact that the number of physicians increased by 22 per cent between the base period and 1950, it is found that each physician, on the average, delivered approximately 50 per cent more care last year than in 1935-39.

"This was possible because of the greatly expanded use of nurses and technical assistants, the introduction of the wonder drugs, improved transportation, the increasing proportion of patients seen in hospital or office, and to other increases in technological efficiency.

* * *

"Students of medical economics suggest—since it is incapable of proof—that advanced technology in the medical field has resulted in a greater output per doctor

(Continued on Page 136)



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NEWS MEDICAL

MICHIGAN AUTHORS

"Ophthalmia Neonatorum," a paper by **William L. Benedict, M.D.**, of Rochester, Minnesota, published in The Journal of Michigan State Medical Society for May, 1950, has been reprinted by special permission in Guildcraft for September, 1951.

J. Lewis Dill, M.D., and **Donald S. Bolstad, M.D.**, of Detroit, are authors of a paper, "Cortisone in Allergic Rhinitis," published in the *Digest of Ophthalmology and Otolaryngology,* November, 1951.

E. Thurstan Thieme is the author of an editorial, "Surgery, Gynecology and Obstetrics," published in *Surgery, Gynecology and Obstetrics,* November, 1951.

Samuel J. Levin, M.D., F.A.C.A., and **Selma S. Moss, M.D., F.A.C.A.**, of Detroit, are authors of a paper, "Repository Penicillin Injections in Allergic Children," published in the *Annals of Allergy,* July-August, 1951.

Carey P. McCord, M.D., of Ann Arbor, is the author of a paper, "One of the Ancients—Modena: Ramazzini's Home Town Today," published in *Industrial Medicine and Surgery,* November, 1951.

V. Everett Kinsey, Ph.D., and **Charles E. Frohman, Ph. D.**, of Detroit, are authors of a paper, "Studies on the Crystalline Lens: IV. Distribution of Cytochrome, Total Riboflavin, Lactate, and Pyruvate and Their Metabolic Significance."

The paper, "The Elderly Patient," by **Edward L. Bortz, M.D.**, published in THE JOURNAL, Michigan State Medical Society, June, 1951, has been published and condensed in the *Current Medical Digest,* October, 1951.

Claire L. Straith, M.D., and **D. Ralph Millard, Jr., M.D.**, of Detroit, are authors of a paper. "Psychologic Aspects of Plastic Surgery," published in *The American Academy of General Practice,* November, 1951.

Ernest H. Watson, M.D., of Ann Arbor, is an author of a paper, "Breast Feeding of Normal Infants," published in *The American Academy of General Practice,* November, 1951.

Robert D. Kiess, M.D., and **Bruce Fralick, M.D.**, of Ann Arbor, are authors of a paper, "New Cycloplegic and Mydriatic Diagnosis" in the *American Journal of Ophthalmology,* November, 1951.

Jack Lapides, M.D., of Ann Arbor, is the author of a paper, "Mechnaism of Electrolyte Imbalance following Ureterosigmoid Transplantation," published in *Surgery, Gynecology and Obstetrics,* December, 1951.

James Milton Robb, M.D., of Detroit, is the author of a paper, "Are You an Otolaryngologist?" published in *The Journal of the American Medical Association,* September 22, 1951.

D. J. Leithauser, M.D.; **Leo Saraf, M.D.**; **Stanley Smyka, M.D.**, and **Michael Sheridan, M.D.**, of Detroit, are authors of a paper, "Early Ambulation in the Prevention of Postoperative Thromboembolism," published in *The Journal of The American Medical Association,* September 22, 1951.

George E. McKeever, M.D., of Detroit, is the author of a paper, "Myasthenia Gravis in a Mother and her Newborn Son," published in *The Journal of The American Medical Association,* September 22, 1951.

Robert C. Bassett, M.D., of Ann Arbor, and **H. Harvey Gass, M.D.**, of Detroit, are authors of a paper, "Ligation of Internal Carotid Artery," published in *The Journal of The American Medical Association,* October 27, 1951.

Vernon H. Plager, M.D.; **Harry M. Nelson, M.D.**, and **Donald C. Beaver, M.D.**, of Detroit, are authors of a paper, "Endometriosis of Cervic Uteri with Large Endometrial Cyst," published in *The Journal of The American Medical Association,* October 27, 1951.

Donald E. Van Hoek, M.D., and **Merle M. Musselman, M.D.**, of Eloise, are authors of a paper, "Diaphragmatic Hernia and Anemia after Transabdominal Vagotomy," published in *The Journal of The American Medical Association,* October 27, 1951.

Jacques H. Ahronheim, M.D., of Jackson, is the author of a paper, "Mass Blood Typing," published in *The Journal of The American Medical Association,* November 27, 1951.

Fred J. Hodges, M.D., and **Howard C. MacMillan, M.D.**, of Ann Arbor, are authors of a paper, "Important Clinical Dividends from X-Ray Examination of the Colon," published in *The Journal of The American Medical Association,* November 24, 1951.

C. J. Velz, M.D., of Ann Arbor, is the author of a paper, "Manpower Prospects within the Population Structure," published in *The Journal of The American Medical Association,* December 1, 1951.

Leonard E. Himler, M.D., of Ann Arbor, is the author of a paper, "Phychiatric Aspects of Aging," published in *The Journal of The American Medical Association,* December 1, 1951.

Frank W. Hartman, M.D., of Detroit, is the author of paper, "Tissue Changes Following the Use of Plasma Substitutes," published in *Archives of Surgery,* December, 1951.

Harry C. Saltzstein, M.D.; **Laurence M. Linker, M.S.**, and **Schayel R. Scheinberg, M.D.**, of Detroit, are authors of a paper, "Subcostosternal (Morgagni) Diaphragmatic Hernia: Report of a Case of Hernia Containing Stomach, Transverse Colon, and Omentum, with Review of the Literature," published in *Archives of Surgery,* December, 1951.

(Continued on Page 132)

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which is not FCC-approved, let us send you information on the new Burdick MF-49 Universal Diathermy. Since old-type diathermy equipment will not be permitted after June 30, place your order soon to assure prompt delivery.

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(Continued from Page 130)

Ivan F. Duff, M.D.; Harold F. Falls, M.D., and **James W. Linman, M.D,** of Ann Arbor, are authors of a paper, "Anticogulant Therapy in Occlusive Vascular Disease of the Retina," published in *Archives of Ophthalmology,* December, 1951.

* * *

Fred J. Hodges, M.D., and **Howard C. MacMillan, M.D.,** Ann Arbor, are authors of an original article which appeared in *JAMA* of November 24, 1951, entitled "Important Clinical Dividends from X-Ray Examination of the Colon."

Leonard E. Himler, M.D., Ann Arbor, is the author of an original article entitled "Phychiatric Aspects of Aging" which appeared in *JAMA* of December 1, 1951.

Meyer O. Cantor, M.D., Charles S. Kennedy, M.D., and **Roland P. Reynolds, M.D.,** Detroit, are authors of an original article entitled "Felfoan and Thrombin in Treatment of Massive Upper Gastrointestinal Hemorrhage" which appeared in *The American Journal of Surgery,* August, 1951.

Jacques H. Ahronheim, M.D., Jackson, is the author of an original article entitled "Mass Blood Typing" which appeared in *JAMA* of November 10, 1951.

* * *

The School of Public Health at the University of Michigan, in collaboration with the Institute of Industrial Health, offers on inservice training course on "The Acoustical Spectrum" to be held in Ann Arbor, February 5-8, 1952. For program and full information, write C. D. Selby, M.D., Faculty Advisor, School of Public Health, 109 South Observatory St., Ann Arbor.

* * *

Michigan Medical Service reported membership on October 31, 1952, as 2,355,129. United Medical Service of New York with nearly twelve million persons to serve has a few thousand more.

Financial reports are available up to September 30, 1951. Total expenditure for services to our subscribers were $62,750,408.07, and for veterans $5,626,821.61, a grand total of $68,377,229.68. Services have averaged $1,400,000 during the first nine months of this year.

* * *

Members of the Michigan State Medical Society now attending postgraduate courses at the Cook County Graduate School of Medicine are: Charles B. Lakoff, M.D., Detroit; John J. Vrbanac, M.D., Hart; William A. Sautter, M.D., Horton; Thomas J. Dillon, M.D., Paw Paw.

* * *

Arizona Medicine, journal of the Arizona Medical Association, in its September number, 1951, devoted a three-page editorial and a picture to the Blue Cross-Blue Shield plan, and its executive. This was an historical account and a glowing as well as deserved tribute.

* * *

The AMA Board of Trustees authorized elimination of any charge to AMA members and to Student AMA members who make use of the AMA library lending

service in the future, but increased the charge for non-members to 50 cents a package for reprints and 15 cents for each journal.

* * *

The AMA has initiated correspondence with the U. S. Bureau of Internal Revenue regarding a review of the 1921 ruling which denied deductions to physicians for expenses incurred in taking postgraduate courses. A report will be made to the Board and to members from time to time as the matter progresses.

* * *

International Children's Conference.—Several prominent persons in this country have been asked to lend their names as sponsors of the International Conference in Defense of Children to be held in Vienna during the month of February, 1952. The National Health Council in New York says it has been informed by the Advisory Committee on Voluntary Foreign Aid of the U. S. Department of State that "this proposed conference is sponsored by the Communist World Federation of Democratic Women."

* * *

The U. S. Budget Bureau, which has the final say on the extent of agency fund requests of Congress, believes the time has come to *limit expansion* of basic Federal health programs to those contributing directly to national defense. In addition, it feels a *"complete and systematic review"* of all Federal grants for promoting health is now in order, with a view toward economy and efficiency and elimination of possible Federal interference in state operations.

Elmer Staats, assistant director of the Bureau who outlined the government position to State and Territorial Health Officer, placed current Federal spending on all health and hospital programs, including the military and for veterans, at $1.75 billion annually. This, he added, is greater than that spent by all state and local governments. Staats listed these facts to show extent of Federal health activities: (1) more than 25 million persons, including 18.5 million veterans, 3.5 million officers and enlisted men and 2 million Federal civilian employes eligible for medical services and hospital care, (2) over 500 hospitals with 220,000-bed capacity under Federal operation or nearly 20 per cent of all hospital beds in the U. S., (3) 10 grant programs costing $233 million concerned directly with health. Mr. Staats observed:

"There is ample evidence that the health of the American people has improved greatly in recent decades . . . Surely (governmental health programs) have been a substantial factor. Whatever the cause, it is both significant and encouraging that *selective service rejection rates on account of poor health are now lower than during World War II.*"

On the question of re-examining grant programs, Mr. Staats said they might be more effective and economical if existing piecemeal programs were consolidated into broader programs and if grants could be more definitely

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related to fiscal resources of the states as well as to the states' needs for services. Further, he believes Federal administrators of programs should be given enough authority to make sure that national interests are protected *"but not so much authority that coercion is substituted for co-operation."*

* * *

The Graduate School of Medicine of the University of Florida is holding another midwinter seminar in ophthalmology and otolaryngology at Miami Beach, Florida, January 14 to 19, 1952. F. Bruce Fralick, M.D., Professor of Ophthalmology at the University of Michigan, Ann Arbor, will give lectures and demonstrations for the hour 3 to 4 p.m., January 14, 15 and 16, and an hour on January 16 at 11 a.m. on the surgical anatomy of operation for glaucoma.

* * *

New Standard Nomenclature.—After three years of intensive work, the American Medical Association will make available to hospitals, January 2, the new fourth edition of Standard Nomenclature of Diseases and Operations.

This high advance registration mark probably has been achieved as a result of good publicity through the western part of the country and the fine, untiring work which has been done by the local committee on arrangements.

A few weeks ago, 49,000 attractive folders publicizing the Los Angeles meeting were mailed to physicians living west of the Mississippi river. Advertisements also have appeared in west coast medical journals as well as in The Journal of the AMA.

More firms will exhibit at Los Angeles than at any previous clinical session. More than 160 have reserved space.

All of this shows that the AMA clinical session is rapidly taking its place as one of the largest national medical meetings, second only to the American Medical Association's annual session.

* * *

Children's Hospital of Michigan, Detroit, has just received a three-year grant from the Playtex Park Research Institute of New York for the purpose of aiding research in certain phases of hematology. Playtex Park Research Institute is a non-profit, public service foundation sponsored by the International Latex Corporation for the support of research in the field of childhood diseases. Children's Hospital is one of 26 medical institutions receiving grants from Playtex. Children's Hospital will carry out investigations in iron metabolism, prevention of iron deficiency anemia, the anemia of infection in early life, and other hematologic problems.

* * *

The Fourth Annual Clinical Conference of the Chicago Ophthalmological Society will be held February 21, 22, 23, 1952, at the Drake Hotel. The first day will be devoted to surgical clinics at the various hospitals. Following will be lectures concerning neuro-ophthalmology, ocular pharmacology, nystagmus, provocative



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tests in glaucoma and the secretion of aqueous. Participants include Drs. Alson E. Braley of Iowa City, Justin M. Donegan, Joseph S. Haas, Peter C. Kronfeld, James E. Lebensohn, Chicago; Irving H. Leopold, Philadelphia, John M. McLean, New York, Samuel J. Meyer, Maurice D. Pearlman, Chicago, C. Wilbur Rucker, Rochester, Derrick Vail, Chicago and Joseph A. C. Wadsworth of New York City.

Further information concerning the conference may be obtained from Miss Maud Fairbairn, 8 W Oak Street, Chicago 10, Illinois.

The conference will be followed by a banquet and the Eighth Annual Sanford R. Gifford Memorial Lecture to be presented by Dr. Alson E. Braley, Professor and Head of the Department of Ophthalmology, The State University of Iowa. Dr. Braley will speak on "Experimental Studies of the Herpes Simplex Virus." The banquet and lecture will be at the Drake Hotel and all are invited. Dinner reservations may be obtained from Miss Fairbairn.

* * *

"**I'm a Doctor—and I'm Human**" was the title of an article by Robert K. Webster, M.D., a general practitioner of Brazil, Indiana, which appeared in the *Saturday Evening Post* of November 17. The article is well worth reading.

* * *

"**Action is due** soon in government's monopoly case against Oregon Medical Society, Oregon Physicians' Service and co-defendants. The Department of Justice is preparing a brief for submission to the Supreme Court next month, preliminary to oral arguments—scheduled for January—on appeal from the Federal Court decision that cleared the alleged 'medical service trust.' "—Washington Report on the Medical Sciences, November 12, 1951.

* * *

Harry R. Lipson, Detroit, long-time sales representative of JMSMS, has been named General Sales Manager of WJBK and WJBK-TV. Mr. Lipson will supervise local and national sales for his radio stations. Congratulations, Harry Lipson!

* * *

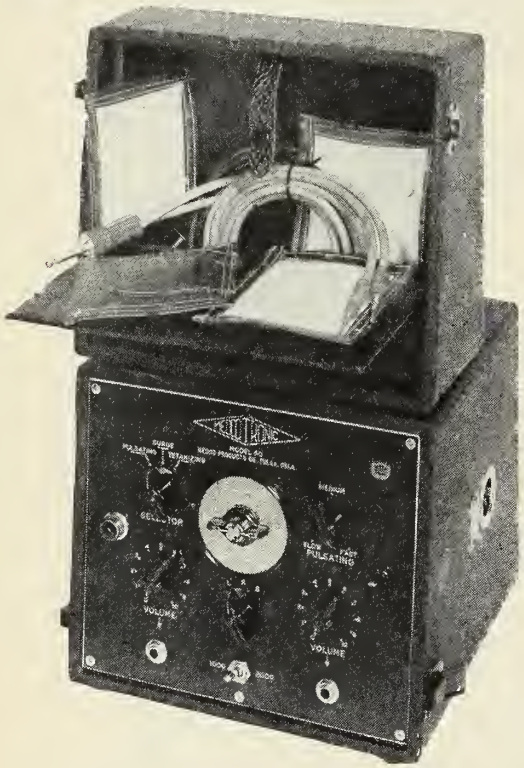
"**Governor Earl Warren**, of California, in common with President Truman and Federal Security Administrator Oscar Ewing, repudiates the term 'socialized medicine,' while warmly embracing the substance. That has become accepted practice among those who seek a politically-dominated medical system, however, and no one should be misled by it."—AMA Campaign Coordinating Committee letter, signed by President J. W. Cline, M.D., and Committee Chairman, Elmer L. Henderson, M.D.

* * *

J. S. DeTar, M.D., Milan, and R. W. Teed, M.D., Ann Arbor, have been chosen Delegate and Alternate, respectively, of the Michigan State Medical Society to the Michigan Health Council.

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The Medcotron Stimulator, Model 50, operates on 110 volt, 50 to 60 cycle alternating current. The current generated by the apparatus is non-sinusoidal alternating current. Output circuits have no direct connection to the power supply. The maximum voltage output is from 15 to 18 volts R.M.S. The protective mechanism consists of a 1 amp. line fuse that will open, should a short circuit ever occur.

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Executive Director Wm. J. Burns, Lansing, addressed the State Medical Journal's Conference at the AMA, Chicago, on November 13. His subject was "Problems of Business Management of State Journals."

* * *

J. S. DeTar, M.D., Milan, one of Michigan's Delegates to the AMA, played the part of Harry S. Truman in the Ann Arbor Players Production of "Follies Berserk" on December 14-15, 1951.

EVERYBODY LIKES TO "BEEF" ABOUT HIS DOCTOR BILL

(Continued from Page 129)

than can be attributed to the man or machine employed in agriculture, industry and transportation.

"Not only are the American people receiving more medical care at lower cost than in 1935-39, but it is of a far higher quality. Maternal deaths per 1,000 of live births have fallen from five in 1935-39 to less than one, in 1950. Life expectancy at birth has increased in this period, from 59.5 years to 68.6 years.

"You complain about the 'high cost of medical care' as though every illness had to be charged against income of any particular week, month or year. But the fact is that such illness is the 'rainy day' for which—presumably—you were laying by a portion of your savings.

"It is possible to budget for illness, and more than half of the American people are doing so through some form of medical or hospital insurance. To budget 4 per cent of income for medical care requires only that the average family expend not more than 25 cents a day, the cost of a package of cigarets.

"But this budgeting, in the form of Blue Cross and Blue Shield insurance, pays an added dividend. It offers an inducement to seek pre-paid medical care at the early stage of illness when it is usually treatable. More cures are certain; thus, the individual is given more and better years in which to earn."

—Allen Schoenfield in *The Detroit News,* December 13, 1951.

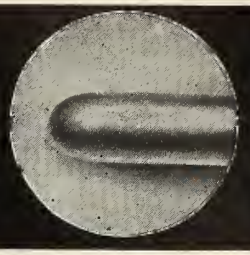
Contributions to AMEF are ruled tax exempt.—

The Commissioner of Internal Revenue of the Treasury Department has held that the American Medical Education Foundation is entitled to exemption for the year 1951 from federal income tax under the provision of Section 101 (6) of the Internal Revenue Code as the Foundation was *organized and operated exclusively for educational purposes.*

The Commissioner further ruled that contributions, payment of which were made to the Foundation during the year 1951, are deductible by the donors in computing their taxable net income in the manner and to the extent provided by Section 23 (o) and (q) of the Internal Revenue Code.

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The Detroit Ophthalmological Society announces its 1952 program as follows:

January 24, 1952—Resident-Intern meeting.

February 21, 1952—Harvey E. Thorpe, M.D., Pittsburgh—"Management of Intraocular Foreign Bodies."

Discussants: Harold Mair, M.D., and Leland F. Carter, M.D., Detroit.

March 20, 1952—David G. Cogan, M.D., Boston—Subject to be announced.

April, 1952—This meeting will be held jointly with the Michigan Triological Society, and the continuation course in Ophthalmology Post-Graduate School, University of Michigan.

Meetings are held at L'Aiglon, Fisher Building, Detroit, and begin with dinner at 6:30 p.m.; scientific session at 8:00 p.m.

Officers for 1951-52 are: Arthur Hale, M.D., President; A. P. Wilkinson, M.D., Secretary; R. E. Anslow, M.D., Treasurer; P. L. Cusick, M.D., Recorder; Duane Beam, M.D., Chairman of Ethics and Admission Committee, and H. D. Scarney, M.D., Chairman of Program Committee. All of Detroit.

* * *

The Berrien County Medical Society and the Southwestern Michigan Academy of Medicine held a Clinic Day on November 20, 1951, featuring the following clinicians from Crile Clinic of Cleveland: F. A. LeFevre, M.D., Stanley O. Hoerr, M.D., Charles H. Brown, M.D., and Willard O. Thompson, M.D., from the University of Illinois.

* * *

The Office of Indian Affairs, United States Department of the Interior, has recently notified the Michigan Department of Health (under date of November 8) that the Agency cannot be responsible for the payment of medical and hospital expenses incurred by one Theodore Clifford Bresette, forty-five years of age, who is of approximately one-fourth degree of Chippewa Indian blood. The Office of Indian Affairs states that both hospitalization and medical attention are available to Clifford Bresette at its Hayward Indian Hospital at Hayward, Wisconsin.

The Agency states that Bresette does not have any authority to obligate Indian Service Funds for hospitalization and medical service, according to E. J. Riley, Chief Clerk in Charge.

* * *

"Return of the Family Doctor."—The citizens of Michigan benefit directly from these programs. With doctors who know what's new in medicine, the people obtain the best services. This program carried on without fanfare, refutes the casual comment of the uninformed that the family doctor is disappearing or is unqualified to give the best treatment."—From *Inside Michigan* (October, 1951 Number).

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INGHAM COUNTY MEDICAL SOCIETY

Eighteenth Annual Clinic

Hotel Olds, Lansing, Michigan.
Thursday, May 1, 1952

PROGRAM

Registration—1:30 p.m.

Afternoon Session—2:00 p.m.

(1) "Aspects of the Choice of Anesthesia of Interest to the Medical Profession at Large."—HENRY S. RUTH, M.D., Professor of Anesthesiology, Hanneman Medical College, Philadelphia, Pennsylvania.

(2) "Treatment of Acute Infections."—FRANKLIN H. TOP, M.D., Professor of Epidemiology and Pediatrics, University of Minnesota Medical School, Minneapolis, Minnesota.

(3) "First Stages in Human Conception."—JOHN ROCK, M.D., Clinical Professor of Gynecology, Harvard Medical School, Boston, Massachusetts.

(4) "Clinical Aspects of the Pituitary Gland."—E. H. RYNEARSON, M.D., Consultant, Division of Medicine, Mayo Clinic, Rochester, Minnesota.

Social Hour—5:15 p.m.

Dinner—6:30

Speaker: FRED A. COLLER, M.D., Professor of Surgery, University of Michigan Medical School, Ann Arbor.

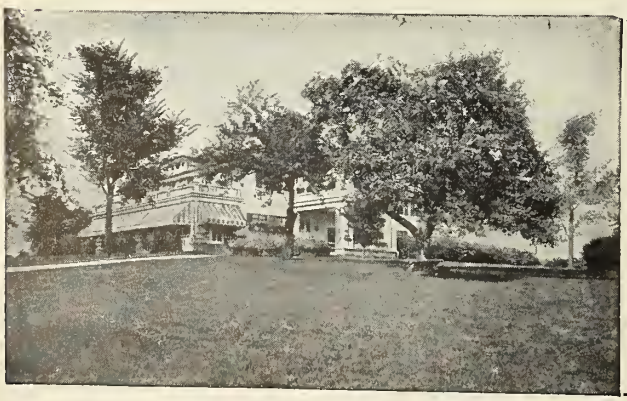
Tuberculosis must be looked for at all ages. Although tuberculosis causes more deaths than any other disease among people between fifteen and thirty-five years of age, it cannot be considered primarily a disease of this age range.

Of the 5,538 new cases of tuberculosis reported in Michigan in 1950, only one-third were in the twenty-year age span between fifteen and thirty-five. The remaining two-thirds were in ages ranging from infants to nonagenarians, with only 8.5 per cent of the total among children under fifteen.

Among women, nearly half of the cases reported were at ages fifteen to thirty-five. Among men, only about one-fourth of the cases reported were at ages fifteen to thirty-five, and twice as many—one-third of all cases reported for both sexes—were at ages thirty-five to seventy-five.

MICHIGAN TUBERCULOSIS ASSOCIATION

Henry J. Loynd, President of Parke, Davis & Co., Detroit, recently stated "Sixty per cent of all drug sales today involve products that didn't exist 10 years ago and ninety per cent of today's prescriptions could not have been written 15 years ago."



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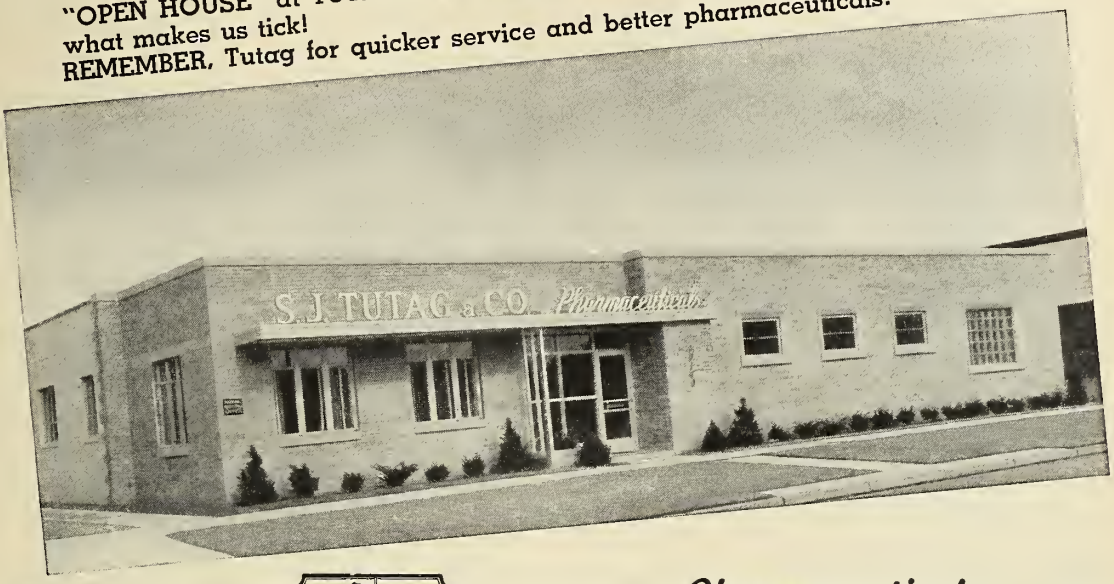
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G. C. Penberthy

Grover C. Penberthy, M.D., Detroit, was chosen as Regent for Michigan of the American College of Surgeons at its San Francisco session.

James H. Maxwell, M.D., Ann Arbor, was elected a member of the Board of Governors for a three-year term to 1954 as representative of the American Academy of Ophthalmology and Otolaryngology.

ACS initiates from Michigan this year included:

George H. Andries, M.D., Detroit

William A. Bailey, M.D., Dearborn; James Barron, M.D., Detroit; William C. Baum, M.D., Ann Arbor; Robert A. Byberg, M.D., Royal Oak.

Robert C. Conybeare, M.D., Benton Harbor.

Richard C. Deming, M.D., Jackson; Melvin S. Dennis, M.D., Detroit.

Aaron A. Farbman, M.D., Detroit; Norman A. Fleishman, M.D., Muskegon.

Edward M. Gates, M.D., Pontiac; Frederick S. Gillett, M.D., Grand Rapids; Fred B. Gray, M.D., Grand Rapids.

Curtis M. Hanson, M.D., Kalamazoo; Edward J. Hill, Jr., M.D., Detroit; Albert B. Hodgman, M.D., Kalamazoo; R. Grant Howard, M.D., Kalamazoo.

Robert G. Jaedecke, M.D., Ishpeming; Henry T. Johnson, M.D., Lansing; Prescott Jordan, Jr., M.D., Detroit.

Ned B. Kalder, M.D., Detroit; George T. Kelleher, M.D., Battle Creek.

Jack M. Leopard, M.D., Alpena; Frederick H. Lindenfeld, M.D., Niles.

Irving J. Martens, M.D., Kalamazoo; Elmer Bowman Miller, M.D., Detroit.

John Edwin Orebaugh, M.D., Ann Arbor.

Thomas B. Patton, M.D., Detroit; Joseph L. Posch, M.D., Detroit; Edwin W. Prentice, M.D., Muskegon; Alexander B. Procailo, M.D., Garden City.

Dean Kingsley Ray, M.D., St. Joseph; Richard G. Ries, M.D., Jackson.

Marion A. Sapala, M.D., Detroit; Leo B. Saraf, M.D., Detroit; Roger A. Scholten, M.D., Kalamazoo; Arthur G. Seski, M.D., Detroit; Emil R. Simon, M.D., Detroit; Homer M. Smathers, M.D., Detroit; George E. Smith, M.D., Royal Oak; Charles H. Stevens, M.D., Detroit.

Richard L. Thirlby, M.D., Traverse City; William H. Tyler, M.D., Muskegon.

Kenneth M. Vander Velde, M.D., Kalamazoo; Harold E. Veldman, M.D., Grand Rapids.

George L. Walker, M.D., Grand Rapids; John B. Wilkes, M.D., Grand Rapids; Cornelius B. Wood, M.D., Mt. Pleasant.

* * *

CHICAGO CLINICAL CONFERENCE, MARCH 4-7

The Clinical Conference which has been established by the Chicago Medical Society for presentation each spring, offers lectures on many aspects of medicine to keep doctors abreast of the new things being developed from year to year. Each year the Society presents something of special interest to those attending. It will be held March 4, 5, 6, 7, 1952, in the Palmer House, Chicago.

The year 1952 will show, in response to popular demand, an increased number of demonstrations or work-

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$10,000.00 accidental death *$50.00 weekly indemnity, accident and sickness*	**$16.00** *Quarterly*
$15,000.00 accidental death *$75.00 weekly indemnity, accident and sickness*	**$24.00** *Quarterly*
$20,000.00 accidental death *$100.00 weekly indemnity, accident and sickness*	**$32.00** *Quarterly*

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$4,000,000.00 INVESTED ASSETS **$17,000,000.00 PAID FOR CLAIMS**

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shop periods in addition to the regular series of lectures. These demonstrations include presentation of patients, carefully selected scientific movies, and other features interesting from an educational standpoint. The lectures are on subjects of interest to both the general practitioner and the specialist and will be one half hour in duration. The faculty, which is now being assembled, will represent outstanding teachers of the medical world.

The scientific and technical exhibits are being selected with great care. The scientific exhibits will present visually some of the most recent advances in medicine. The technical exhibits are both helpful and time-saving and worthy of real study. To those who have attended previous clinical conferences, the wealth of material is well-known.

For newcomers, to this activity of a great medical center, it will be an opportunity to renew old acquaintances as well as improving one's medical outlook. The Chicago Medical Society Clinical Conference should be marked on every physician's calendar right now. The completed program will be available shortly and will be printed in our Bulletin or mailed upon request. This meeting has earned the reputation of being one of the most outstanding medical conferences in the country.

* * *

Arch Walls, M.D., Detroit, President of the Wayne County Medical Society, has been selected as General Chairman of Arrangements for the 1952 MSMS Annual Session scheduled for Detroit, September 24-25-26, 1952, Book-Cadillac Hotel.

PROCEEDINGS OF MSMS

(Continued from Page 116)

add new names and to initiate men of lesser experience in the workings of the Society. We want their judgment. Sometimes we seem to overload a committee on paper, and then don't give them anything to do. Sometimes we find a lot to do for a committee that is made up of comparatively few people. That cannot always be foreseen.

XVII—f. REPORT ON MOBILIZATION OF M.D.s FOR THE ARMED SERVICES

The summary presented by G. C. Penberthy, M.D. (Wayne) will be published in THE JOURNAL.

THE SPEAKER: I believe we are ready to adjourn. (The meeting adjourned *sine die* at 11:45 p.m.)

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THE DOCTOR'S LIBRARY

Acknowledgment of all books received will be made in this column, and this will be deemed by us as full compensation to those sending them. A selection will be made for review, as expedient.

DIMENTIONAL ANALYSIS. For the Student of Medicine. By Harold A. Abramson, M.D., Associate Clinical Professor of Physiology, Columbia University; Associate Physician and Chief Allergy Clinic, the Mt. Sinai Hospital, New York City; Consultant (Physiology), Department of the Army. New York: The Josiah Macy, Jr., Foundation, 1950. $1.00.

This book is an attempt to help the student grasp the significance and meaning of various devices of expressing exact physical terms. It illustrates the development of many of the formulae used in physics, in science, and in medicine. The first chapter is a general discussion, followed by equations used in current texts to describe certain aspects of the circulatory system. A chapter develops the chemical formulation, one the physical, and lastly, the electrical. The book is small, forty-one pages, paper covered, but contains a mass of detail and the explanation of hundreds of equations.

THE CHANGING YEARS. By Madeline Gray, M.S. (Journalism). Garden City, N. Y.: Doubleday & Company, 1951. Price $2.75.

Mrs. Day is the author of numerous books, including "How to Cook for Profit" and "How to be a Success in the Restaurant Business." "The Changing Years" tells about menstruation, superstition and fact, also hormones, male and female, hot flashes, sex life and control of figure. The book is just as interesting to the man as to the woman. Many problems are common to both sexes. The chapters on food values and diet are well worth the price of the book if there were no question of menopause, male or female. The book is well written by a trained writer.

HANDBOOK OF NUTRITION. A Symposium Prepared under the Auspices of the Council on Foods and Nutrition of the American Medical Association. Second edition. Published for American Medical Association. New York: The Blakiston Co., 1951. Price $4.50.

This is a well-prepared study based on caloric requirements and expenditure, taking into consideration the basal metabolism, muscular activities, climate, and other factors which enter into daily living.

The author points out how poorly prepared many physicians are to cope with the problem of the actual nutritional state and the needs of each individual patient, and the extreme difficulty which he encounters because of the patient's attitude or complicating disease.

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PRINCIPLES AND PRACTICE OF OBSTETRICS (Originally by Joseph B. DeLee, M.D.). By J. P. Greenhill, M.D., Attending Obstetrician and Gynecologist, The Michael Reese Hospital; Obstetrician and Gynecologist, Associate Staff, The Chicago Lying-In Hospital; Attending Gynecologist, Cook County Hospital; Professor of Gynecology, Cook County Graduate School of Medicine. Tenth edition with 1140 illustrations, 194 in color. Philadelphia: W. B. Saunders Co., 1951. Price $12.00.

The tenth edition of DeLee and Greenhill's very complete thesis on obstetrics far surpasses its predecessors. It has kept pace with developments in antibiotics, hormone therapy, and recent concepts of the physiology of the birth canal and ovulation. New treatment for toxemias and pathological complications of delivery are considered.

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PEPTIC ULCER. Clinical Aspects, Diagnosis, Management. Editor, David J. Sandweiss, M.D., F.A.C.P., Associate Attending Physician, Division of Internal Medicine, Harper Hospital, Detroit, Michigan. Editorial Committee: A. H. Aaron, Henry L. Bockus, George E. Daniels, George B. Eusterman, L. Kraeer Ferguson, A. C. Iva, Sara M. Jordan, Frank H. Lahey, Walter L. Palmer, Harry Shay, Albert M. Snell and Dwight L. Wilbur. Philadelphia: W. B. Saunders Co., 1951. Price $15.00.

This book represents the efforts of the American Gastroenterological Association to compile in one volume the best that is currently known about the diagnosis and management of peptic ulcer. Dr. David J. Sandweiss, Editor-in-Chief, with the aid of seventy-seven contributors, has produced a monumental work of 790 pages. Few will read it from cover to cover; many will use it as a reference, for which purpose it should prove extremely valuable. The book is well printed. J. W. H.



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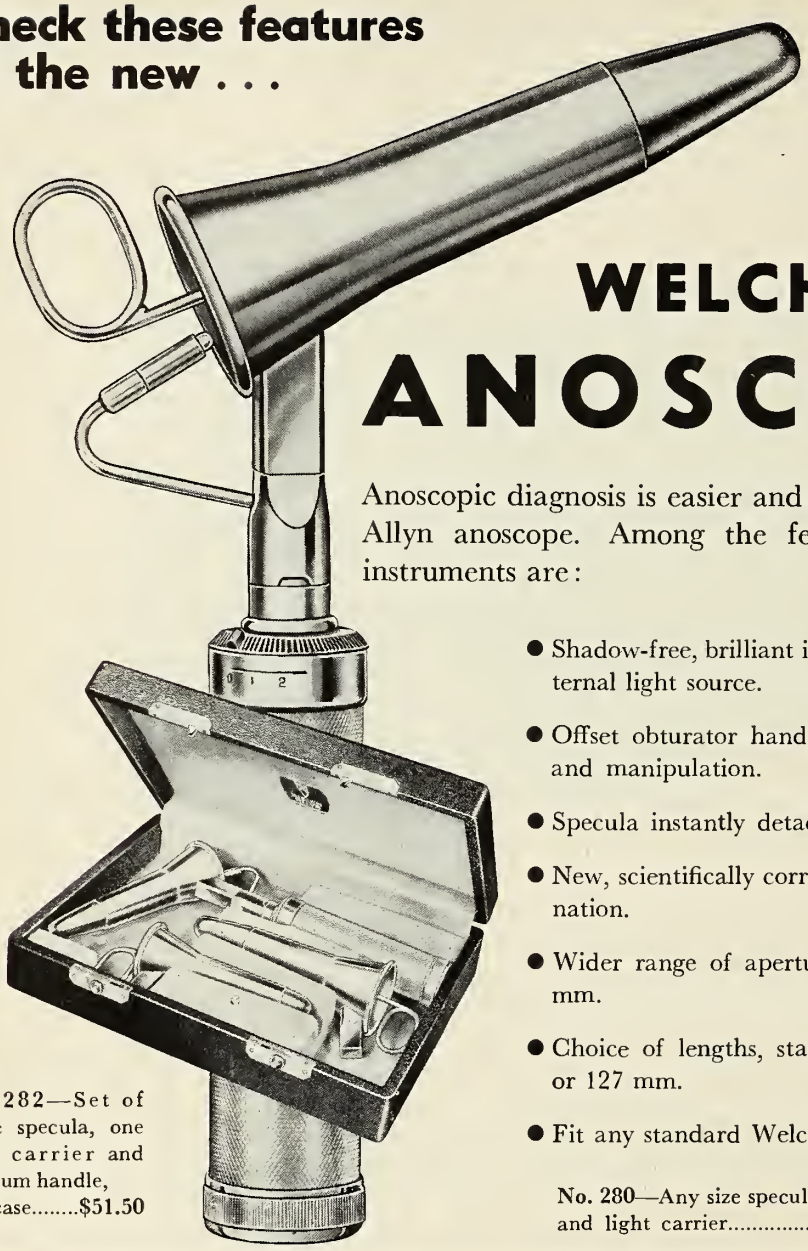
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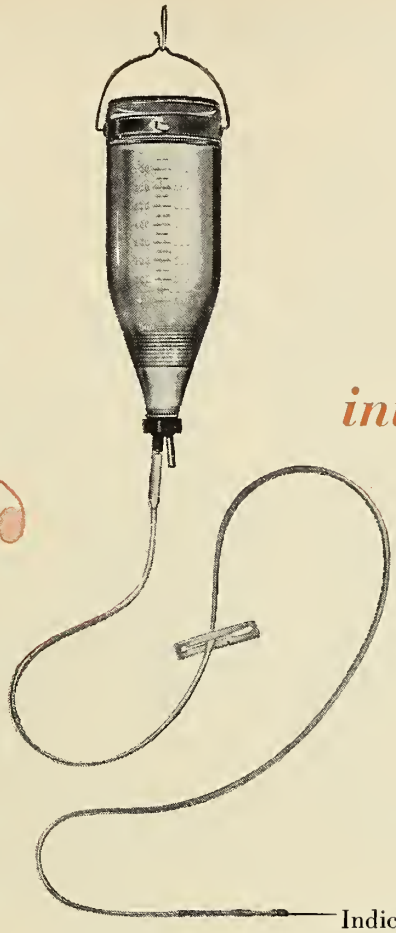
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All Children Can Benefit from *this* Protective Hot Drink at Breakfast

In its widely distributed leaflet No. 268, "Eat a Good Breakfast," the U. S. Dept. of Agriculture states: "Summer or winter, there's something hot, as a rule, in a good breakfast.... Something hot is cheering and tones up the whole digestive route."

The problem of encouraging children to eat an adequately protective breakfast finds easier solution when Ovaltine in hot milk is recommended as a breakfast beverage. Many children clamor for a hot drink at the morning meal, and hot Ovaltine is the right kind of drink to recommend.

A cup of hot Ovaltine makes an excellent contribution of virtually all essential nutrients, adding substantially to the nutritional start for the day. It also serves in a gustatory capacity by enhancing the appeal of breakfast and making other foods more inviting.

The nutrient contribution made by a cup of Ovaltine is apparent from the table below. Note the wealth of essentials added to the nutritional intake by making the simple recommendation of adding a cup of hot Ovaltine to the child's breakfast.

THE WANDER COMPANY, 360 N. MICHIGAN AVE., CHICAGO 1, ILLINOIS



Ovaltine

Here are the nutrients that a cupful of hot Ovaltine, made of ½ oz. of Ovaltine and 8 fl. oz. af whole milk,*provides:

PROTEIN	10.5 Gm.	IRON	4 mg.	NIACIN	2.3 mg.
FAT	10.5 Gm.	COPPER	0.2 mg.	VITAMIN C	10 mg.
CARBOHYDRATE	22 Gm.	VITAMIN A	1000 I.U.	VITAMIN D	140 I.U.
CALCIUM	370 mg.	VITAMIN B_1	0.39 mg.	CALORIES	225
PHOSPHORUS	315 mg.	RIBOFLAVIN	0.7 mg.		

*Based on average reported values for milk.

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Neurologists and Neurosurgeons
often choose

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It readily passes into the cerebrospinal fluid, the presence of meningitis making little difference in its concentration.

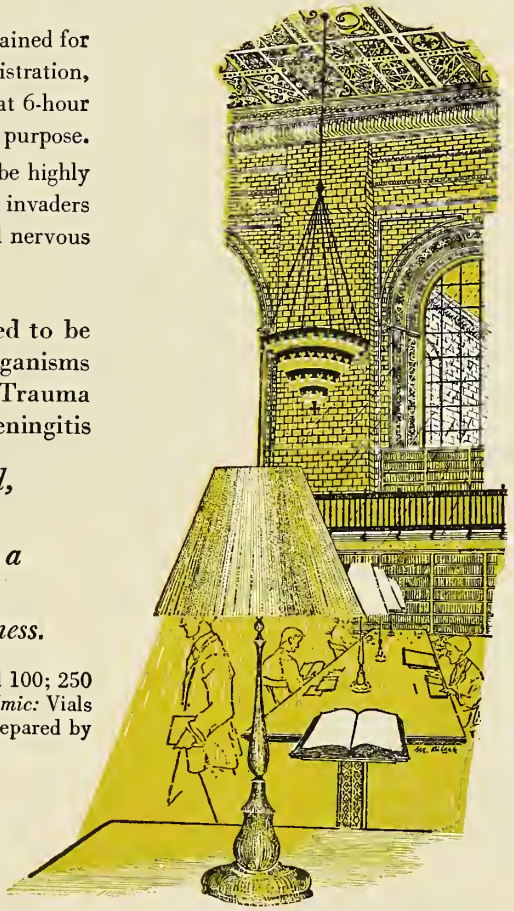
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Aureomycin has been reported to be effective against susceptible organisms in: Brain Abscess • Cranial Trauma Infection • Encephalitis • Meningitis

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These are some of the unique values of buttermilk in combatting certain intestinal derangements among infants and adults, in relieving constipation and alleviating stomach disorders. For buttermilk of uniformly high quality, made with pasteurized milk, may we suggest Sealtest Buttermilk?

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One investigator notes: "We have not been impressed by the severity or frequency of side-effects . . . The side-effects due to excessive adrenal cortical hormone disappeared when the hormonal agent was discontinued."

NORCROSS, B. M., *N. Y. State J. Med.* **51**: 2356, Oct. 15, 1951.

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MICHIGAN STATE MEDICAL SOCIETY ANNUAL SESSION
DETROIT—September 24-25-26, 1952

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A list of known medical meetings and clinic days, sponsored by county medical societies and other physicians' groups in Michigan, follows:

1952

March 12-14	MICHIGAN CLINICAL INSTITUTE Detroit
March 14	Michigan Heart Day (part of M.C.I.) Detroit
Spring	MSMS Postgraduate Extramural Courses State-wide
April 3	Jackson County Medical Society's Clinic Day Jackson
April 9	Genesee County Medical Society's Cancer Day Flint
April	Highland Park Physicians Club Clinic Highland Park
May 1	Ingham County Medical Society's Clinic Day Lansing
May 7	Third Michigan Industrial Health Day Flint
May 14	Wayne University Medical Alumni Clinic Day and Reunion.....Detroit
June 9-13	AMA Annual Session.....Chicago
July 24-25	Annual Coller-Penberthy Medical Surgical Conference.....Traverse City
July 24-26	Conference on Housing and Living Arrangements for Older People....Ann Arbor
August	Third Annual Clinic, Central Michigan Committee, ACS Michigan Committee on Trauma, plus Michigan National Guard Medical Personnel, and Michigan Society of North Central Counties Grayling
Sept. 24-26	MICHIGAN STATE MEDICAL SOCIETY ANNUAL SESSION.....Detroit
Oct. 8	Clara Elizabeth Fund—Genesee County Medical Society—Lectures of 1952...Flint
Oct. 9-10	Fourth Michigan Cancer Conference Kellogg Center, East Lansing
Autumn	MSMS Postgraduate Extramural Courses State-wide

Additions to this list of meetings are invited by the Editor of JMSMS, in order to make this monthly announcement complete and accurate.

MEDICAL CIVIL DEFENSE NIGHT —MARCH 12, 1952

Norvin C. Kiefer, M.D., Washington, D. C., Director of Health and Special Weapons Defense Division, FCDA, will speak on "The Physician in Civil Defense" at the Medical Civil Defense meeting, Grand Ballroom, Sheraton-Cadillac Hotel, Wednesday, March 12, 1952, 8:00 p.m.

This medical civil defense meeting is sponsored by the Wayne County Medical Society, the Michigan Clinical Institute, and the Michigan State Medical Society.

All members of the Michigan State Medical Society and their wives and guests are cordially invited to hear the interesting presentation of Doctor Kiefer on a subject of intense importance to all residents, especially of critical areas.

MICHIGAN M.D.s PAY AMA DUES

The high percentage of American Medical Association dues paid by Michigan State Medical Society members in 1951 is a matter that offers more than passing interest. Not too long ago, Oscar Ewing, well publicized Administrator of the Federal Security Agency, offered the gloomy prediction, in one of his periodic raves, that the medical profession would not support the American Medical Association by payment of the annual dues levied two years ago.

Michigan's medical men chalked up a 96 per cent record in the payment of 1951 AMA dues!

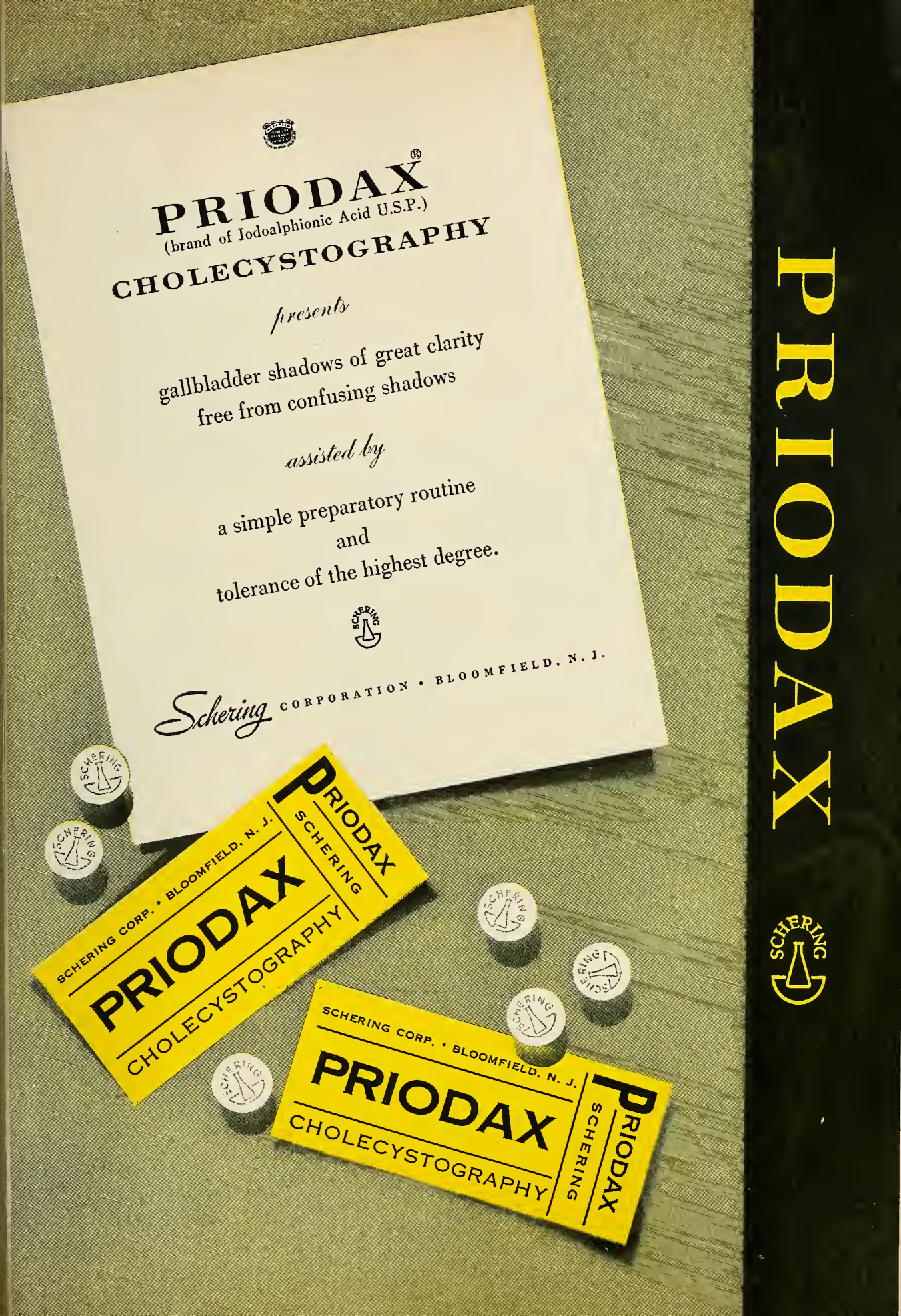
The Michigan medical profession, by its splendid record of 1951, gallantly and magnificently repudiates the sour predictions of Mr. Ewing.

"HESS REPORT" CLARIFIED BY AMA

The AMA Clinical Session in Los Angeles had a total registration of 10,071, including 4419 Doctors of Medicine.

Highlights of the House of Delegates Proceed-

(Continued on Page 158)


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"HESS REPORT" CLARIFIED BY AMA

(Continued from Page 156)

ings included the following clarification of the "Hess Reports," covering the complex and controversial problem of the relation of physicians and hospitals. By action at the Los Angeles meeting, the House of Delegates issued "Guides for Conduct of Physicians in Relationships with Institutions" which supersede the earlier "Hess Reports." These are its significant passages:

1. A physician should not dispose of his professional attainments or services to any hospital, corporation or lay body under terms or conditions which permit the sale of the services of that physician by such agency for a fee.

2. Where a hospital is not selling the services of a physician, the financial arrangement if any between the hospital and the physician properly may be placed on any mutually satisfactory basis. Thus, any hospital, corporation or other lay body may properly remunerate a physician for teaching, research, charitable services or the like.

3. The contract provisions of hospital service plans should be limited exclusively to hospital services. Medical service plans should limit benefits to medical services. The House declared radiology, anesthesiology, pathology and physiatry to be an integral part of the practice of medicine, and thus constitute *insurable medical* services, *not hospital* services. Blue Cross and Blue Shield were urged to implement this decision.

4. The lay hospital management should give proper consideration to the advice of the professional staff on financial problems of the hospital.

5. The pathologist, roentgenologist, anesthesiologist and physiatrist, as well as other staff members, should have equal rights, privileges and standing as active staff members.

6. Controversies between physicians and hospitals which cannot be settled locally should be submitted to county and state society hospital relations committees and to the AMA Judicial Council, in that order, for advice and recommendation.

In contrast to the "Hess Reports," the new "Guide" makes no mention of disciplinary action against a hospital which persists in keeping an "unethical" physician on its staff. At the same time, the "Guide" makes it clear that the decision as to the ethical or unethical nature of contract practice must be based on its ultimate effect on the public, and that this relationship might vary according to differences in many sections of the country.

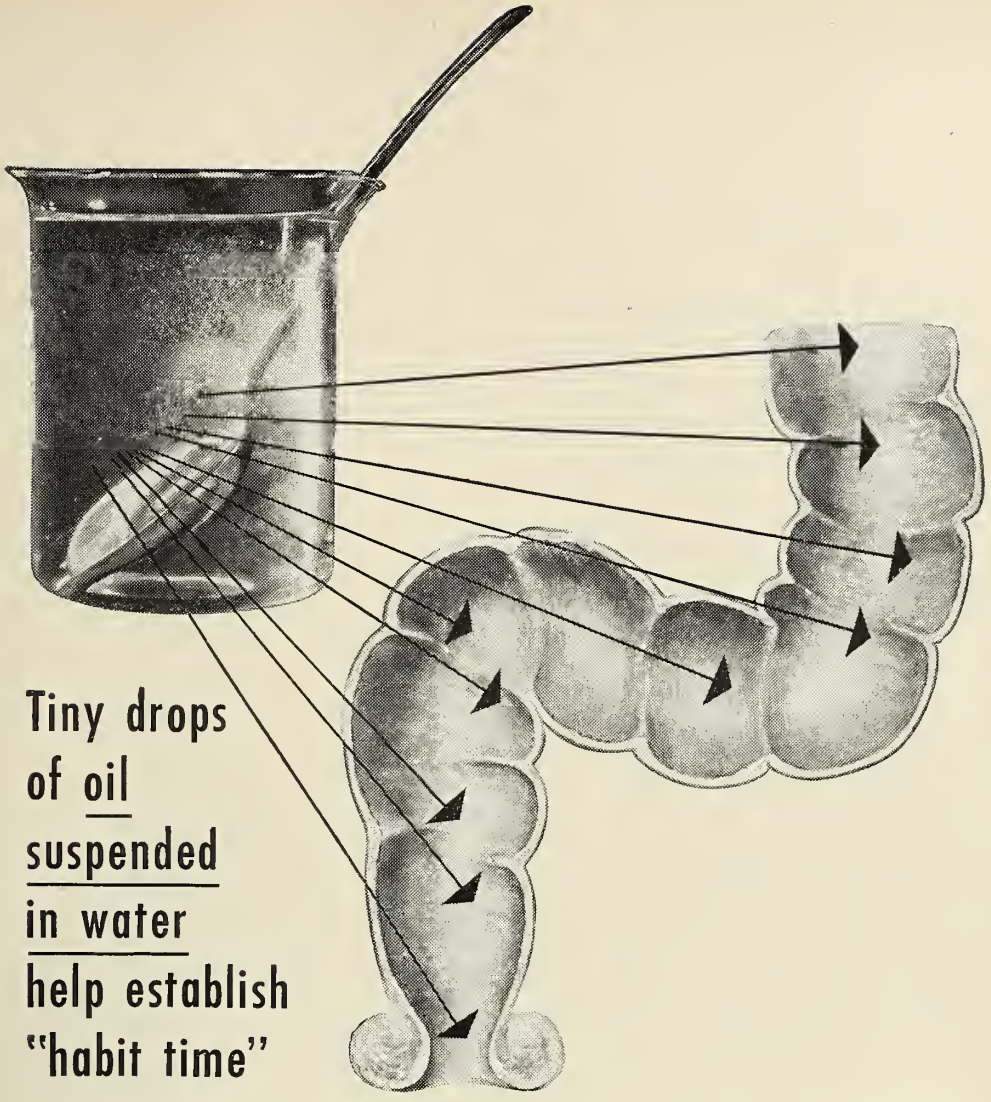
HIGHLIGHTS OF EXECUTIVE COMMITTEE OF THE COUNCIL

Meeting of December 13, 1951

Seventy-two items were presented to the Executive Committee on December 13. Chief in importance were:

- Financial reports were presented and the high percentage of AMA dues paid by Michigan State Medical Society members was noted—it was requested that this fact be placed before The Council at its January Annual Session. Bills payable were presented and approved for payment.
- The Committee of Seven to Study Basic Science Act was maintained on a "stand-by basis" and the 1951 House of Delegates' instructions concerning proposed amendments to the Basic Science Act were referred to the MSMS Legislative Committee for implementation.
- Committeee reports—the following were given consideration: (a) Mental Health Committee, meeting of November 11 (including "Suggested Plan for Department of Mental Health as developed by the Michigan State Medical Society," which Plan was approved by the Executive Committee of The Council, with commendation to the Mental Hygiene Committee for a job well done); (b) Beaumont Memorial Restoration Committee, meeting of November 25; (c) Maternal Health Committee, meeting of December 4; (d) Postgraduate Medical Education Committee, meeting of December 6; (e) Committee on Study of Medical Practice Act (MSMS representatives to), meeting of December 13; and (f) Advisory Committee to Michigan Social Welfare Commission, meeting of December 7.
- Committee appointments. The President appointed John G. Slevin, M.D., Detroit, to the Legislative Committee; E. C. Long, M.D., Detroit, and C. J. Poppen, M.D., Lansing, to the Rheumatic Fever Control Committee. The Chairman of The Council appointed Harry J. Loynd, Detroit, and Lawrence Reynolds, M.D., Detroit, to the Beaumont Memorial Restoration Committee. Also, Max L. Lichter, M.D., Melvindale, to the Committee on Atomic and Allied Procedures and H. Marvin Pollard, M.D., Ann Arbor, to the Committee on Study of "Little Hoover" Commission Report, and J. A. Witter, M.D., Detroit, as MSMS representative to the Committee on Careers in Nursing (a Committee of the Michigan Nursing Center Association). These appointments were confirmed by the Executive Committee of The Council.
- Occasional "profiles" in THE JOURNAL of doctors who have done outstanding work in behalf of Michigan Medicine were approved, as per

(Continued on Page 160)



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HIGHLIGHTS OF EXECUTIVE COMMITTEE OF THE COUNCIL

(Continued from Page 158)

the suggestion of Editor Wilfrid Haughey, M.D.

- Following the suggestion of AMA Delegate J. S. DeTar, M.D., Milan, The Council Chairman appointed members of the MSMS Geriatrics Committee as official representatives to attend the 1952 Conference on Handicapped Workers Over Forty. The Council Chairman also announced that, at the invitation of Dr. Wilma Donahue, Secretary of the Conference, the following MSMS representatives are nominated on the Planning Committee for the 1952 Conference: R. L. Novy, M.D., Detroit, L. Fernald Foster, M.D., Bay City, J. S. DeTar, M.D., Milan, Wilfrid Haughey, M.D., Battle Creek, and William Bromme, M.D., Detroit. These appointments were confirmed by the Executive Committee of The Council.

- Max R. Burnell, M.D., Detroit, Chairman of the MSMS Industrial Health Committee, was appointed as MSMS representative to the AMA Industrial Health Conference to be held in Pittsburgh, January 18-19, 1952.

- Report was made that the November, 1951, Bulletin of the Wayne County Academy of General Practice included the guest editorial of The Council of the Michigan State Medical Society signed by its Chairman, following instruction of The Council given on September 23, 1951: "That a letter be written by The Council, to be signed by the Chairman of The Council."

- The Legal Counsel's report included written opinions on (a) Rules of evidence; and (b) Law re indication of professional status on prescriptions and other documents of medical practice.

- Rheumatic Fever Coordinator Leon DeVel, M.D., presented a detailed report on progress and activity in each of the Rheumatic Fever Control Centers of Michigan; Dr. DeVel was requested to provide a summary of his report for the County Societies Committee of The Council, meeting on January 24.

- Proposed hospital in South Oakland County. A resolution from the Oakland County Medical Society, adopted December 5, 1951, re two concepts for the operation of the proposed hospital in South Oakland County was presented and thoroughly discussed. The general principles enunciated during the discussion were developed into a resolution which was adopted by the Executive Committee and forwarded to the Oakland County Medical Society.

- Three problems of mutual interest were presented by State Health Commissioner A. E. Heustis, M.D., and discussed by members of the Executive Committee of The Council.

THREAT OF SOCIAL SECURITY

Both the life insurance industry and the medical profession have been blithely indifferent to the threat of Social Security. They have failed to see that this law is a cleverly devised scheme to socialize the United States. The purpose and meaning of the law have been concealed. Ultimate costs have been played down; benefits have been maximized and glorified.

Physicians, farmers, undertakers, and a few other favored groups won a temporary reprieve when the 1950 amendments were passed. It has been next to impossible to persuade individual physicians or organized medicine to become interested in the entire Social Security program and its background.

Five members of Congress now propose to enslave another 11 million persons who are presently free from the Social Security yoke. Senators Herbert H. Lehman (D., N.Y.), James E. Murray (D., Mont.), Hubert H. Humphrey (D., Minn.), Representatives John Dingell (D., Mich.), and Franklin D. Roosevelt (D., N.Y.) plan to introduce a bill extending coverage and increasing cash benefits. Persons who would be dragooned into the system would include 4,500,000 farmers, 1,400,000 farm workers, 1,300,000 domestic workers, and 30,000 professional workers—engineers and architects. Will physicians be far behind?—The Shearon Legislative Service, January 10, 1952.

PRESIDENT'S STATE OF THE UNION MESSAGE

The President, on January 9, read to a joint session of the House and Senate a nine-page State of the Union message. Following are quotations pertaining to medical legislation:

"I think everybody knows that social insurance and better schools and health services are not frills, but necessities in helping all Americans to be useful and productive citizens, who can contribute their full share in the national effort to protect and advance our way of life.

(Continued on Page 162)



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PRESIDENT'S STATE OF THE UNION MESSAGE

(Continued from Page 160)

"We urgently need to train more doctors and other health personnel, through aid to medical education. We also urgently need to expand the basic public health services in our home communities—especially in defense areas. The Congress should go ahead with these two measures immediately.

"I have set up an impartial commission to make a thorough study of the Nation's health needs. One of the things this commission is looking into is how to bring the cost of modern medical care within the reach of all our people. I have repeatedly recommended national health insurance as the best way to do this. So far as I know, it is still the best way. If there are any better answers, I hope this commission will find them. But of one thing I am sure: something must be done—and be done soon."

Meanwhile, the Commission has started on its task, under the direction of Dr. Paul Magnuson. At the group's first meeting, Dr. Magnuson announced that the Commission staff would be supervised by Dr. H. A. Press, who was closely associated with Dr. Magnuson when the latter was head of the Veterans Administration's Department of Medicine and Surgery. Dr. Press is taking a leave of absence from the Veterans Administration, where he has been serving as Director of Program Analysis in the medical department. Several other staff appointments will be announced shortly. Although the survey originally was scheduled for completion in about a year, Dr. Magnuson says he now thinks more time may be needed. He expects shortly to announce appointment of another physician to the Commission to fill the place left vacant by the resignation of Dr. Gunnar Gundersen, AMA Trustee. The Commission includes labor, farm, and consumer members, as well as representatives of the health professions.

FRANK'S BOYS WIN DEBATE

Frank G. Dickinson, director of the AMA Bureau of Medical Economic Research, coached two "boys" on a debating team who took the negative side of the subject: "Resolved: That this House recognize the need for a free National Health Service."

The affirmative side was taken by two young students from Britain, members of the Oxford University debating team.

A great deal of literature and statistics was sent by both Dr. Dickinson and the AMA Council on Medical Service to Murdo, the Robber, and Bill, the Bad Check Passer. They were members of the debating team of the Norfolk State Prison Colony at Norfolk, Mass.

The two teams debated the subject before an audience of 600. The judges were former Governor William S. Flynn of Rhode Island, Justice Harold Williams of the Massachusetts Supreme Court, and Dean Erwin N. Griswold of the Harvard Law School.

The judges' unanimous decision was a victory for the Norfolk prison team.

In a "letter of appreciation" to Dr. Dickinson later, Bill, the Bad Check Passer, said that this was the first time the British team had been defeated in fifty-two debates in which it had participated throughout the eastern part of the United States. In most of the debates, the free national health service subject was discussed. After the prison debate the audience voted, too. The vote was four to one against.

Bill, the Bad Check Passer, said he thought he clinched the decision of the judges with:

"Guests of Norfolk, voluntary and involuntary, a free national health service will not make medical service better, but worse. The neurotics and malingerers will swamp our doctors and make it impossible for them to tend the really sick. I have been an unwilling native in a socialist Utopia for some time, and I know it will not work. . . . This talk of free service is just political camouflage."

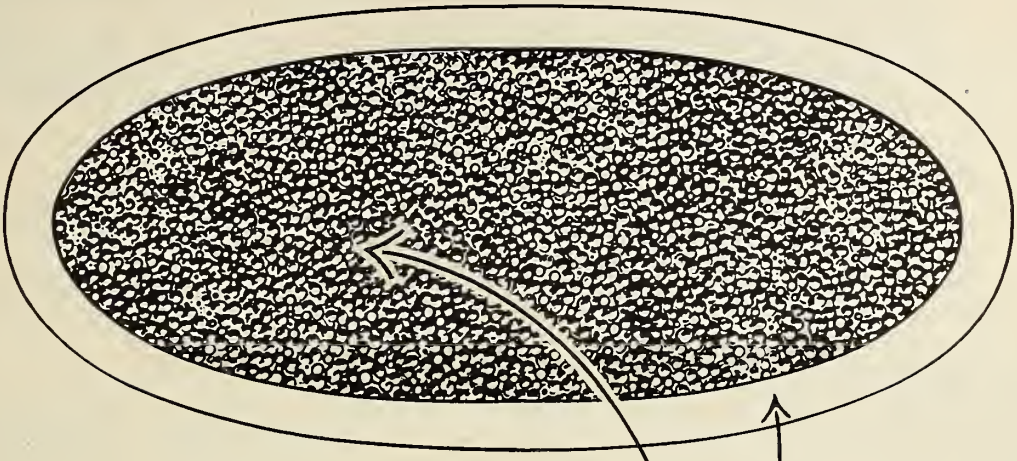
His argument apparently did the trick.

(The Editor heard this item announced over the radio, to the effect that the English boys had not lost a debate against the best in our colleges but went down to defeat against two prison inmates. Make your own deductions.)

WELFARE SPENDING

In 1932 the Federal Government spent $4.4 million on public charity and related programs. Combined expenditures by Federal, State, and local governments for public aid that year were $207.6 million. In 1950, less than two decades later, in a period of full employment, high wages, and seeming prosperity, the Federal Government spent $6,691.9 million and the combined total for Federal, State, and local governments for Social

(Continued on Page 164)



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The Easter Seal Appeal

Next month, between March 13 and April 13, 29 million American homes will receive through the mails a gaily colored sheet of Easter Seals. Accompanying these bright symbols of hope will be a letter asking support for one of our nation's most important voluntary health and welfare organizations.

It is a cause in which the doctors of medicine of this nation have both a keen interest and a large stake.

Their interest stems from the fact that thousands of medical practitioners in all the states, the District of Columbia, Alaska, Hawaii and Puerto Rico, participate in the work being done by the National Society for Crippled Children and Adults and its 2,000 affiliates—the Easter Seal societies—like the Michigan Society for Crippled Children and Adults, Inc. Since its founding in 1921, literally hundreds of M.D.s have been and are now actively working with these National Society affiliates as advisors, counselors and consultants.

As a matter of fact, planning and development of Easter Seal programs for crippled children are done at the national level in close co-operation with and under the direction of the appointed liaison officers of the American Medical Association, medical specialty groups and other allied professional organizations. Similarly, at the state and local levels, advisory committees and councils composed of physicians, educators and other professionally trained persons guide service programs. Just one instance of this is apparent in the fact that 492 pediatricians—representing only one specialty field—are assisting the programs of state and local crippled children's societies.

The doctors' stake in this great nationwide network of facilities and services is twofold. It is through the more than 500 specific facilities maintained by the Easter Seal societies and through the services of more than 2,000 professionally trained persons such as therapists, psychologists, medical social workers and educators they employ that doctors find the treatment and training for crippled children which implement their own efforts.

Of significance to American doctors, also, is the fact that this cause is a great voluntary effort, representing the American people's way of providing help for those who are unable to obtain it for themselves. It is a cause which demonstrates dramatically the sense of individual responsibility for one's neighbor. Last year this help was extended to 228,000 crippled children and adults.

Because this is a voluntary effort, the major source of support for these services is the American people themselves. The annual Easter Seal appeal began in 1934 and today has the support of millions of small donors throughout the nation, as opposed to large corporate contributors. As we mentioned, in 1952 Easter Seal letters will go to 29 million homes. That will be the only approach, no door-to-door solicitation or in-plant solicitation being made. Today, more than ever, this appeal needs the support of the medical profession.

Funds are needed this year to support a $10 million program. In a period of rising costs, it is obvious that services for crippled children, always expensive, will cost more than ever before. Less than $10 million will mean curtailment of existing services.

Doctors of Medicine can share the leadership in seeing that this 1952 Easter Seal appeal is successful, thus once more showing their fellow Americans that where there is a need, the doctor will help find a way.

Each kind of *bird*, for some reason yet unknown, tends to build a nest different from every other kind.

WELFARE SPENDING

(Continued from Page 162)

Security and related programs was $13,064.5 million—over $13 billion!

In other words, we now spend each year 63 times as much for public charity and related programs as we did in the depth of the Great Depression. The Federal Government is spending over 1,500 times as much. If we spend in such a wild fashion during an era of prosperity, what would the cost be during a depression?—W. Rulon Williamson, a distinguished actuary, at the Life Insurance Conference, White Sulphur Springs, June 14-16, 1951.

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Let the Patient Beware

"A patient who seeks treatment from an osteopath for the cure or alleviation of his condition is charged with knowledge of the fact that the osteopath would follow the methods and practices observed in the osteopathic system of treatment, and is not in a position to complain that the methods and standards of practice customarily observed by another school of medicine were not followed."

This is part of the syllabus in the case of Bryant v. Biggs, decided by the Michigan Supreme Court on September 5, 1951 (Mich. 331-64). Its implications are obvious, chiefly that the patient "is not in a position to complain" if he receives treatment from an osteopath which he feels is not up to the standards of medical practice.

The following are additional extracts from the Bryant v. Biggs syllabus:

"The implied contract between a patient and a surgeon requires the latter to use the degree of diligence and skill ordinarily exercised by the average of the members of the profession in the same locality or in similar localities, with due consideration to the state of the profession at the time."

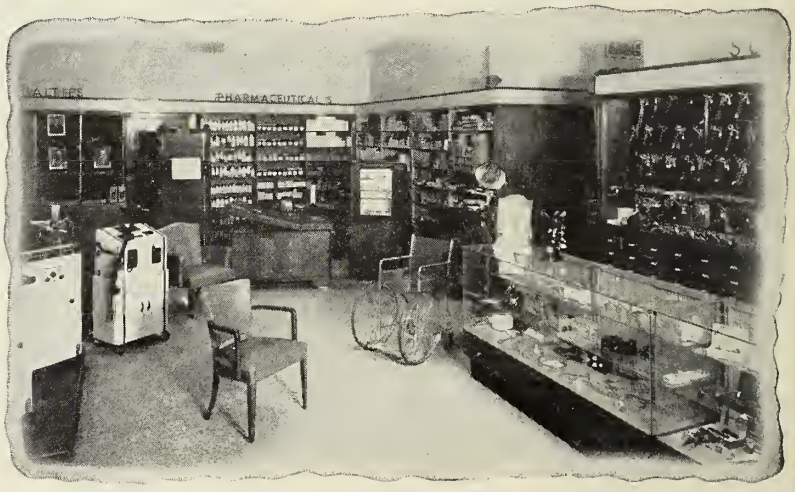
"An osteopathic surgeon has the duty to use that degree of care and skill in the handling of a thyroid condition in a patient, and in the treatment given the patient, that is customarily used in the community or similar communities by ordinary or average practitioners of osteopathy and is not held to the observance of standards of practice or methods of practice customarily observed by practitioners belonging to other schools devoted to the cure, alleviation, and treatment of human ailments and diseases."

A second damage suit against an osteopath (Pedler v. Emmerson, Mich. 331-78), brought by a patient who erroneously believed the standards of practice of M.D.s and osteopaths were the same, also was decided by the Michigan Supreme Court on September 5, 1951, along the same lines as Bryant v. Biggs (above).

All patients should be informed concerning this *double* standard of practice, to obviate additional misunderstandings requiring Supreme Court determination.

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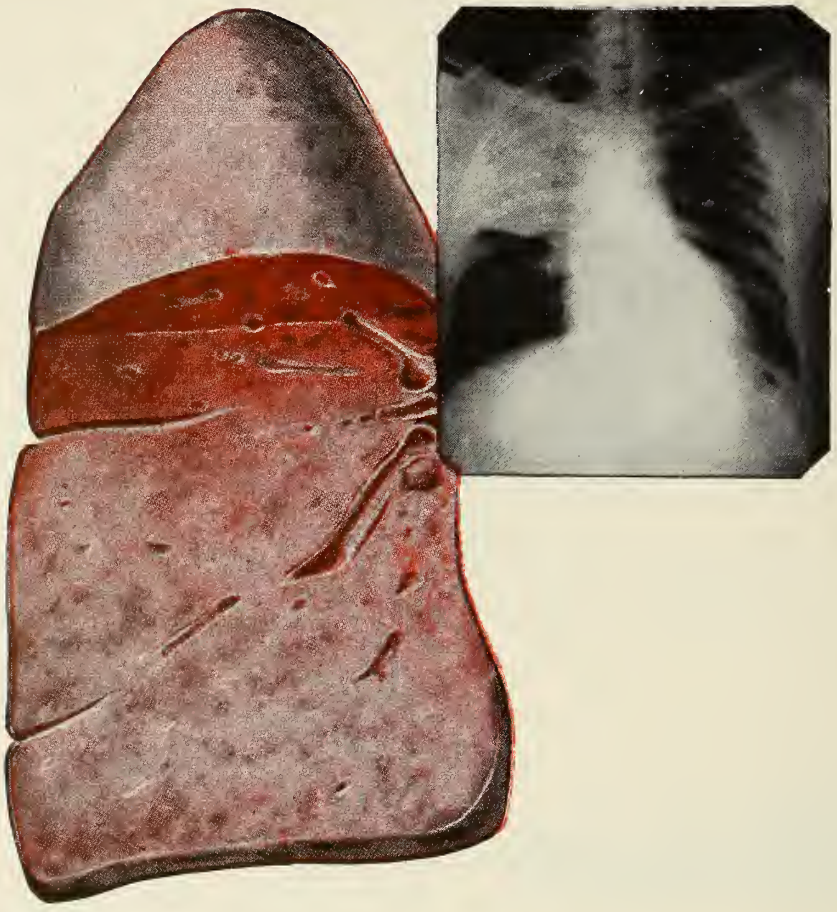
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Potterfield, T. G., and Starkweather, G. A.:
J. Philadelphia General Hosp. 2:6 (Jan.) 1951

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GRAM-POSITIVE BACTERIAL INFECTIONS

Lobar pneumonia • Mixed bacterial pneumonias
Bacteremia and septicemia
Acute follicular tonsillitis
Septic sore throat • Pharyngitis
Acute and chronic otitis media
Acute bronchitis • Laryngotracheitis
Tracheobronchitis • Sinusitis
Chronic bronchiectasis
Pulmonary infections associated with pancreatic insufficiency
Scarlet fever • Urinary tract infections
Acute and subacute purulent conjunctivitis
Acute catarrhal conjunctivitis
Chronic blepharoconjunctivitis not involving the meibomian gland
Abscesses • Cellulitis
Furunculosis • Impetigo
Infections secondary to Acne vulgaris
Erysipelas • Peritonitis

GRAM-NEGATIVE BACTERIAL INFECTIONS

Gonorrhea • Brucellosis
Bacteremia and septicemia
Friedländer's pneumonia
Mixed bacterial pneumonias
Pertussis • Diffuse bronchopneumonia
Post-partum endometritis • Granuloma inguinale
Dysentery • Urinary tract infections
Respiratory tract infections
Cellulitis • Peritonitis • Tularemia

SPIROCHETAL INFECTIONS

Syphilis • Yaws • Vincent's infection

RICKETTSIAL INFECTIONS

Epidemic typhus • Murine typhus
Scrub typhus • Rickettsialpox
Q fever • Rocky Mountain spotted fever

VIRAL INFECTIONS

Primary atypical pneumonia (virus pneumonia)
Lymphogranuloma venereum • Trachoma

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Cancer Comment

CANCER IN CHILDHOOD

Cancer in childhood is assuming greater importance and in Michigan now occupies second place as a cause of death from disease in the age group five to fourteen. It ranks fourth as a cause of death from disease in ages under five. These facts, often not appreciated by the public or medical profession, indicate that tumors, both benign and malignant, are taking a heavy toll of life among the younger age groups.

All tumors in childhood are dangerous irrespective of their location or histological character. So-called benign tumors may cause serious disability, deformity or death from their location, size, or interference with vital functions. Probably the most striking example of this type of tumor is the astrocytoma of the central nervous system.

The six principal sites of cancer in children are the bones, eyes, kidney, central nervous system, blood-forming and lymphoid tissues and the skin and its supporting structures. All physicians are familiar, or should be, with the symptoms of retinoblastomas, Wilms' tumors and the leukemias. Almost daily the newspapers carry reports of the presence of one or more of these types of cancer in some child in their communities so they are becoming commonplace news items.

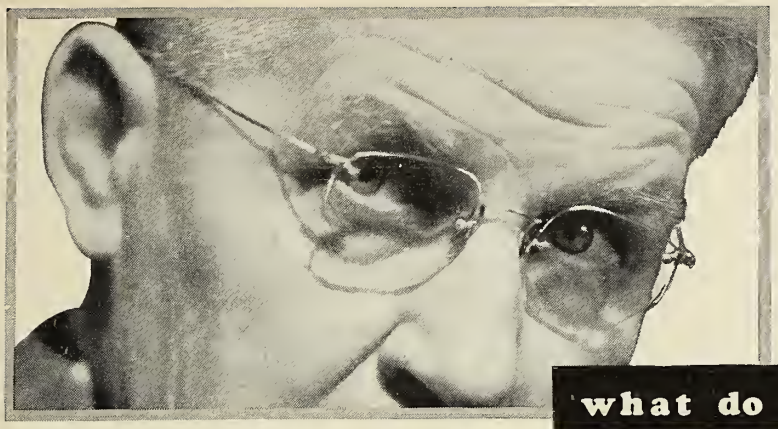
What is less appreciated by the public and medical profession are the danger signals of a central nervous system tumor in a growing child. Authorities in this field stress the emotional and personality changes that often direct attention to these patients and assist definitely in the diagnosis. In a child who changes from a well-behaved, studious, and co-operative individual to one of the opposite type or who complains of visual defects, headaches, or other symptoms incompatible with his former character, a central nervous system neoplasm should be strongly suspected and a definite diagnosis established before disciplinary measures are taken. The need for this appreciation of the child's condition applies to his class room teacher as well as to the family physician and is an added argument for requiring an understanding of fundamental cancer knowledge by all teachers in schools and colleges.

A favorable aspect of many types of childhood cancer is their accessibility for examination. With the exception of tumors of the central nervous system and some lymphomas, diagnosis often can be made on the physical examination alone. Thus, theoretically at least, many more such patients should be cured than is now the case.

It should be remembered that most childhood cancers differ as to location and structure from the forms most commonly seen in adults. Many of them develop more rapidly than do adult tumors and for this reason prompt diagnosis and treatment are imperative measures to save a life. There is a widely held belief that cancer in childhood is a more fatal disease than in adults but this is so only because many such cases are diagnosed late. In the very young, symptoms must be elicited objectively as the patient cannot help in describing his condition. A healthy suspicion of cancer in the mind of the physician, especially the pediatrician, when making his routine examination of children, particularly of those under ten years of age, often will pay handsome dividends in the discovery of early and curable neoplasms in those patients. It should be kept in mind that development of a tumor may antedate the possibility of a diagnosis by several months and so the early diagnosis becomes a relative possibility.

The public must realize that neoplasms constitute a real health hazard during childhood. The periodic examination during these ages should be regularly continued in the absence of obvious signs of illness.

Public health personnel also have a responsibility in this matter, largely through the lay education program. Parents should be made to see the necessity for regular examinations of their children and as the child advances through his education to the high school he should have sound health teaching in cancer control as it applies to himself. Such an educational program would enable the individual to face his later years much better equipped for protection against this disease than would be the case if his early cancer education had been neglected.



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Editorial Comment

SUSPICIOUS AUSPICES

Dr. Gunnar Gundersen of La Crosse, Wisconsin, is a former president of the Wisconsin State Medical Society and a regent of the University of Wisconsin. He is better acquainted than most with the convictions of a majority of the 15 members of the commission which President Truman has appointed to study the "health needs of the nation."

Dr. Gundersen has declined to serve on the commission. He terms it a "masquerade," packed with advocates of the President's compulsory health insurance scheme.

Honestly and fairly conducted, such a survey could be useful in suggesting policies to improve medical training, to correlate public and private health services, to get more, better and less expensive care of the sick.

Precedent, however, supports Dr. Gundersen's conclusion that Mr. Truman's interest in health is largely confined to the convalescence of his political machine. Under his auspices, the findings of the commission are discounted in advance, on the theory that he is far too cagey to risk a report that might be critical of one of his favorite vote-getting appeals.—*Chicago Daily News,* January 2, 1952.

CAVEAT EMPTOR

Treatment by a practitioner of one school of medicine cannot be adjudged malpractice by the standards of any other school of medicine. The decisions in two cases* recently reviewed by the Michigan Supreme Court emphasize this point, and, in effect, put the public on notice to be wary, since *there is more than one standard of medical practice.*

Standards for the practice of the healing arts have been established and improved by doctors of medicine for many years and have been widely publicized and accepted. The entry of other systems of practice with their claims to equality and even superiority and their not too clearly defined methods of practice is responsible for the confusion now disclosed by the Court.

Patients who select *any* healer, assuming that all have the same standards, belatedly discover, when they find themselves aggrieved, that what they thought was the real article was something of foreign quality based on a different set of standards.

Illustrative of this rude awakening are the two cases referred to above: one, in which the widow of a patient subjected to thyroidectomy by an osteopath claimed malpractice and was denied damages because she wrongly assumed that the standards of the allopathic school applied. The other, involving an injury to a hand in which it was claimed the defendant osteopath failed to suture cut tendons, with resultant disability, was also denied redress for the same reason.

Among the several reasons leading to the decisions is one which puts the blame squarely on the shoulders of the patient, to wit: "a patient who seeks treatment from an osteopath for the cure or alleviation of his condition is charged with knowledge of the fact that the osteopath would follow the methods and practice observed in the osteopathic system of treatment, and is not in a position to complain that the methods and standards of practice customarily observed by another school of medicine were not followed."

With no uniform set of standards for the various systems of practice now legalized by the State, it is incumbent on the patient to inform himself as to the differences that exist, since he alone is responsible for his choice. And the Court has in effect wisely cautioned: let the buyer beware.—W. S. Reveno in *Detroit Medical News,* December 31, 1951.

*Mich. Reports, 331:64-81, Oct. 4, 1951.

ANOTHER CLOAK

The refusal of Dr. Gunnar Gundersen to serve on President Truman's commission to study the Nation's health needs is not surprising. Like Judge Thomas F. Murphy, who refused to carry the whitewash pail for Mr. Truman in "cleaning up" corruption in the Government, Dr. Gundersen, a former president of the Wisconsin State Medical Society, declines to take part in what he calls a "masquerade." The commission, Gundersen intimates, is weighted with advocates of the Truman-Ewing plan for compulsory health insurance, as a forerunner of socialized medicine.

An honest inquiry into the state of our public health by competent and unbiased medical men would be one thing. An "investigation" for the purpose of stimulating the flagging interest in Ewingism is quite another. A man of Dr. Gundersen's personal integrity and professional ethics would hardly lend the authority of his name and reputation to any such political ruse.—*The Detroit Free Press,* January 3, 1952.

Most ovarian tumors are resistant to irradiation, and it should never be employed as a substitute for surgery.

* * *

Routine pelvic examination at frequent intervals seems to offer the only solution to the problem of early diagnosis of ovarian malignancy.

frozen

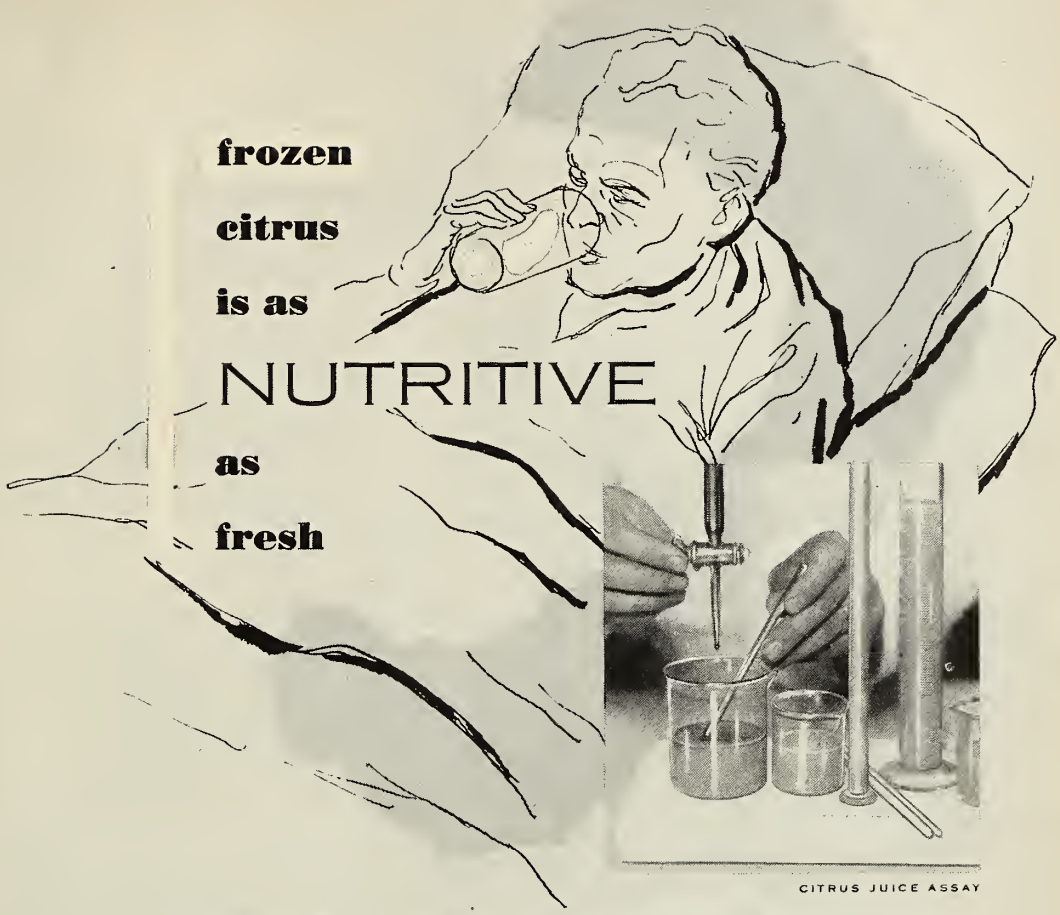
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**J.A.M.A. 146:35, 1951.*

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Michigan Clinical Institute Presents 1952 Heart Day Friday, March 14



S. A. Levine, M.D.

In keeping with its policy of bringing the latest scientific information concerning cardiovascular diseases to Michigan's Doctors of Medicine, the Michigan Heart Association will once again present its Annual Heart Day in Detroit on Friday, March 14, 1952 (in conjunction with the Michigan Clinical Institute, March 12-14).

Headlining the Third Annual Heart Day will be Samuel A. Levine, M.D., of Boston, Massachusetts, who is an internationally recognized authority in the field of heart disease. In addition to serving on the staff of the Peter Bent Brigham Hospital in Boston, Dr. Levine is also Clinical Professor of Medicine at the Harvard Medical School.

A preliminary advance digest of Dr. Levine's paper, "The Importance of the History and Physical Examination in the Diagnosis of Heart Disease," indicates that many valuable practical aids in cardiac diagnosis will be offered. Particular emphasis is given to those aids available to all practicing physicians which require none of the elaborate and often expensive laboratory procedures that are necessary only in less common cases. Dr. Levine's paper will be presented at the noonday luncheon on Heart Day.

In addition to Dr. Levine's paper, this year's Heart Day program will also feature the presentation of six scientific papers concerned with heart research work being conducted in Michigan, by Michigan Doctors of Medicine, under the financial sponsorship of the Michigan Heart Association. The Heart Day speakers, including a brief summary of their research projects, are as follows:

1. Franklin D. Johnston, M.D., University Hospital, Ann Arbor

 "The Proper Place of the Electrocardiogram in Clinical Practice."

Studies on low frequency vibrations over the Precordium have been carried out in this project. These vibrations are of clinical importance because many of them can be seen or felt by any physician who is aware of their existence. Most of the vibrations are inaudible because the frequency is below the audible range. The study of these vibrations is important to the Doctor of Medicine since their recognition may help in the diagnosis and in estimating the outlook of heart patients.

2. Conrad R. Lam, M.D., Henry Ford Hospital, Detroit

 "The Surgical Treatment of Mitral Stenosis"

Funds for this project were appropriated so that research in the vital and important field of heart surgery could be continued.

Methods of transplanting heart valves, methods of "splicing" sections of blood vessels, methods of permanently closing defects in the walls of the chambers of the heart are being developed and perfected in this project. The perfection of these techniques will eventually permit more successful operations on the heart and blood vessels.

3. Gordon B. Myers, M.D., Wayne University College of Medicine, Detroit

 "Modern Treatment of Congestive Heart Failure"

This project is a continuation of previous work in cardiorenal research. It is concerned with the effectiveness of using an extremely low salt content in the diet of patients who do not readily respond to the usual methods of treatment of dropsy due to heart failure. Other types of salts, such as calcium, magnesium, and potassium, are also being measured since it is becoming evident that they too play a part in the causation and treatment of dropsy.

4. Manes S. Hecht, M.D., Children's Hospital, Detroit

 "Current Therapy of Rheumatic Fever in Children"

Funds have been provided for this project so that research in the treatment of rheumatic fever and rheumatic heart disease through the application of ACTH and cortisone could be undertaken. A total of 28 cases, in the acute stage, have been studied and a follow-up on each patient is now being conducted to determine whether these hormones will prevent the development of rheumatic heart disease.

5. Sibley W. Hoobler, M.D., University Hospital, Ann Arbor

 "Drug Therapy of Hypertension"

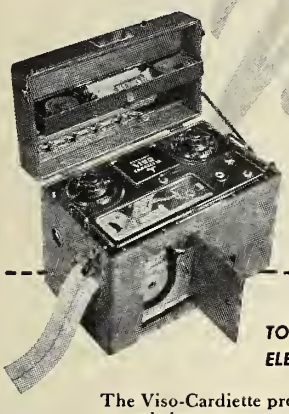
Grant was made to conduct research into the problems of hypertension and uremic poisoning. An "artificial" kidney has been constructed at the University and it has been used successfully in the treatment of patients who have temporary kidney shutdown. In addition to treatment, the kidney is being used to investigate and measure certain pressor substances present in the blood stream of patients with malignant hypertension. Refinements of the technique for more accurately measuring these pressor substances have been developed during the past year. The exact measurement and isolation of these pressor substances is necessary to the ultimate understanding and alleviation of high blood pressure.

6. M. S. Chambers, M.D., Hurley Hospital, Flint

 Panel Discussion on "The Flicker Photometer"

The funds for this project were made available late in 1950. The project is concerned with evaluating the usefulness of the flicker photometer machine as a method of detecting early evidence of diseases of the heart or blood vessels caused by hardening of the arteries.

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DIRECT WRITER

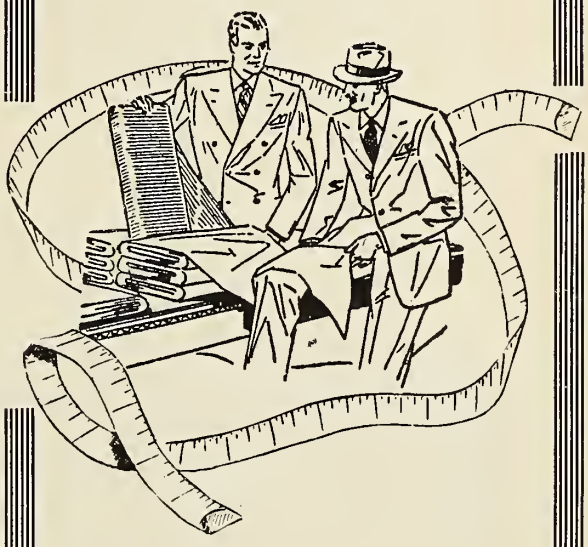


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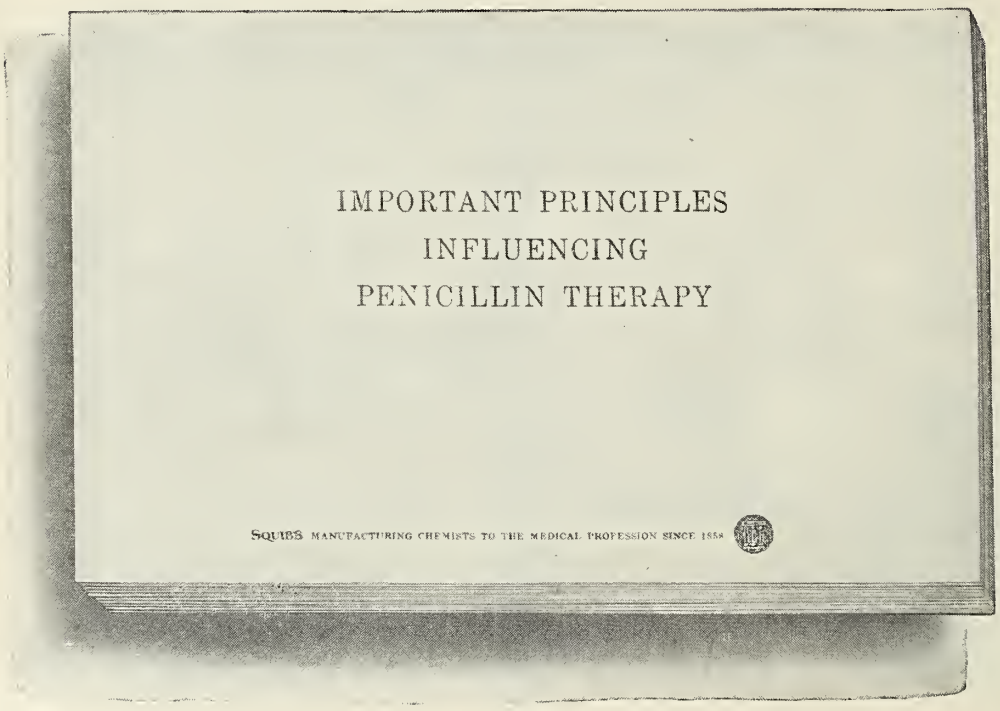


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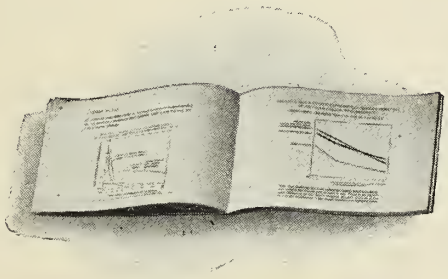
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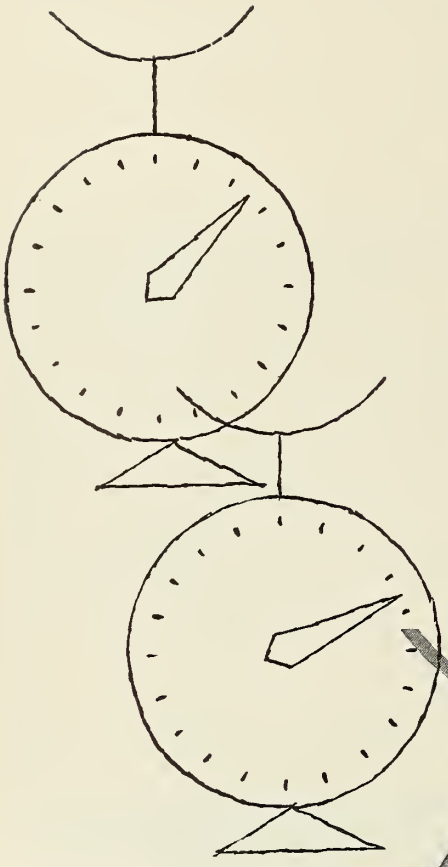
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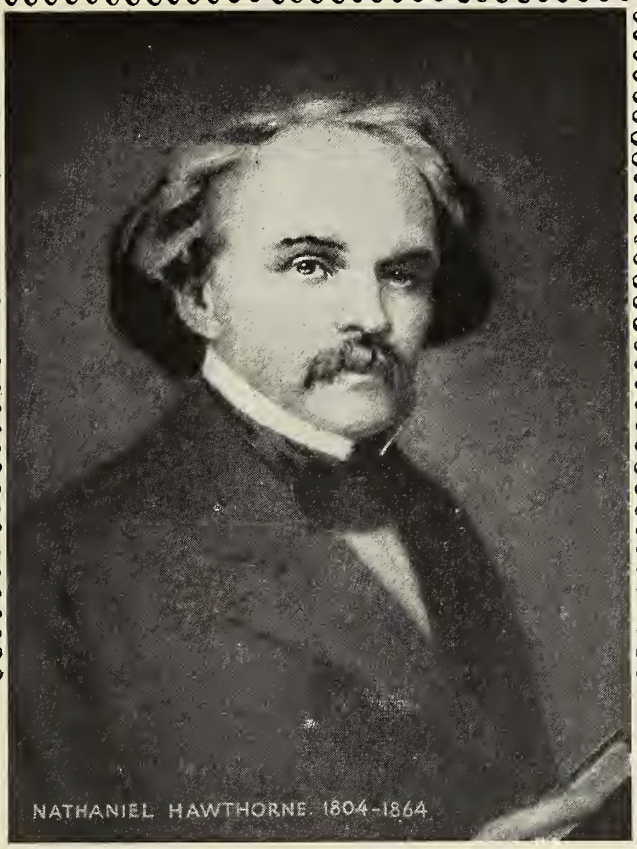
1 Gardner, L. I., Butler, A. M., et al.: Pediatrics 5:228, 1950
2 Nesbit, H. T.: Texos State J. M. 38:551, 1943
3 Bull. Natianol Research Council No. 119 Jon. 1950
4 Recammended Daily Dietary Allawances, Revised 1948, Foad and Nutritian Baard, Notional Research Council

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Sprague, R. G.: Cortisone and ACTH, Am. J. Med. *10*:567, 1951.

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The JOURNAL
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Issued Monthly Under the Direction of the Council
VOLUME 51 FEBRUARY, 1952 NUMBER 2

The General Adaptation Syndrome

By Bruce C. Lockwood, M.D.
Detroit, Michigan

THE CONCEPT recently developed by Dr. Hans Selye[12,13,14] and others[1,2,4,10] regarding the reaction of the animal body to environmental stress is intriguing because it opens up a vast field for research and thought.

Modern research has mostly been in narrow channels, studying various individual glands, hormones, enzymes, salts and psychic reactions. The general adaptation concept, however, gives consideration to the response of the body as a whole. It is a study of the *strain* produced by *stress* and shows that the body responds biochemically and morphologically in much the same way to various different *stresses*. It has been shown that the animal organism possesses a general defense or adaptation mechanism which it automatically mobilizes against any injurious agent, whatever the nature. Further, it has been shown that this defense mechanism often overdoes itself or reacts abnormally, resulting in serious damaging effect to the animal. The principal agent of this mechanism is the endocrine system. Thus our knowledge of the endocrines is gradually emerging from a state of imagination and theory into some real scientific knowledge.

While investigating the response of animals to injections of various gland extracts, it was found by Selye in 1935 that large doses of several different gland extracts produced similar results. He and others have found that three parts of the body are invariably affected: (1) the adrenal glands are swollen to twice their normal size and are brown-red in color insteal of their normal yellow; (2) the mucosa of the stomach and duodenum is spotted with submucous hemorrhages and bleeding ulcers, and (3) the thymus gland withers to almost nothing.

Further investigation[1,2,12,13,14] showed that these same reactions were obtained in animals by the use of other widely diverse forms of stress such as (1) large doses of various drugs such as atropine, strychnine, formalin, et cetera, (2) various infections and bacterial toxins, (3) excessive muscular exercise and fatigue, (4) fasting,[9] (5) excessive exposure to heat, cold, sun and x-rays,[5,15] and (6) excessive emotional excitement.[7]

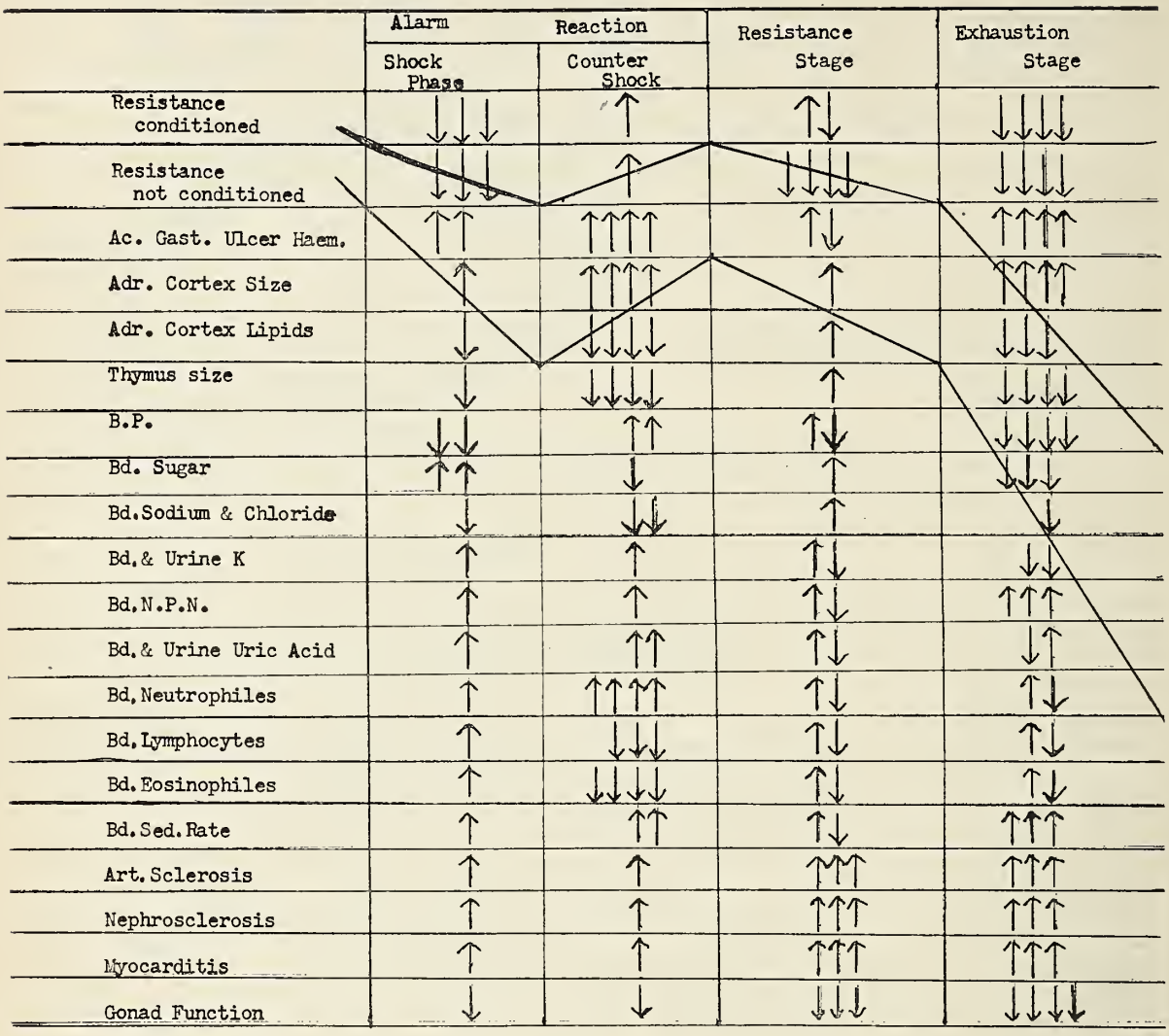
It has also been found that with the above reactions, there are certain characteristic changes in the chemistry of the blood and body fluids and also in the formed elements of the blood and tissues.[3,16]

As the result of a great amount of study, it has been determined that the reaction of the body to stress can be divided into three phases: (1) the alarm reaction (AR), consisting of a shock phase and a counter shock phase; (2) the stage of resistance (where the stress agent was not sufficient to prove rapidly fatal), and (3) the stage of exhaustion. The characteristic findings in these three different phases are shown in Table I. These reactions have been studied in several species of animals and there is no doubt that they represent a general defense reaction against stress in the higher vertebrates including man.

The sequence of events, beginning with the alarm reaction (AR) is started by a stimulation of the anterior pituitary (the boss gland), which increases its secretion of adrenocorticotropic hormone (ACTH), which in turn causes an increased secretion of the adrenal cortex (adrenal corticoids).[1,2,12,13,14]

From the Division of Internal Medicine, Harper Hospital.

TABLE I. THE GENERAL ADAPTATION SYNDROME (SELYE)



The pathway of action of stress to the anterior pituitary is not definitely established. Experiments have shown that it is not always due to hypothalamic stimulation, or to adrenalin (adrenal medulla), or to histamine, or to thyroid hormones.

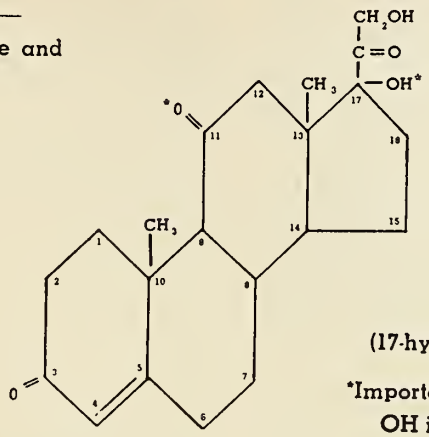
The chief organ where marked and dramatic changes occur due to stress is the adrenal cortex.[3,16] These two adrenal glands normally weigh only about 5 grams each, yet they hold a key position as regulators of vital functions. When they are destroyed, as in Addison's disease, death is inevitable. When they are removed from animals, death occurs within a few days.

The adrenal has a cortex and a medulla. It has been known for many years that the medulla secretes the hormone adrenalin, which has definite actions, such as constricting blood vessels, raising blood pressure and helping to change the liver glycogen to glucose and mobilizing it into the blood stream, especially during emergencies. More recently the functions of the adrenal cortex have been revealed. The adrenal cortex has been found to make a number of hormone substances indispensable to life, storing them as steroids (corticoids), that is, fat soluble solid compounds, which give the glands their normal yellow color. At least thirty of these adrenal cortex steroids have been isolated. Seven different such corticoids have been found to maintain life.

The chemical structure of these adrenal corti-

PRINCIPAL GROUPS OF ADRENAL CORTICAL HORMONES

11- and 11.17-oxysteroid group —
affect chiefly carbohydrate and protein metabolism.

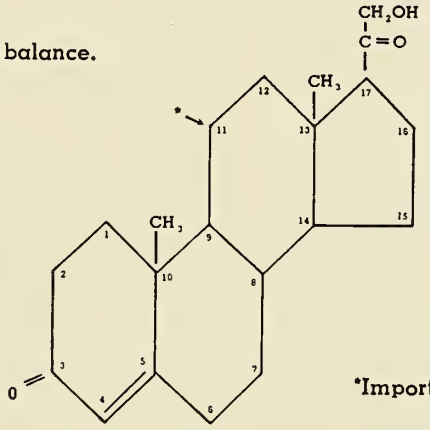


CORTISONE

(17-hydroxy-11-dehydrocorticosterone)

*Important features – O atom in position 11, OH in position 17

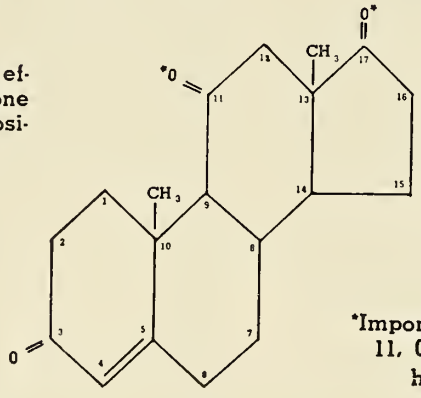
11-desoxy group —
affect chiefly electrolyte balance.



Desoxycorticosterone
(11-desoxycorticosterone)

*Important feature – no O atom in position 11.

Adrenal androgens —
androgenic and anabolic effect; related to testosterone but have an O atom in position 11.



Adrenosterone

*Important features – O atom in position 11, O atom in position 17 hence 17-ketosteroid.

Fig. 1. (Carlisle, Gibson, Schmatolla) Principal groups of adrenal cortical hormones.

coids is similar to cholesterol, the bile acids, viosterol, and the androgens. They all have the phenanthrene nucleus. Their activity and physiological properties vary much, however, with only slight variations in the structural formula, i.e., the presence or absence of an O or OH at certain carbons.

The basic chemical structure of these substances is shown in Figure 1, which also graphically shows the molecule numbering system with a carbon atom at each number. The substitution of an oxygen atom or a hydroxyl at certain carbon numbers alters definitely the metabolic activity of the compound.

There are three important chemical classes of

active adrenal steroids: (1) those which do not have an oxygen at carbon number 11 (the desoxy type); (2) those that do have an oxygen at carbon number 11 (the oxy type); those which do not are easy to synthesize, but unfortunately do not possess complete therapeutic powers; and (3) those which have an 0 at both C-11 and C-17, the androgens.

Pharmacologic and physiologic observations of many of the adrenal steroids have been limited, up to the present, by their scarcity and expense and can be considered only as preliminary. The following grouping has been established, which, however, may represent an over-simplification, as their functions probably somewhat overlap.

I. The Mineral Corticoids.—Structurally these substances are characterized by an absence of an oxygen (desoxy) at carbon 11. 11-desoxycorticosterone is the most potent of this group which has been synthesized. It is used as the acetate (DCA) in the treatment of Addison's disease. Other steroids of this group include 17-hydroxy-11-desoxycorticosterone (Reichstein's compound S).

These mineral corticoids have a predominant effect on electrolyte and fluid balance. The effects may be listed as follows:

1. Urinary retention of sodium.
2. Urinary retention of chloride.
3. Increased urine excretion of potassium.
4. Increased plasma and extracellular fluid volume.
5. Decreased concentration of sodium and chloride in sweat.
6. Increased connective tissue collogen, fibrin, and hyaline formation.

II. The Gluco-Corticoids.—This group of steroids is characterized by having an oxygen at carbon 11. The 11-oxysteroids and the 11, 17-oxysteroids. They are concerned with the metabolism of carbohydrate, protein and fat, and also the control of lymphoid tissue. Cortisone is in this group.

Their principal effects are as follows:

1. An increased production of glucose (gluconeo-genesis) from protein and fat.
2. An effect on the lymphatic system, involution of the thymus, decreased blood lymphocytes and eosinophiles, and stimulation of the reticuloendothelial system.
3. Increased urine excretion of uric acid and urates.
4. An inhibitory effect on the activity of the mineral corticoids.
5. Decreased production and excretion of adrenal androgen (17-ketosteroids).
6. Decreased normal reaction of tissue to chemical or mechanical trauma; inhibition of inflammation and healing; decreased fibroblast formation; decreased change of histadine to histamine; decreased antibody production; inhibition of tuberculin and other immune reactions.

III. The Androgen-Corticoids (17-ketosteroids).—These steroids have a similar formula to testosterone but differ in having an oxygen at carbon 11. Their metabolic effect is similar to the testicular androgens:

1. Masculinization.
2. Retention of nitrogen, phosphorus, potassium, sodium and chloride.

After the alarm reaction findings were established by experimentation, the next step was a study of the animal's response to a less intense but continuous prolonged stress, not sufficient to be lethal. When animals are subjected to daily sublethal stress with the same agent for weeks instead of days, there occurs during the first few days the usual alarm reaction, with the usual organic and chemical changes.

However, if the animal survives the alarm reaction period, with its shock and counter shock phase, then occurs a stage of resistance in which the adrenals shrink back to normal size and regain their normal yellow color with deposits of steroids, the stomach and duodenum begin to heal, and the thymus regains its normal size; also the blood chemistry changes return to normal.

It has been found, however, that this acquired resistance increases only against the one type of stress employed from the beginning. If in the middle of the stage of resistance period the type of stress is changed to a different one, the animal immediately succumbs. Experiments with graded amounts of stress have shown that the animal's specific resistance to the initial type of stress increases, but its resistance to other types of stress decreases.

The stage of resistance, or adaptation to the original continuous stress, is not permanent. The animals become progressively weaker and after

variable periods of time again get the alarm reaction findings of swollen red adrenals, gastric ulcers, and thymus atrophy. This last stage of exhaustion is similar to the initial alarm reaction. The end is like the beginning.

Thus the struggle of life against stress is found to consist of three secessive stages. The whole battle is named the "general adaptation syndrome" (GAS). Life as a whole can be regarded as a GAS, that ends when resistance or adaptation energy is exhausted.

Further study of the findings produced by prolonged sublethal stress have indicated that certain degenerative diseases are the consequences of "overadaptation."[12]

Animals can adapt themselves to certain stresses, such as to cold, for example, for periods as long as two or three months. These animals then show interesting changes. The arterial walls are thickened and the lumen almost obliterated in parts of the body; the heart is enlarged and shows Ashoff-like nodules as seen in rheumatism; the kidneys show findings as are found in human nephrosclerosis; the blood pressure shows a marked rise. In other words, long-lasting stress can produce arterial hypertension and cardiovascular disease in animals.

These findings suggested the possibility that the pathological findings might be due to an excessive or abnormal action of the pituitary-adrenal mechanism. Selye theorizes that under certain circumstances or in certain subjects the pituitary ACTH may vary in constituent activities, or cause an adrenal cortex secretion abnormally predominant of the *mineral* or of the *gluco* or of the *andro* effect.

Further study has shown that these same pathologic findings can be produced in animals within three weeks by the injection of large quantities of pituitary extract, or of adrenal cortex hormones. To this purpose, the crystalline desoxy-corticosterone, or DCA, was used, and also a water suspension of the powdered whole anterior lobe of the pituitary, termed "lyophilized anterior pituitary" or LAP. The continuous injections of LAP or DCA are equivalent to the prolonged and excessive secretion of hormones of the pituitary and adrenal, brought about by continuous STRESS.

After determining the relationship of various stresses to the pituitary and adrenal internal secretions and to the development of degenerative body changes, further investigation was done to determine procedures for combating this vicious mechanism.[12] Numerous methods, mostly by trial and error, have been studied in attempting to find ways of preventing or treating the condition. Animals have been subjected to a great variety of procedures and diets.

From the many tests, two clearly defined constructive findings were made. First, it has been found that experimental hypertension and vascular sclerosis produced by injections of DCA was markedly influenced by sodium chloride in the diet. A high sodium intake increased the frequency and intensity of the pathological processes caused by the hormone. Further, on the other hand, when the animals are fed a salt-free diet, hypertension and sclerosis is prevented even when very large amounts of DCA are given.

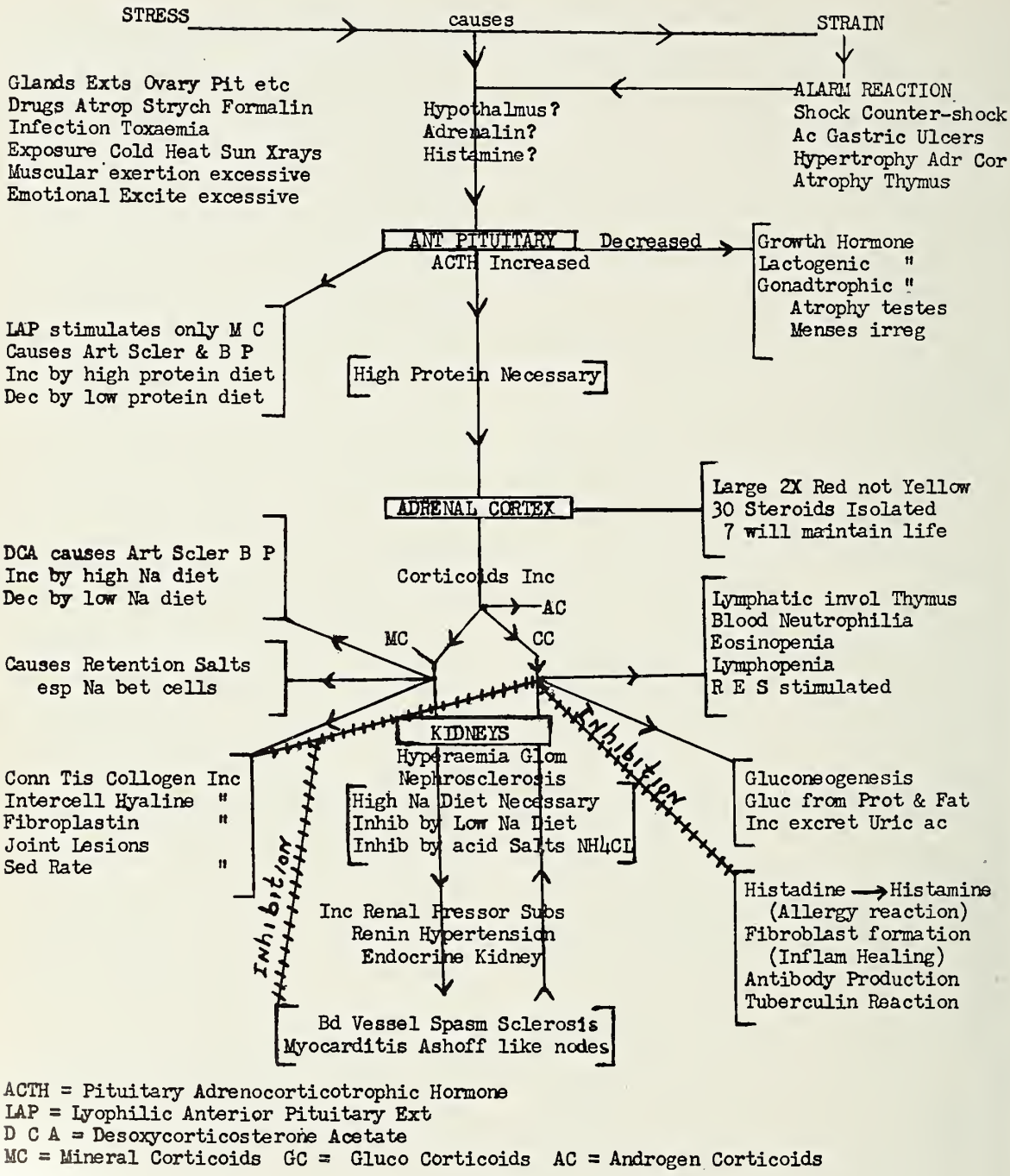
The second finding of importance was that hypertension and arteriosclerosis caused by stress or by injections of LAP was not affected by salt but was influenced by protein in the diet. A high protein intake aggravated the damage while a low protein intake caused considerable protection to the animals.[13]

Thus in animals, sodium intensifies the action of the adrenal corticoids, and protein intensifies the effects of the pituitary hormones in their injurious effect on blood vessels and blood pressure. The exact mechanism of action has not been determined. Perhaps DCA cannot act without the simultaneous presence of sodium. The pituitary may require food proteins to manufacture its ACTH; perhaps it may later be determined that only certain proteins or amino-acids are necessary.

These experiments strengthen the rather widely held belief that arterial hypertension is a reaction of the body to various forms of stress. Also the findings indicate that the mechanism of action of stress is through the pituitary-adrenal mechanism.

These experiments also strengthen the case of those who believe that a low-protein low-sodium diet is of benefit in the treatment of arterial hypertension.

In all of the experiments, it was found that the earliest and greatest effect, during the resistance phase of the GAS, was on the kidney blood vessels. Thus there is formed the so-called "endocrine kidney," in which when the blood supply is reduced from a strong pulsating to a slow nonpulsating current, the kidney suffers anoxia, and in some way liberates substances, renin and hypertension, which raise blood pressure.[11,16]



ACTH = Pituitary Adrenocorticotrophic Hormone
LAP = Lyophilic Anterior Pituitary Ext
D C A = Desoxycorticosterone Acetate
MC = Mineral Corticoids GC = Gluco Corticoids AC = Androgen Corticoids

Fig. 2. The general adaptation syndrome (Selye).

Thus, correlation of the findings derived from much experimentation dealing with the alarm reaction and the general adaptation syndrome has led Selye to formulate the hypothesis: long lasting *stress* causes an excessive continuous production of ACTH; this forces the adrenal cortex to an intensive discharge of DCA-like steroids which, among other things, affect the kidney in such a way as to release hypertensive substances.

Further, the commonly accepted idea of the cause of chronic gastric ulcer postulates that it begins as an acute ulcer (as occurs in the alarm reaction) and is perpetuated by the corrosive digestive action of HCl, as occurs in a person who by

constitutional endowment makes excessive and continuous gastric acid secretion. Thus the etiology of peptic ulcer probably is connected with the alarm reaction.

Here are seen the outlines of a great biological chain reaction which can be set off by almost any form of stress and which may frequently lead to the suicide of the animal. Some of the links are still missing. As a result, large-scale research is being carried on in many laboratories. Figure 2 shows in a diagrammatic graphic form most of the actions and reactions herein discussed.

If further study confirms the application of these animal experiments to the human, it would appear that the most frequent and often fatal diseases of man are due to the wear and tear of modern life. The reaction of the body depends upon the degree and type of the stress and upon the resistance to the stress. Selye thinks that the following conditions, in addition to nephrosclerosis and hypertension, should also be included among the diseases of adaptation, periarteritis nodosa, certain rheumatic and gouty diseases, eclampsia, some types of diabetes, some types of acute infections, and possibly other conditions.

Conclusions and Comment

One might ponder that stress today is mostly a result of our sheltered lives and many comforts; our modern labor-saving devices, clothing, heating, as well as government promise of social security without working, all have rendered many people more vulnerable and sensitive to slight stress. That which was a mild stress to our ancestors now frequently is a major crisis. Moreover, the modern attitude toward life situations apparently causes more emotional conflicts, frustrations, anxieties and repressions, all of which are equally as damaging as physical injury. The modern world of economic and political insecurity, government-instigated inflation and war, also causes formidable stress. We live under constant strain and are losing our ability to relax and to be happy without fresh physical or mental stimulation or relaxing drugs.

Thus it would not be surprising that much of our organic disease derives from psychological trauma, with the general adaptation syndrome as the mechanism of action. If this be true, the function of medicine will be to find a shock-absorber for the consequences of stress; but prevention of stress is a task that lies beyond the reaches of medicine.

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DEFINITION OF BUREAUCRACY

This anecdote in a recent sermon by the Rev. Kenneth W. Sollitt, pastor of the First Baptist Church, Mendota, Ill., caught our eye:

"I was once in a small hotel in Vermont when one of the guests, a foreigner unfamiliar with American ways, brought the proprietress of the inn a beautiful bouquet. The proprietress was delighted beyond words—until she discovered that her gallant guest had picked the flowers in her garden back of the inn.

"Whenever government hands you a bouquet, you can be perfectly sure it was picked out of your garden. But we go right on accepting bouquets in the vain hope that some day we will get flowers that somebody else planted and brought to bloom."

And that is a precise definition of bureaucracy as we see it today.—*AMA Secretary's News Letter.*

Myotonia Congenita

Report of Four Cases in One Family; One With Autopsy Findings

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"TONIC SPASMS of voluntary muscles in consequence of an inherited disposition" was Thomsen's original description of the disease process now known as myotonia congenital.[22] A few years preceding his description, Bell and Benedict briefly described this condition. Leyden also preceded Thomsen in describing this syndrome. Thomsen, who suffered from the disease, reported twenty-three cases in 1876. His son, a victim of myotonia, had been shabbily treated while in military service because of mistaken ideas of the nature of the disease. Thomsen drew attention to the cramps which occurred on voluntary contraction; onset in childhood; its distribution through the voluntary muscles, and its hereditary nature, as demonstrated by its occurrence through several generations of his own family. The first systematic attempt to study the disease was made by Erb. He described an increased irritability of the muscles in response to galvanic, faradic, and mechanical stimulation. This he believed to be characteristic of myotonic muscle and he called it the myotonic reaction. He was first to report morphological observations in this disease.

The etiology of myotonia congenita has long been in dispute. Several theories have been formulated. The two of foremost prominence are those of intrinsic disease of muscle and a disturbance in the excitability of motor end plate causing abnormal neuromuscular transmission. There has been some discussion about the presence of excess acetylcholine or a decreased amount of choline esterase. This has been disproved by many observers.[15] It has also been observed that blood transfused from a myotonic individual to a myasthenic caused no change in myasthenia gravis. Lindsley and Curnen[11] presented the theory that myotonia is a neurogenic rather than a myogenic phenomenon and he believed that continued contraction is of reflex origin; this being due to persistent discharge of hyper-excitable end organs in muscles. However, it has been shown that spinal anesthesia does not abolish the myotonia.[10] Therefore, it is unlikely that myotonia is of reflex origin. Wolf,[25] one of the foremost workers in the field, is of the opinion that the etiology of the disease must rest with neuromuscular transmission; the threshold of the end plate being lower or the excitation wave being more slowly destroyed. Wolf was also the first to point out the ability of quinine to relieve the difficulty in muscular relaxation of patients with myotonia. Convernton and Draper[5] present interesting analogies between state of contracture of muscle and myotonia. Contracture has been extensively studied in animal muscle preparations. Contracture has been defined as a state of contraction in muscle which persists for an abnormally long period after the stimulus for its production has been removed. Thus, contracture differs only in nature and duration of the protoplasmic excitation; the metabolism is the same. It has been suggested that the tendency to contracture may be associated with ontogenetic and phylogenetic antiquity of the muscle structure.[20] Accordingly, myotonic reaction might be associated with a primitive evolutionary state of muscle to a more embryonic type.[23] Actually, contracture has other similarities to myotonia in that both contracture and myotonia are improved by repetition of muscular activity and quinine, and exacerbated by prostigmine. Some authors stress that these conditions cannot be humoral because only certain muscles are involved. While this is certainly true, it is equally true that humoral mechanisms may have different target organs.

Emotional upsets and exposure to cold seem to have an adverse effect on myotonia. This is thought to be due to vasoconstriction in the peripheral extremities.[24] Epinephrine given parenterally or endogenous excess has the effect of causing peripheral vasoconstriction and vasodilatation of vessels in the muscle substance. Vasodilatation then may cause an excess of acetylcholine to be liberated. It has been shown that sympathetic fibers supplying blood vessels in muscles may liberate acetylocholine. The muscle then may react in myotonic manner.

We have been interested in the endocrine implications and associations of myotonic diseases. This interest was first stimulated by the sudden death and subsequent necropsy findings in a young medical associate with myotonic congenita. His death, following a mild upper respiratory infection, was

apparently precipitated by acute adrenal insufficiency. A more detailed description will be found in our case reports. A fairly comprehensive review of the literature did not reveal any similar reports; nor have any authors incriminated the adrenals in association with myotonia. However, there have been scattered reports of endocrine aberrations and associations with the myotonic state. Lord reported a case of a white woman, aged twenty-three, who had periodic myotonic difficulties at the menses. Once menstruation began myotonia would disappear.[12] Gardiner, at the turn of the century, reported a case of a woman who had myotonic difficulties during pregnancy which cleared after delivery. Her child, however, developed myotonia.[8] Fraink, in 1917, reported a case of myotonia congenita which was improved by the administration of thymus.[7] This is of interest insofar as in myasthenia gravis, which has been considered to be the antithesis of myotonia, a persistently enlarged thymus is frequently found. Actually, the field of endocrinology is still only partially explored. Eventually we feel that the endocrines will be proven to be inter-related with all metabolic and enzymatic reactions of the body. If we could understand these processes, we would then be able to explain and treat various diseases with much greater discernment. An indication of this is the role of potassium in myotonia and myasthenia. Myasthenia is made worse by potassium administration, myotonia is ameliorated. This is all intimately tied in with creatine-creatinine metabolism, which has been proven to be of great importance in muscle contraction.

"The capacity of muscles for contraction is related to their phosphocreatine content; the force of contraction is proportional to the extent of breakdown of the latter, and restoration of excitability in the muscle after contraction is dependent upon re-syntheses of the hydrolyzed phosphocreatine.[2] Creatine is present in the urine of prepuberal children, during pregnancy and the puerperium, but is absent from the urine of adults on normal diet (rarely present in adult females). Excessive creatinuria appears rather consistently but not invariably in adults with myotonia congenita. In this respect it is interesting to note that physiologic creatinuria of infancy disappeared in myotonic infants. However, in these same infants when given thyroid, physiologic creatinuria was re-established and they improved noticeably. These results could not be duplicated in adults. Moreover, diets high in protein and creatinuria caused by intake of aminoacetic acid could not accomplish symptomatic relief.

So in brief summation of the pathogeneses the two prevailing opinions are: (1) that myotonia is primary either in the muscle per se or (2) in the myoneural junction, creatine-creatinine metabolism playing a rather devious role.

There are many variations of myotonia congenita. Many names have been applied to these variations including myotonia atrophica and myotonia dystrophica. The latter being characterized by presence of premature baldness, premature cataracts, muscular atrophies, endocrine disturbances (such as gonadal atrophy), coronary sclerotic[6] changes, in addition to usual myotonia. Since typical cases of myotonia congenita may progress to develop these other changes in later years, many people feel that they are simply variants of the same disease. Of course, if gonadal atrophy is present, propagation will be curtailed. On the other hand it has been mentioned that there seems to be an increased propensity for twinning in myotonia.[13] Thomsen himself had two sisters who were twins, one of whom was affected. The unaffected one became the mother of four sons, two of whom were twins. Myotonia, it has been noted, may become progressively worse with succeeding generations as is frequently observed in diabetes mellitus, and many other seemingly unrelated diseases. Myotonia also may lead to mental enfeeblement. In one family mentioned by Caughey there was a steady decline of intelligence in each generation.[3] The sex incidence shows some predominence among males. The disease is transmitted as a dominant factor. It is commonly observed that in myotonic families individuals clinically symptom free may show a myotonic reaction.

The myotonic reaction, as first mentioned by Erb, has also been useful in confirming the diagnosis of myotonia. The main characteristics of the myotonic reaction are the persistence and slow subsidence of contractions on faradic stimulation of nerve and muscle and the double reaction of muscle on galvanic stimulation. This is described as a quick contraction from nerve or motor point and a slow vermicular contraction or sustained contraction on stimulation away from the motor point.[18] The electrical reaction is the same in myotonia congenita and atrophica. There is a relative diminution of coarse striated muscle fibers

and a relatively increased proportion of slowly relaxing non-striped sarcoplasmic muscle fibers. The slowness of reaction is possibly related to the relative preponderance of non-striped muscle fibers.



Fig. 1. Characteristic position of hands in myotonia congenita. This picture is taken immediately after closing hands.

From the clinical viewpoint the symptoms of myotonia congenita are fairly characteristic. The onset is usually in childhood but may not appear until adolescence or later. The history is that of difficulty present only on voluntary motion. There may be a slow contraction, and a slow relaxation is characteristic. This slowness is present only at the start of a movement, with gradual improvement on repetition. Thus, on starting to walk the patient has difficulty in putting his leg forward. He must then stop for a second or two before he can move the other leg. After a few steps, the legs become limber and the patient is able to walk without difficulty.[14] Attempts at quick movements cause the greatest difficulties. On quickly getting up from a chair, the patient may fall flat on his face, being unable to get his legs moving in time to prevent this. Patients do well in sports activities in which they can keep moving, such as baseball; the afflicted are unable to get started on base-running after successfully hitting a ball. One of our patients is a baker, and describes his inability to knead dough when he starts in the morning because of inability to release the material quickly enough. However, after a short time, he is perfectly capable of keeping up with his fellow workers as long as he doesn't stop to rest. In this sense, he is a valuable employe. The symptoms of muscle stiffness as described are not usually progressive over the years, but do tend to persist. Physical examination reveals no evidence of muscular atrophy except late in the disease perhaps, as described previously. Usually these patients are quite muscular and sometimes there is actual hypertrophy but muscle strength is not proportionate to their size. A characteristic physical finding is the slow contracture with slow relaxation of a muscle, when struck with a percussion hammer. There may be a transient groove produced in the muscle when only several muscle-bundles are stimulated rather than the entire muscle.

Differential Diagnosis

The differentiation of myotonia congenita from the other diseases affecting the muscles is based largely on the following features:

(a) Presence of painless tonic contraction followed by slow relaxation on voluntary, mechanical or electrical stimulation of voluntary muscles. This can be readily ascertained by simply asking the patient to shake hands and having him quickly release the handshake. The slowness of relaxation thus manifested, created a rather characteristic appearance of the hand of such patient (Fig. 1).

(b) A history of familial tendency.

(c) Tendency towards relief of symptoms on repetition of contractions.

(d) Some authors have used the aggravation of symptoms by the giving of prostigmine to be of diagnostic value.

(e) Further relief with quinine is of diagnostic value.

(f) The absence of fibrillary contractions or fasicular muscular twitchings aids in differentiating myotonia from muscular disturbances of neurogenic origin.

Actually, the diagnosis of myotonic congenita is not a difficult one to make. The chief difficulty is that of nomenclature since this disease is frequently confused with the other muscular dystrophies in terminology. These include progressive muscular dystrophy and its various forms; amyotonia congenita or Oppenheim's Disease and

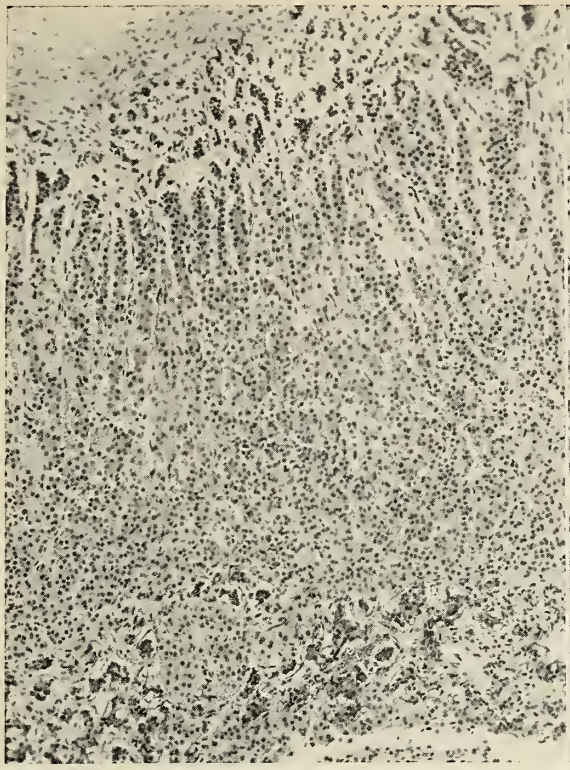


Fig. 2. Case 1. Hypoplastic adrenal cortex one-half normal; possibly related to the myotonic congenita.



Fig. 3. Case 1. Kidney showing edema of tubules and glomeruli compatible with acute outpouring of sodium chloride.

myotonia atrophica. The first two are associated with muscular flaccidity and wasting; whereas, the latter is closely related to myotonia congenita in that it is hereditary, there is myotonia which is progressive and continues on to muscular wasting. It may represent an end stage of myotonia congenita as mentioned earlier in this paper.

From the therapeutic aspect, little can be said, since the disease is seldom incapacitating. Patients usually adjust quite well to their muscular malfunction and seldom require any specific therapy for the myotonus. However, since the discovery of quinine as an effective method of treatment by Wolf[25] in 1936, many patients have shown clinical and subjective improvement by taking five to fifteen grains of quinine three times daily. The rationale for this therapy lies in the curare-like action of quinine with diminution in effectiveness of neuromuscular transmission and diminution of the refractory period of muscle, nullifying the tendency of myotonic muscle to respond repetitively to any stimulus. Some patients prefer to keep their symptoms in preference to the side reactions of quinine (tinnitus, blurring of vision, and nausea). They may use the drug for occasions when improvement in myotonia is of special importance.[4]

Reports of Four Cases in One Family

Case 1.—W. J. W., a thirty-two-year-old white male physician, first developed symptoms of myotonia congenita in 1942. These were mainly those of weakness and marked increase in tonicity of hands, increased fatiguability, slowness of speech and movement, and drooping of facial expressions. These manifestations were ameliorated by exertion and quinine and exacerbated by inactivity, emotional excitement, and prostigmine. Past history was characterized by pneumonia and cholecystectomy in 1939. This disease did not interfere too greatly with the performance of his medical activities. On August 18, 1947, he complained of a head cold. The following day he had a rise of temperature to 103°, sore throat, aches and pains, "grippe," and respiratory distress. He was dead within five minutes from what was probably a combination of respiratory and adrenal insufficiency.

On post-mortem examination, the main feature of interest was the remarkable amount of thymus gland remaining, and the fact that the cortices of the adrenals were about one-third to one-half normal size and depleted of lipids. On microscopic examination, the three layers of the cortex were intact and the reticular layer seemed

most involved. There were no post-mortem autolytic changes. The spleen on gross examination was two to three times normal size, and it showed considerable pulp hyperplasia and prominence of Malpighian bodies but no infarcts or other pathological features. The kidneys showed on microscopic section considerable edema of tubules compatible with increased outpouring of salt.

Comment: What was so remarkable and tragic about this case was the sudden death of this young physician following mild upper respiratory infection; also the presence of myotonia congenita and its possible interrelationship. It seems to us that death was precipitated by acute adrenal insufficiency, following mild infection. A contributing factor was that the patient had lost a large amount of salt because of the very hot temperature and his excessive activity.

Case 2.—J. W., a white man, aged forty-seven, had symptoms which apparently started about twelve years ago. At that time, he noted gradual onset of weakness and spasticity of hands. This first affected him when he had to discontinue golf, because of inability to properly grasp the clubs. He has noticed weakness and mild spasticity of legs during the past few years. When walking, his gait resembled the slapping gait of early tabes dorsalis. However, he has shown no other neurological symptoms. Also, he has noted mild dysphagia which is described as a "dry apple sticking in throat." He suffered a traumatic cataract ten years ago which was operated upon. Physical examination was normal with the exception of premature baldness, spasticity of muscles of the hands, and a mild degree of increased tonicity of the feet.

This patient has been treated in the past with testosterone, amphetamine and vitamin preparations with indifferent results. Laboratory data: RBC 4,820,000. Hgb. 86 per cent. Color index .89. WBC. 6,500. Neutrophils 71 with 65 segmented forms and 5 stabs. Lymphocytes 21, monocytes 5, and eosinophils 3. Blood sodium 322 mgm per cent. Blood potassium 14.1 mgm per cent. Blood cholesterol 371.9 mgm per cent with 245.5 mgm per cent as cholesterol esters 68 per cent of total. Glucose tolerance curve: fasting .094; half hour 120; 1 hour .135; two hours .124; three hours .100. NCN 50. Blood Kahn negative.

Seventeen ketosteroids 6.9 mgm per twenty-four hours. Thorn test (giving four doses of 25 mgm ACTH at six-hour intervals) showed change in eosinophils from 171 per cm to 109 per cmm for 30 per cent drop.

Basal metabolic rate was plus 9, and electrocardiogram was normal.

Comment: This patient does not show a full blown picture of adrenal insufficiency but 24-hour eosinophile count after ACTH and low ketosteroids are suggestive of renal insufficiency. It is interesting in this individual that in addition to spasticity, weakness is one of the predominant complaints. This patient also showed some mental deterioration, which is a finding seen in this group.

Case 3.—J. W., thirty-three years old, a white man, first noted the onset of symptoms ten years ago. First manifestations of the disease process were mild spasticity of hand muscles and lack of ability to release objects immediately once grasped. This has progressed slowly but steadily since onset. At the time of examination, the patient was unable to relax grip fully for a period of fifteen to twenty seconds after shaking hands. No muscular atrophy was found. The remainder of physical examination was normal except for the facies. This was characterized by mild drooping bilaterally of eyelids, and paucity of facial expressions. In addition, his clinical course has been marked by occasional tingling in hands and feet. He has a past history of frequent upper respiratory infections and a right lower lobe pneumonia. There have been no cramping pains of his muscles, no marked weakness and no visual disturbances. He has two children who have been in perfect health.

Glucose tolerance test: fasting 106; half hour .180; one hour .156; two hours .131; three hours .115; Kahn negative. Blood chloride 596 mgs per cent as NaCl. Blood sodium 315 mgm per cent. Potassium 13.7 mgm per cent. NPN 35. RBC. 4,800,000 per cmm. Hgb. 86 per cent. WBC. 8,700. Neutrophils 72 per cent. Segments 70. Stabs 2. Lymphocytes 25. Monocytes 3. Eosinophils 1. Blood cholesterol 229.7 mgm per cent with 132 mgm per cent Esters. Twenty-four-hour 17 ketosteroids in urine revealed 5.7 mgm per twenty-four hours with the normal expected 8 to 20 mgms. Ketosteroids were determined by rapid chemical method of Robbie and Gibson.[19] Thorn test 156 eosinophils per cmm. followed by 25 mgm. ACTH giving 106 Eosinophiles per cmm. in four hours for a 32 per cent drop. By giving 25 mgm ACTH every six hours for four doses, a count of 122 eosinophiles per cmm. was obtained for a 22 per cent drop. Urine acid/creatinine ratio, however, was not in keeping with four-hour and twenty-four-hour eosinophil test. Many normal people were checked with normal Thorn test results.

$$\text{6 to 8 a.m.}\quad \frac{\text{uric acid}}{\text{creatinine}} = \frac{16.6}{78.7} = .20$$

$$\text{9 to 12 following 25 mgm ACTH}\quad \frac{\text{uric acid}}{\text{creatinine}} = \frac{45.9}{82.4} = .56$$

Uric acid with creatinine ratio would seem to indicate adequate adrenal function as borne out by a 100 per cent or more increase in ratio. Electrocardiograms were not remarkable except that they showed flat P waves with amplitude of 1 mm.

X-ray studies revealed heart within normal limits. Barium study of bowel revealed many diverticulae of descending colon.

Robinson-Kepler-Power test was negative. Quinine given 10 grains four times a day, relieved the symptoms of spasticity. 1 cc. of Prostigmine (1-1000+) given intramuscularly aggravated degree of spasticity. Testosterone has been previously used with value in these cases and was mildly successful on Mr. J. W., in that there was a sense of euphoria and some increase in muscle strength.

Comment: Diagnosis of myotonia congenita was

made by the clinical picture and family history. Because there was no baldness, testicular atrophy, muscular atrophy, cataracts and so forth, he was considered not to have myotonia dystrophica. Of course, some believe these forms are variants of one another. One of his brothers had died un-

90 to 106 over 40 to 68. Other members of this group have hyperflexia of varying degree. In November, 1946, follicle stimulating hormone assay of urine showed 26 mg.u (normal 5-50).

Seventeen ketosteroid urinary excretion was 6.4 mgm per twenty-four hours (normal 5 to 15 mgm per twenty-four hours). Basal metabolic rates on two instances in

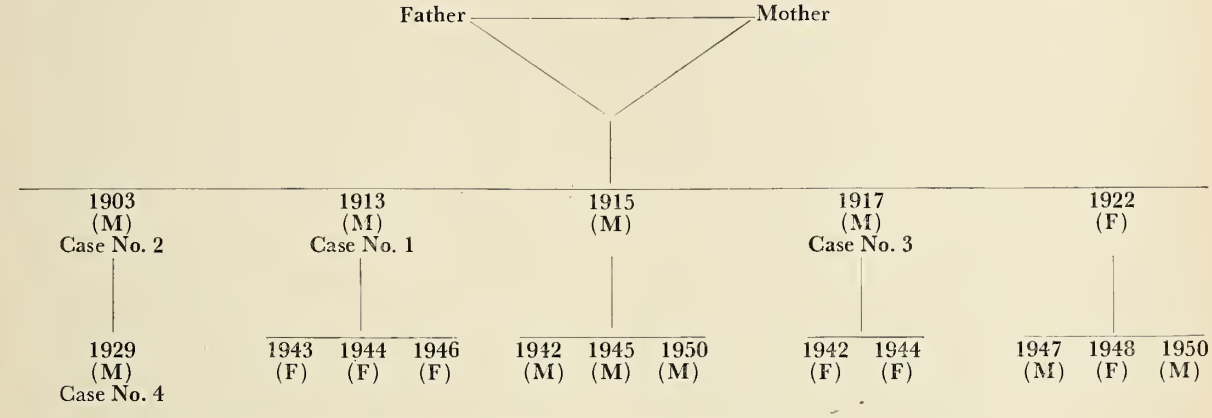


Fig. 4. Genealogical chart of patients reported in Cases 1 through 4.

expectedly of an upper respiratory infection and had myotonia congenita. On post-mortem examination, adrenal hypoplasia was discovered. Therefore, investigation of the adrenal function on other members of the family was undertaken. The four-hour and twenty-four-hour eosinophil test performed with adrenalin and ACTH indicates adrenal hypofunction. This is collaborated by the low ketosteroid output in the urine. However, Kepler water test, uric acid/creatinine ratio after ACTH, normal glucose tolerance curve, slightly low blood chlorides and sodium would all tend to point toward normally functioning adrenals. Suspecting possible laboratory errors, several trial runs were carried out with satisfactory results.

Case 4.—M. W., twenty-one years old, the son of J. W. (Case 2), has a history which begins between the ages of eleven and twelve. At that time, he noted he was lethargic and was not as active as other boys. Subsequently, he noticed a mild degree of weakness, sleepiness, and spasticity of the hands. He had been treated with testosterone, amphetamine, thyroid, adrenal cortical extract, with little success. Lately, his symptoms had been easy fatiguability, weakness and spasticity of back. While in the Army (two months' service) he was unable to release a rifle after shooting. He is now working as a baker's assistant. His main difficulty occurs in the morning, but once his muscles have been used for any period of time, spasticity decreases. His speech is slow, movements slow, reactions slow (as in other members of the family). The only physical findings excluding muscular difficulty are generalized hyperflexia and hypotension, May, 1949, were minus 14 per cent and minus 20 per cent. In May, 1949, Kepler water test was normal. 17 ketosteroid 9.5 mgm per twenty-four hours and 11 oxysteroid 1.43 mgm per twenty-four hours. Blood sodium, chlorides and potassium were normal as was the glucose tolerance curve. Electrocardiogram showed low voltage of QRS with diphasic ST in CF4. The patient had been receiving thyroid for an extended period. The electrocardiogram was compatible with thyroid deficiency.

Laboratory examination on August 21, 1950, showed RBC. 4,690,000. Hgb. 13.5 gms. or 88 per cent. WBC. 5,400: Differential, neutrophils 42, lymphocytes 44, monocytes 2, eosinophils 22 (Patient had no allergic or parasitic history and stools were normal on repeated occasions). FBC .095; Serum Sodium 285 mgm per cent. Serum Potassium 13.95 mgm per cent. Urine negative. 17 Ketosteroids 11.7 mgm per twenty-four hours, 11 Oxysteroid 2.3 mgm per twenty-four hours. Direct eosinophil count 560 eosinophiles per cmm, after 25 mgm ACTH 470 eosinophils per cmm. Slit lamp examination: numerous individual small punctate opacities present deep to anterior and posterior capsules in both eyes. These were whitish and brownish in color.

Electrocardiogram showed low voltage. Patient was started on 200 mgm of cortisone for the first dose and then 100 mgm of cortisone I.M. daily for seven days. There was no improvement on cortisone treatment.

Comment: Low blood pressure, asthenia, weakness are possible clinical confirmations of lowered adrenal function. Drop of eosinophils of only 16 per cent would indicate adrenal hypofunction. However, with high initial eosinophil count usual 50 per cent drop is frequently not obtained. Use of various adrenal hormones including cortisone

did cause mild improvement. Quinine also caused some clinical improvement while prostigmine caused exacerbation of symptoms.

Discussion

Myotonia congenita, in itself, is not a common disease, as actually only a few people are afflicted. Moreover, those who have the disease are not totally incapacitated. The reason for writing this report is to attempt to stimulate interest in the inter-relationship between muscular disease processes and possible hormonal background. Changes in the adrenal glands will not uncommonly be found in any chronic disease. Thus, we have noted lowered 17 ketosteroids and other manifestations of altered adrenal function in such conditions as peptic ulcer, ulcerative colitis and even chronic myocardial insufficiency. It may be difficult to judge which is cause and which is effect. Stimulated by the finding of adrenal insufficiency in our myotonic physician we sought further confirmatory evidence. This was verified partially by minor drops of eosinophil count after ACTH and clinical evidence. We certainly do not feel justified in incriminating the adrenal cortex in the pathogenosis of myotonia congenita. We do feel this should be investigated further. Bardier and Bonne have shown from their studies that there is modification in the structure of the adrenal cortex after continued tetanization of muscles. We believe it possible that the creatine-creatinine metabolism is under the influence of adrenal secretions. Prolonged contractions would then be due to alterations in creatin-creatinine breakdown as influenced by adrenals.

Cortisone has been reported[21] to have abolished the myotonic response in two patients with myotonia dystrophica. The use of cortisone resulted in partial amelioration of myotonia in three of our patients.

Summary

1. Four cases of myotonia congenita are presented. One patient who died with acute adrenal insufficiency is reported with post-mortem findings. The other three had findings suggestive of altered and depressed adrenal function.

2. Possible relationship between prolonged muscular contraction states and adrenal insufficiency has been mentioned.

3. Cortisone was only partially effective in treatment of three of our cases of myotonia.

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Political Vandalism Versus the Rights of the Individual

By Clarence E. Umphrey, M.D.
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IF WE RECOGNIZE confusion, dereliction, insincerity, unrestrained spending and ideologies of tyranny in our high governmental bureaucratic levels, it is our business to do something corrective. This does not mean that I am blaming any one political party. In fact, it may be necessary to form a new political grouping composed of citizens who recognize and deplore the fact that the machine politics of today is controlled by individuals and factions who think only of legalized crime and filching the public rather than serving our citizens. The people know what is going on, but they do not know how to stop it. Our honest citizens are looking for a way out of the mess in which we are becoming mired. Certainly, doctors cannot help solve this problem if they think only of medical care and its cost. We must work with the clergy, lawyers, engineers, businessmen, educators, labor and all others who are interested in a return to a sane incentive type of Americanism. I am proud of capitalism and what it has done for the American people. Everyone who owns property or is compensated for work done is a capitalist. If and when this ceases to be true, we shall have statism. The state will then rule by tyranny. Who wants tyranny? Those who deride capitalism. These people compose the 2 per cent of our population working day and night for Socialism and Communism. The difference between these two "isms" is only one of degree. Communism is communalism by force. The flag of Communism should be embossed with the picture of a labor camp. I wonder, then, how many of the members and fellow travelers would want to wave it.

In Michigan, we have an organization called CAP (Co-Operation with the American Public). It is the purpose of this organization to educate our citizens in those things which will produce good Americanism. For one thing, we believe, our colleges should have Political Science Departments that would train aspirants to public office on the highest professional plane. Those who choose to follow a political career should be thoroughly indoctrinated with the ideologies of Americanism. They should also know the destructive principles of Socialism and Communism, and how to combat them. They should be aware of how our government was established to maintain the individual's rights and that each division of government was so constructed as to prevent centralization of power. There is no reason why such an organization as CAP should not work as well for every other group or profession.

As a nation, we have developed a number of detestable characteristics which make creating a state of realism very difficult. We do a great deal of smug boasting about our democracy without knowing what it cost us or what it means to us. We talk freedom but are headed rapidly toward Socialism. We speak glowingly of "freedom of speech" and "the rights of the individual" without knowing how rapidly these same rights are being taken away from us.

Let us review our losses so far. We have lost most of our financial security. To a great extent we have lost our spiritual security. We have lost our physical security. No one knows what tomorrow will bring in the way of atomic, chemical or bacteriological warfare. Certainly, we are not protected against such an emergency. We have lost our political security. Of all our losses, I believe the losses of our spiritual and political securities to be the greatest. We are even led to believe that the laws and government, as set up by our forefathers, based on individual rights are obsolete and so we change them. We have even gone so far as to change the Ten Commandments. Many covet that which is not rightfully theirs, so the next step is to legalize through our government certain forms of theft. We have pushed the citizen aside and made a feudalistic baronage of our nation, which will soon be in a position to dispense with all rights of the individual.

We assume the attitude that all politics are dirty and beneath us, and many of us seem to feel that a donation to the Republican or Democratic Party acquits us of all responsibility. In one of the recent elections, only 44 per cent of those privileged to vote in Ohio exercised that franchise. Well, don't look down on the lowly Ohioan as a

Address of C. E. Umphrey, M.D., as President of the Michigan State Medical Society at the annual meeting of the American Association of Physicians and Surgeons, Indianapolis, Indiana, October 4, 1951.

poor citizen. In Michigan, it was even worse, only 41 per cent voted. In common parlance, I think that is a "stinking" type of Americanism. Perhaps, in view of such statistics, we deserve just what we are going to get, which is the police state, unless we overcome our lethargy. This, then, becomes every good citizen's job. We must stop statism. We dare not fail.

One of the projects undertaken by our CAP was getting out the membership vote at the last election. I am happy to report that because of this effort we were able to register a 97 per cent efficiency. Those who voted were also aware of the qualifications of those who sought to represent us on the political front. Politics need not be dirty and beneath us and will be so only if you and I permit it. Do you know those who presently represent us in the state and national legislature? If not, you should make it a "must" in the near future. You will be happy to learn that with few exceptions they are men and women of honesty and integrity who are doing an excellent job. Occasionally, they will make mistakes because they have been intentionally and cleverly misinformed. That is why those of us who have helpful information about the problems confronting our senators and representatives are duty bound, as good American citizens, to contact them. That is why you and I must know the facts. The American people have arrived at sane conclusions when fully aroused. We must give them facts and dispel lethargy. A few of our elective representatives have been placed in office through the efforts of minority groups. Their interests are not for the best of the citizenry. In fact, they do not need to think of what is best for the people for in the long run they will do what they are told to do. Those individuals are easy to spot and must be relegated to the limbo of a dead political past by us who exercise our franchise to vote. This emphasizes our duty to those who serve us well. Get acquainted with them. Offer them help and finally give them a pat on the back for a job well done. This will offset some of the pressure groups who are constantly making progress very difficult and life miserable for the legislators.

A few months ago I wondered whether my patients were interested in our political problems. I placed petitions in my office, offering those who were opposed to socialism, including socialized medicine, a chance to demonstrate their opposition by signing to reactivate American Principles of Freedom. In a short time there were 400 signatures. A similar procedure in every doctor's office in Michigan would create 2,400,000 Minute Men and Women. Each of us, no matter what his profession, must not underestimate his influence in rejuvenating Americanism; it is and will remain tremendous. There must be no lag in this program. When I hear someone say "but my effort won't amount to anything," I am pleased to remember the outdoor night lecturer who was confronted with that same statement. His reply was to ask everyone in that huge stadium to light a match when he counted three. No one in that audience will ever forget the brilliance of their combined effort.

In our public relations planning we must decide whether or not other emergencies exist. If so, are they singular or multiple? Are they external or internal? What defenses should we use and how can they best be prepared?

We know there is an external danger, and everyone is constantly aware of it. The trouble is that the external war we were so cleverly euchred into may be only a means to an end. If Communism can drag us into insolvency through our deficit spending, then Americanism will surely succumb to tyranny and statism. We have endured two world conflicts to maintain freedom and now are engaged in a third. Each conflict finds us closer to bankruptcy with an increasing acquiescense to Socialist ideologies. Thus our external danger becomes our internal danger. Twice we have gone through the routine of unprovoked attacks, primary heavy losses, prayer for divine guidance, American production gets rolling, supply lines established, brilliant victories, we win the war, but *We Lose the Peace.*

Ever since the beginning of history man has possessed some means of destroying his fellow man. In our so-called highly civilized countries the science of murder has been developed almost to the point where we can begin to look for what appears to be the desired end, extinction. I predict this will not happen. In this prediction I can rest assured that no one will come and say "I told you so," if I am wrong.

The great civilizations or nations which have reached the pinnacle of glory, have not been destroyed by war, but by the devouring vandalism of taxation. This always happens when John Q.

Citizen gives up his personal rights for security as provided by the State. Since the beginning of time very few have known freedom as exemplified here in America. Please tell me, then, why must we follow in the footsteps of Europe? No Peace —No Freedom—No Hope! The fear is not of atomic, chemical or bacteriological extinction, but that there will be a million tomorrows for you and me and our families of serfdom.

Is there anyone here who believes we do not lack leadership? Is there anyone who believes we are being guided by the principles laid down in the "Sermon on the Mount"? Are we thinking of our fellow man? These are some of the outstanding reasons why we need leadership. Why should we see published, day after day, pictures of faces surrounding the United Nations' conference tables expressing hate and distrust? If we wish to have our neighbors of other countries trust us, we must win a moral victory at home and live closer to the ideals we teach. If we can do this, the areas of despotism will shrink in favor of freedom of government based on the individual's rights. Communism now controls about 800 millions of the peoples of this earth. Those subscribing to our western ideas of freedom would number about 750 millions. The remaining 750 millions of Asia will not always remain neutral. If we can influence them to join us, and we can prove our efforts are truly for the good of mankind, we can win a bloodless victory.

So far, I have not discussed the results of our so-called lend-lease program. It would seem that it has fallen far short of its anticipated results. It has not greatly influenced Communism. It has not given us security. It has not provided us with allies. It has brought us much closer to bankruptcy.

I suppose no one knows what our national debt is at present, but it probably is crowding 300 billions. The interest on such an amount alone would have run the government, including Social Security Program, for twenty years at the rate of expenditures in 1915.

As to the federal debt mortgage, it means that every family in America is obligated to the extent of between seven and eight thousands of dollars. This should arouse us to the fact that federal aid is federal take. When we ask for federal security, we should be honest enough to admit we want something now that will be charged to our children, and they will be forced to pay later. I am reminded of the little old lady, who died in Minnesota and left $1,300.00 to pay off her share of the national debt. How chagrined she must be from her spot in heaven to realize that her noble effort had fallen at least $400.00 short.

One of the conditions that we feel has caused a laxity of close federal supervision has been the complete lack of an over-all auditing and accounting system. Never at any time is any one individual or a group of individuals in position to know what our actual financial status is. This was brought out in the Hoover Report.

We note with interest that within the past few years the number of Government units has increased from 350 to 1,812. It is a common charge that overlapping, duplication and waste with each bureau vying with the other for federal funds, has brought about a condition that is almost beyond any bookkeeping system. How could we expect to correlate records and reports delivered in carload lots?

In other words, we are creating a machine of such gargantuan size that eventually it will devour the holdings of all citizens it is supposed to serve.

Let us dwell for a moment on the effect this tremendous debt, with increase of taxes and inflation, has had upon our insurance. A $10,000 policy purchased in 1940 has strunken in protective value by at least 50 per cent. A typical life insurance holder today should have a planned estate of about $150,000. In five years, it probably will be $200,000 to offset a 25 cent dollar.

Let me give you another example. In 1936, the medical men of Michigan established a group budgeting system to provide for catastrophic medical care. It provided protection for the single person who earned up to $2,000 per year, and the married man who made up to $2,500 a year. It was thought that would cover 75 to 80 per cent of our citizens. By 1946, however, spiraling prices, increased taxes and inflation had reduced the number covered to approximately 30 per cent. Those who were receiving compensation above the limits set up ($2,000 and $2,500) could buy less for their dollar. Both employers and employes expressed their dissatisfaction in a very tangible way. Many contracts for medical service were dropped. After four years of study, a new plan covering those who earned $3,750 a year, if single, and $5,000 a year, if married, was approved. How

long will this plan be satisfactory? For but a short time probably, when it will be necessary to compensate for a 25 cent dollar. We are bound to follow the usual plan of inflationary disaster if we cannot curb this nonsensical spending being done by the Washingtonian bureaucratic institute of delirium.

In our discussion, we have not mentioned the Savings Bank book picture or those millions invested in Government Bonds. The handwriting on the wall is just as legible and draws the same conclusions.

Aren't these facts concerning our Federal Financing apparent to the millions who vote? In my opinion, they are not informed, and when they are, will demand a balanced budget.

Why should our Federal Government be in business where the huge losses sustained must be borne by the already overburdened taxpayer? I challenge anyone to name a well-run Government Federal Bureaucratic enterprise. Why should the Post Office lose 500 millions each year? Why should Government-controlled power industries lose 450 millions a year, while those under the egis of private enterprise pay taxes in a like amount? In spite of these facts, our Government, which now controls 200 power plants and dams, is planning on building 500 more. Many a taxpayer has helped support a Government Co-operative which has eventually ruined his own business.

Our Government is already in the banking business, financing endeavors from race tracks to soda fountains. It has built up a tremendous insurance business for War Veterans and their dependents. It is in the peanut, cotton, beans, turpentine, turkey and wool business. It buries thousands of tons of eggs underground to make you pay more. It owns at least two railroads, several barge lines and many merchant marine ships. It smelts metals, refines sugar and proposes to build steel plants. It operates scores of hospitals, hires doctors, dentists, oculists and surgeons. It is in the business of fixing wages, pensions, prices, profits, interest rates and dividends.

The above are a few of the blunders which ruined England. A few years ago Mr. Edwards, a past member of the British Parliament, came to this country to tell his friends why he was joining the Socialist Party and how he expected it to do great things for the public of England. In 1949, he returned to tell us how Socialism had ruined the British Empire and how if we do not control our present debacle Socialism and so-called American planning can bring nothing but financial ruin and compulsion to the United States. According to Harold E. Stassen, England ignored these encroachments too long. Are we doing the same thing? You know we are.

This pyramiding picture of Federal spending and bureaucracy has crept upon us insidiously. The first appropriation to a Federal Bureau in 1912 was less than $22,000. Now, more than $1,200 is spent annually by the Federal Government for every family of four, an increase of 4,038 per cent. Each family's share of the Federal debt has jumped from $50 to between $7,000 and $8,000—an increase of over 14,000 per cent.

In bringing these facts to our friends, doctors of medicine have had the co-operation of such organizations as the press, radio, television, Woman's Auxiliary, Michigan Health Council, labor organizations, churches and clubs. For their help, we are most appreciative. I have found that each of these organizations became alarmed when they were told that according to the Secretary of the Treasury Snyder we will spend 75 billions this year. More recently, that estimate has been increased by 25 billions. With a Federal revenue of 51 billions, our yearly deficit will be about 50 billions a year. Is there anyone here who does not believe our financial structure is tottering?

In our contacts with Labor, we must ever strive for those things that are best for those who work for compensation. If their leaders use tactics we cannot condone, we should not hesitate to take issue with them. The unions do not fear a strong centralized government. Apparently they feel they are big enough to direct statism, if it should materialize, to their own advantage. We do not agree with them and would direct the attention of labor leaders to the sorry plight of laboring classes in England at present. The medical profession believes in developing local government and preserving the rights of the individual. We will not bargain our freedom for any projected security. As long as there is a free America, we shall insist on protecting the rights of any minority group. Fundamentally, we cannot understand or condone many methods used in the unions' so-called bargaining.

A few months ago Mr. Reuther and Mr. Becker of the UAW-CIO invited a number of us to be

their guests at dinner. Following the dinner, Mr. Reuther opened the discussion with the statement that for bargaining purposes he would support the Murray-Waggoner-Dingell Bill, or some similar legislation, for complete medical care for the people he represented. Mr. Reuther was not only informed as to why we opposed socialized medicine, but why we opposed socialization and communization in general. He was told we opposed statism and why. We suggested that if he thought the unions were big enough to control statism that he regard carefully the sorry plight of labor in England. We reminded Mr. Reuther that he had been very loud in his decrying the horrors of slave labor during the last war. Before the evening was over Mr. Reuther said, "We are not in favor of socialized medicine any more than we are in favor of slave labor." He believed the next move should be a meeting of the national leaders in medicine and the national leaders in labor. One such meeting has been held. We hope they made progress. We believe the profession of medicine should always stand ready to discuss means of improving medical care and making it more completely available. Basically, we feel the unions fear statism as much as we do, and here rests the hope of future successful planning.

We should then be able to list our guiding standards as follows:

The Constitution and its bill of rights must be preserved.

Every individual's right must be protected.

State and local government should be free of federal financing and administration.

Taxpayers' money must not be used to compete with private enterprise.

Smear campaigns and intimidations must stop.

Washington Bureaus must stop spending millions for purposes of propaganda as disclosed by the Harkness Committee.

Stop inflation as it ruins insurance policies, bank deposits and investments.

We must protest the control of votes by offering federal aid for education, socialized medicine and public housing.

Research as exemplified by American leadership in all phases of services and commodities must be supported.

Stop thinking security instead of opportunity. The spenders in Washington can help the little fellow most by reducing his taxes and thereby increasing his opportunities to do those things he has always wanted to do.

We must show our citizens that medical care will advance faster, their protection will be cheaper while utilizing voluntary insurance, and that totalitarian, compulsory socialized medicine is not desirable.

While we work let us keep in mind that the Revolutionary war was won, the Government established and the Constitution put in force by a compact, highly intelligent loyal minority.

In our over-all planning, it may be a long time before the American people can entirely eliminate poverty. We must first eliminate greed. We must live closer to the principles and ideals taught by the greatest of all Healers, and remember, ideals are like stars to one lost in the desert. He may not succeed in touching them with his hands, but by following them he will reach his destination.

MSMS

WELFARE SPENDING EATS UP THIRD OF ALL PUBLIC FUNDS

One-third of all the money spent last year by Federal, state and local governments went for welfare programs, according to the United States Chamber of Commerce.

A survey revealed that approximately $23,000,000,000 annually was turned over to some 300 public welfare programs.

The Chamber said this meant that the equivalent of $565 for every taxpaying American family was given to a government charity, relief or welfare organization.

The Chamber said that "despite relatively full employment," one person out of every thirteen got a regular monthly payment from a government agency, not counting salary checks.

If farm programs are counted, one out of every nine persons gets a monthly check of one kind or another from some government agency.

Last September, the Chamber found 800,000 persons were drawing government unemployment checks. In this same month, the Social Security agency listd 6,000,000 persons to receive old-age or disability checks.

Other government checks went to 2,500,000 persons drawing survivors' checks. Some 5,000,000 persons were on government relief rolls.—*Free Press-Chicago Tribune Wire.*

Medicine Is Arming For Atomic Defense

By M. L. Lichter, M.D.
Melvindale, Michigan

THERE ARE no experts in Civil Defense. This is because our country has never lived through that crueible of experience from whieh experts are developed. While it is a fervent hope that our Nation will never be confronted with such a situation, it must be recognized that the possibility of atom bomb attaek upon our eivilian population is a real one. Man is eapable of visiting untold horror upon man and this realism must be faced. Planning and preparation must be approached with deadly seriousness. Passiveness and panic are foreign to the American people and have no place in our thinking. Civil Defense is not a frivolous thing, nor an exereise in mental gymnastics for a few dreamy-eyed planners. It is a new way of life, something which will be with all of us in the forseeable future.

It is fortunate that among the members of the medical profession throughout this eountry there are some doctors of medieine with sufficient forcsight and devotion to the responsibilities our profession has to the eitizens to dedieate themselves to lead the way in planning the medieal aspects of eivil defense. It was such a group† that was ealled together, under the sponsorship of The Wayne County Medieal Soeiety, as representatives of the major cities in the nation, to discuss common problems in planning for Medicine's participation in eivil defense. The County Medieal Societies Civil Defense Conference, whieh was the first of its kind, was held in Detroit, Miehigan, on December 15-16, 1951. The meeting was held in the nature of informal diseussions on many important and troublesome points without any prepared speeches. There were no experts present: there was no one who knew the answers to the problems. All present entered into the dieussion, each eiting his experienee in attempting to find a solution to the situations confronting him in his own locality. It was surprising that, while the details of planning differed somewhat from one community to another, all met on eommon ground in that they faeed common problems. It was gratifying to note the eagerness with whieh all of these physicians entered into the spirit of the eonferenee, each desiring to learn from the experienees of others and willing to give of his thinking. It must be emphasized that all of these physieians were volunteers in this important endeavor of Civil Defense, each giving of his own time taken from hours when he should be relaxing from a busy private practice. Many had difficult transportation problems to overcome in attending the eonferenee since the first severe winter storm began the day before. Yet in their devotion to the problem all of these diffieulties were overeome.

During the eourse of the two-day meeting many points of mutual interest were diseussed. It is not my purpose to detail each one of these, but rather to point out the thinking expressed in some of the more important problems, thinking which might be of interest to the medical profession at large.

(A.) *Role of the Physician in Civil Defense.*

There was no question that all physicians throughout the entire nation must stand prepared to participate aetively in medical civil defense planning. This meant that all physicians must aceept assignment in the civil defense organization and assist in training the huge army of non-professional individuals required to fill out the units to be formed. In many of the metropolitan areas, as in the Detroit area, the cognizant medical society has adopted as society poliey the principle

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that all members will participate in Civil Defense. As a result, in the majority of the metropolitan areas physicians have been assigned arbitrarily with every effort made to keep assignments as logical as possible yet with the full realization that all regions in the area must be covered. While most of the cities had made assignments on the previously mentioned basis, it was apparent that none had attempted as yet to have organizational meetings of the various units. It was further apparent that, with the exception of two or three cities, the profession as a whole had not reacted very favorably to the matter of assignments for the participation in the organizational phases of the problem. In the discussion concerning how to overcome this seeming apathy, several suggestions worthy of note were made among which were the following:

1. Organizing on a local neighborhood community level with each school being the neighborhood focus for organization.
2. Having assignments made at top level with these key people in turn recruiting physicians for their own unit.
3. No assignments should be made until a definite program has been developed and an intensive educational program carried out to acquaint the profession and the public with the overall plan. In some areas where the profession has been informed of the planning this seemed to offer no stimulation to general participation.
4. Setting up a skeleton organizational force only, relying upon some form of State or martial law which would force physician participation in the event of atomic disaster. However all agreed that Civil Defense is a civilian job and not one of military or martial law.

The general opinion was expressed that to some measure the apathy of the profession could be laid to the widespread conception that once atomic disaster struck military law would prevail and all previous planning would be washed out. This is not true. Such a procedure would be contrary to all democratic principles of our nation. The Federal Civil Defense Act recognizes this when it states "It is further declared to be the policy and intent of Congress that this responsibility for civil defense shall be vested primarily in the several States and their political subdivisions. The Federal Government shall provide necessary co-ordination and guidance."

It was the consensus of the group that all physicians must recognize their responsibility, must realize that in the event of widespread disaster the public would look to physicians for help. All physicians must recognize that in the initial phases of large scale disaster medical assistance is the most important thing. It was further the consensus of the group that the attitude of the profession as a whole was rather disappointing but it was felt that as planning proceeded more and more physicians would come forward and actively participate.

(B.) *Utilization of Other Professional Groups and Their Duties.*

It was felt that all ancillary professions would have to be up-graded. For example, it was felt that dentists, by their training and experience, could very quickly learn to take over many of the duties customarily performed by physicians. They could manage shock cases, administer anesthetics, give blood transfusions and other fluids, do suturing, handle minor fractures and many other duties too numerous to detail. Nurses, it was felt, should be used in a high professional capacity and could do many of the things ordinarily done by physicians. In many of the cities it was reported that nurses had organized their own groups and were ready to integrate them into whatever units might be formed. It was felt that pharmacists should be used in administrative capacities, handling of supplies and as members of treatment teams.

(C.) *Education of Physician and Other Professional Groups and Civilian Volunteers.*

The subject of the education of physicians and other professional groups and civilian volunteers, coupled with the problem of development of uniform treatment procedures, provided the basis for a considerable amount of very interesting discussions. As far as professional groups were concerned it was felt that the medical school was perhaps the best source for preparing information for postgraduate dissemination. In several of the areas the medical schools were participating most actively. In the State of New York, for example, representatives from the nine medical schools in the state met and developed a series of short lectures to be given to physicians throughout the state. In addition this group also considered the problem of uniform treatment procedures and kept working at this until a simple set of instructions was developed. It was pointed out by several of the dis-

cussants that uniform treatment procedure was most essential so that stockpiling could be kept as uncomplicated as possible and further that physicians, following a prescribed treatment guide, would be able to work with varying units under different conditions. The same would apply to ancillary professional groups since much of the planning is based upon upgrading them.

In discussing the training of non-professional personnel it was generally agreed that while the Red Cross Manual was the best source for this purpose, objection could be raised to it since a good bit of the material was considered irrelevant and too elaborate. However as a whole the experience with The Red Cross Manual had been good. It was the general feeling that as far as possible training in this group would best be carried out on a unit basis, that is after the civilian volunteers had been recruited and assigned. The group was impressed by the five point program suggested by the Chicago Medical Society as follows:

1. Anti panic.
2. Red Cross training for all adults.
3. Blood typings and identification for everyone.
4. Immunization against smallpox, diphtheria and tetanus.
5. Elimination of rats and flies.

Another point suggested in education of physicians was the utilization of hospital staff meetings as a medium for getting important information to physicians. However it was pointed out that little interest in this method was evinced in one of the areas which used this approach. It seemed that announcement of Civil Defense as the topic for a staff meeting offered a good excuse for non-attendance.

While in many of the represented areas planning for training of all groups has been progressing, it was the conclusion of the conference that educational programs should not go too far until a nationwide policy on training is established.

(D.) *Integration of Suburban Communities.*

This subject provided interesting discussion. As satellites to every large community there are many small communities all of which enter into the formation of a metropolitan area. Each one of these small communities apparently wishes to set up its own Civil Defense plan and to impress upon the others its strategic importance as a target site. The integration of each of these communities into an over-all plan has caused great difficulty in many of the metropolitan areas in this country. It was remarked that the Civil Defense Director in each wants the power or responsibility of placing the doctors in his community under his thumb and wants complete control of his community; that these communities were too interested retaining and obtaining individual recognition. It was felt that in each area there should be one over-all medical civil defense plan with advisory committees made up of some of the representatives from each community. It was further felt that small communities should be urged to co-operate and to appropriate funds and personnel so that the whole civil defense effort would be on a metropolitan basis and truly one of community participation.

(E.) *Psychologic Aspects of Civil Defense.*

The psychologic aspects of Civil Defense were considered as most important and very difficult to solve. It was felt that a very active public relations program designed to reach as many people individually as possible was most essential. The public must be made aware of what Medicine is doing in the field of Civil Defense and must be told what they in turn can do. The following suggestions were felt to be most important in combating panic and hysteria.

1. Give every man, woman and child a specific job to do and then train them in advance so well that they can carry out this job under stress with complete confidence.
2. Carry on a constant educational program to counteract previous propaganda on the atomic bomb, particularly pointing out that there is a defense against this weapon and that it is possible for people to live through a bombing by following certain rules.
3. Prevent the hysterical person from contaminating others.

The purpose of this conference was to enable physicians the opportunity of finding out just what others were confronted with in developing a medical organization in Civil Defense. Conferences had been held at higher levels notably at the state level and national level. It was felt important that the people who are actually doing the work at the local level were not receiving enough guidance in the development of specific detail necessary in

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Pediatric Problems Arising from Atomic or Biological Warfare

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THE TITLE of this paper would appear to imply that past experience has furnished information which can be discussed with assurance and the finality of a topic like "Reactions Following the Use of Penicillin." Fortunately for the human race, but unfortunately for the development of the assigned topic, relatively little experience can be brought to bear on the subject and although atomic bombs were used at Nagasaki and Hiroshima, information gained was limited; subsequently, it was added to by data from postwar studies on the effects of atomic bombing in Japan[18] and by control experiments in the Pacific. To date, biological warfare has not been utilized and any discussion concerning pediatric problems resulting from its use must be accounted as largely in the realm of speculation. However, on both phases of warfare certain broad statements can be made and implications drawn.

Atomic Warfare

Atomic warfare utilizes atomic energy produced by atom splitting to explode destructive materials.[5,17] To date, bombs have been used for this purpose and atom bombs cause more destruction than do others using different mechanisms for explosion. The damage inflicted by any bomb on humans is in general the same for adults and children and the atom bomb is no exception in this respect. The number of casualties due to the A-bomb are greater than those due to other bombs but it is still a matter of degree for the height in the air at which the explosion occurs, aggregation of people, the construction of buildings, the amount of inflammable material among other conditions increase or modify the amount of damage done. The atom bomb has three destructive actions, namely:

1. *Blast effect*—which is much greater than the most effective ordinary bomb.
2. *Heat ray effect*—much more intense than the most destructive ordinary bombs.
3. *Atomic ray effect*—not present after an ordinary bomb explosion.

A word about each of the effects is in order after a few general facts gleaned from the Japanese bombings are mentioned. Explosion of an A-bomb without prior warning over any given inhabited spot would likely result in chances of survival by reason of position as follows:

1. Directly under the bomb—the epicenter—practically no chance of survival.
2. Within ½ mile of the epicenter—10 chances in 100 of survival.
3. From 1 to 1½ miles from epicenter—85 chances in 100 of survival.
4. From 1½ to 2 miles from epicenter—97 chances in 100 of survival.
5. Beyond 2 miles from epicenter—an occasional death occurs.

In Hiroshima, slightly more than half the people survived, and at Nagasaki 70 per cent of the people one mile from the damage center lived to tell about it. The danger of injury is far greater than the danger of death. *Blast effect* is accountable for more than half the deaths and injuries and results from being tossed about or struck by falling or flying objects. *Heat ray effect* causes flash burns by means of heat generated by the explosion of the A-bomb—nearly one-third of the casualties in the Japanese bombings were due to flash burns. Burns may be fatal if contracted near the epicenter and serious burns may occur as far as five miles away. Contrary to general opinion, the *atomic ray effect* is least destructive, accounting for only 15 per cent of the total deaths and injuries in Hiroshima and Nagasaki. With the exception of underwater or ground explosions, radioactivity from atomic bursts causes less harm than blast or heat effects. Roughly, there are two kinds of radioactivity produced by atomic explosions. The first and most important in airbursts is the initial or explosive type of ray which is released quickly and dies out promptly—the danger to human beings lasts about one minute within a radius of one mile of the bomb burst. A fatal dose of rays is likely if a person is totally unprotected and within two-

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thirds of a mile from the explosion center; under a mile some illness is likely to follow and over a mile away may result in temporary blood changes. Protection is afforded by concrete buildings that stand between an individual and the burst. Induced or lingering radioactivity is the result of penetration of metallic or other radioactive or holding objects which are penetrated by A-bomb rays. This phenomenon occurs within two-thirds of a mile from the bomb epicenter. Such induced rays, if concentrated enough, may do harm to humans. The first signs of ray effect are nausea and vomiting which may occur as early as two hours after a heavy dose; delayed symptoms, such as falling hair or anemia develop after lighter, but prolonged, doses. Individual reaction to ray effects plays an important role.

As noted above, survival is likely for a large number of individuals who experience an A-bomb burst. Injuries and crippling may result, burns may cause unsightly scarring and blood changes may incapacitate. However, survival will likely bring with it other effects which were noted after ordinary bombing episodes in World War II, namely war strain, which affects children particularly. War strain may manifest itself because children are in an area where bombing is frequent or because they are evacuated from the danger area away from home and parents. A considerable literature has developed from the British experience in this regard and there is no unanimity of opinion regarding the value of evacuation for children as against their remaining in bombed areas with their parents.

Bodman[2] reports a survey made by Dunston of 8000 school children exposed to bombing in Bristol, England, where air raids were occurring fairly often. Dunston found that roughly four per cent of the large sample showed some signs of strain following shortly after a series of severe air raids. Among 300 children showing evidence of strain 120 demonstrated psychological symptoms of aggressive behavior, nervousness, trembling or crying while over 170 suffered from psychosomatic disorders such as headaches, epistaxis, pallor, anorexia, indigestion, enuresis and soiling. The proportion affected appeared to be relatively small considering the type of trauma to which children were exposed.

Mons[13] states that the child exposed to bombing may suddenly become lazy, obstreperous, mischievous, a truant from school and unmanageable in evacuation billets. Burburry[3] finds from a comparison of reactions of evacuated and non-evacuated children, that there appears to be little relation between heavily bombed areas and anxiety about raids. Further, more complaints were received from parents concerning children's anticipation and talk of air raids and noise of sirens in evacuation reception centers than in bombed areas. Alcock[1] also showed that among evacuated children breakdown was often precipitated by the problem of separation from home and its protective authority; among 15,000 city-bred evacuees there were 420 cases of breakdown, most of them between the ages of seven and one-half and eleven and one-half years, while those children remaining in bombed areas were most affected between the ages of one and five and one-half years. Kimber[10] was struck by the effect on evacuated children of the threat by air raids to their parents left behind—the feeling of guilt in having run away from a danger their loved ones were still exposed to—a feeling found even in very young children. Burburry[3] concludes from her evaluation of evacuated children versus air-raid exposed children that whatever the ultimate outcome, the immediate effect of evacuation is worse than the immediate effect of air raids and that "the fantasy, waking or dream of the raid is provocative of greater anxiety than the reality."

What is the long term effect of air raid strain? Bodman[2] assesses this factor among Dunston's 300 children who showed signs of air strain in the Bristol raids. He finds that 61 per cent of the 300 children from among 8,000 studied were affected for a period of three weeks to two months, that after seven months, 11 per cent still showed persistent symptoms but that none did so for this long period of time who were under one year or over five and a half years of age.

Whether civil defense against bombing and atomic bombing will consist in evacuation on a grand scale or shelters at home, the experience of either will have a marked impact on children and result in definite psychological and psychosomatic strain in a number of them.

Thus far the threat of immediate death or injury and of the effects of war strain on surviving children have been mentioned. There remains the question of the anticipated greater hazard during periods of heavy bombing of an increase in infectious diseases as the result of disruption of adequate water supplies and proper disposal of sewage. Also the possibility of higher incidence of or the occur-

rence of outbreaks of the common communicable diseases among rural children with whom evacuated city children would come in contact. Glover[7] gives a comprehensive report of observations on the first four months experience after the great evacuation of some 1,000,000 children between September 1 and 3, 1939. A comparison is made with the four identical months of September, October, November, and December, 1938. The incidence of infectious diseases was remarkably low and out of all proportion to expectations.

The fall prevalence of poliomyelitis, diphtheria, scarlet fever, rheumatic fever, epidemic jaundice and enteric fever is well known. Diphtheria and scarlet fever had shown rather high attack rates in 1938 and recent preceding years so that a mixture of city carriers and rural susceptibles might readily precipitate outbreaks of these diseases. Poliomyelitis had been severe in England in 1938 and enteritis and dysentery had shown increases in the two months preceding evacuation. The outcome was favorable beyond expectations for the incidence of infectious diseases was remarkably low, except for impetigo and the nuisance infestation, pediculosis. Although evacuees received good medical attention, reported instances of diphtheria, scarlet fever and poliomyelitis were lower in number than for the similar period in 1938. There was no real increase in dysentery or enteric fever and a fall evacuation was a happy circumstance as regards infections such as whooping cough, influenza, the common cold and measles. The reasons for such low rates are not too readily apparent but the following factors probably contributed greatly:

1. School instruction was carried on at first in two shifts so that half of the evacuees and local children were out of doors in good autumn weather while the other half were in school, thus exposure of native children to imported carriers was gradual and at a lower dosage level.

2. Only one-third of the anticipated number of children and women to be evacuated actually reached the rural reception centers—for evacuation was on a voluntary basis and air raids had not as yet occurred.

3. Many children began to drift back to the cities after the immediate threat of air raids did not materialize.

The disconcerting factor from the nuisance standpoint was the increase in the evacuated area of impetigo and pediculosis; fortunately the incidence of scabies was less than anticipated and ringworm was reported in very small numbers. To get a complete picture of evacuation and its problems and greater details concerning the diseases mentioned, Glover's article[7] must be read in its entirety. The report covers the first four months after evacuation but the result of invasion of hundreds of thousands of rural homes by city bred children did not result in the anticipated rise in incidence of certain infectious diseases and the experience during the remainder of the war was much the same.

In Germany also,[19] the expected increase in infectious diseases after excessive bombing did not occur and no explanation for this was readily apparent though the German population was, up to the last year of the war, in good physical state and had excellent hygienic standards for that period.

Bacteriological Warfare

Dealing with bacteriological warfare from the standpoint of restricted information concerning it and lack of actual reported field experience against the enemy, leaves much to be desired and makes one reluctant to make assertions. Informed individuals are of course sworn to secrecy and their publications merely touch on some of the more obvious implications and do not reveal whether there is a difference of opinion among them concerning the role of Biological Warfare in conflicts of the future. There is, however, lively controversy among those not actively engaged in the field of Biological Warfare. Opinions vary as to the feasibility of its application on a grand scale as against mere local nuisance or "morale-breaker" value. The basic differences have not been resolved even by the more recent attempts of Langmuir[11] on an epidemiological appraisal basis and that of Haas[8] in an article on medical aspects of Civil Defense.

The manual, "Health Services and Special Weapons Defense"[6] issued in December, 1950, by the Executive Office of the President categorically states, "an enemy could employ . . . biological warfare against us effectively." One must then choose his own position with relationship to the possibility or importance of this method of harassing or destroying the enemy.

What is biological and/or chemical warfare? It is an attack on the enemy utilizing germs, toxins

or chemicals, or, as the manual states[6] with reference to the agents available, "a wide variety of viruses, rickettsiae, bacteria, fungi, protozoa, and soluble toxins . . . might be employed." No mention is made of a hypothetical new agent of unknown characteristics or of "supervirulence" so that in this matter pure speculation enters into the reckoning.

Biological warfare presumably is directed at:

1. Producing a large number of casualties in cities, to create hysteria and undermine public morale.

2. Affect local groups to incapacitate key industries and individuals.

3. Cripple the food supply and thus undermine public morale.

The forms in which a biological attack might be made are two, according to the manual:[6] (a) by clouds of pathogenic aerosols released over large cities and (b) contamination of water and food supplies or the air of strategic buildings by means of sabotage. In the first instance, the aerosols might be released by emanations of a fine mist or spray containing organisms or toxins from a spray bomb or from a fixed dispensing unit on a submarine in coastal waters. In the second instance, besides sabotage, organisms might be directed at animals or at their food supply so that secondarily and more slowly it would deprive the enemy of food derived from animals or plants used by man for food.

A self-propagating epidemic might be started but this is seriously questioned because from past experience with known agents the history of epidemics does not furnish a premise for believing that such an outbreak can be initiated and if it were possible there is every reason to believe that public health and medical organizations could control it. A "superagent," then, and an uncontrollable epidemic can be dismissed from consideration at the present time. The problem, if it arises, will likely be limited to known disease agents and their old and perhaps new potentialities for effective use either by ingestion or inhalation. Langmuir[11] states that the scientific basis for assessment of the problem rests with epidemiological facts relating to common vehicle epidemics and airborne infections.

Common-Vehicle Epidemics.—Past experience with epidemics due to contamination of water and food supplies is ample to indicate how repeat performances could be caused by purposeful contamination of foodstuffs by the enemy. Before purification of water supplies became universal, epidemics of typhoid fever were numerous. The outbreak of amebiasis in Chicago some years ago also serves as an example. Foodborne outbreaks have occurred and are again possible particularly by inoculation of custards and foods that are moist and warm. Saboteurs may inoculate food readily by posing as bakers or by contaminating water supplies in the role of caretakers, janitors or employes of waterworks. In such instances, high attack rates might result among individuals who ingested such inoculated foods or water.

In addition to organisms, toxins derived from organisms or a variety of other bacterial or vegetable toxins might be employed. The toxins of Cl. botulinum are to the point and would act quickly but there are others whose action is delayed for days and weeks allowing an enemy agent plenty of time to disappear and leave few clues. Considered from the mass standpoint common-vehicle epidemics would have nuisance and morale undermining value but would likely affect relatively few people and here children must be accounted as susceptible as adults.

Airborne Infection or Epidemics.—The importance of air as a mode of spread has been a long-disputed question. Prior to 1890, both scientifically informed individuals and the lay public believed air was the dominant mode of spread of infection. During the era of bacteriology, roughly from 1880 to 1920, the idea was given less and less credence and rapidly disappeared. About fifteen years ago the idea was revived by British and American investigators and the outcome of their studies was responsible for advances in the disinfection of air by means of controlled ventilation, ultraviolet irradiation, dust suppression and glycol vapors. But the application of engineering methods to the control of naturally occurring disease in general population groups was disappointing. It remains to be proved that airborne infection is an important mode of spread of naturally occurring infections.

The mechanics of airborne infection have been better understood in the past decade and spread of infection by air has occurred as the result of:

1. Experimental demonstration by such workers as Dunkin and Laidlaw[4] in dog distemper; Lurie

and co-workers[12] in infection of rabbits with tubercle bacilli; and Rosebury and his associates[14] at Camp Dedrick, working with organisms causing undulant fever, tularemia and psittacosis.

2. Accidental laboratory infections which have for a long time been considered an occupational hazard and accepted as a calculated risk. The recent studies of Sulkin and Pike[15,16] on viral infections contracted in the laboratory indicates that many infections are possible by this means.

3. Penetration and retention of particles of proper size in the respiratory tract—the work of Hatch,[9] in this respect, is outstanding.

Time does not allow a more extended discussion of the above known methods by which airborne infections have occurred. The question is, can the enemy reproduce at will conditions known to cause airborne infection on a scale harmful to many individuals, utilizing no new principle or no new organisms. Perhaps the question is not whether it can be done but whether it is feasible. The methods could very likely be applied on a grand scale so that large clouds of contaminated or poisoned air would be produced but no one can predict appropriate weather conditions, the proper air level at which real harm will be done and the extent of attack rates. From our present knowledge concerning the possible role of airborne infection, it may be concluded that:

1. Biological warfare is possible but would likely affect a relatively small number of people—millions at once is nonsense.

2. No new diseases are likely involved—rather, new methods of spreading known diseases.

3. Toxins may be exceedingly potent but distribution to affect large numbers of individuals is difficult.

4. No single organism affects everyone.

5. Natural epidemics travel slowly in terms of control methods available to stop them.

6. The enemy might be more interested in making people sick than in killing them—sick individuals demand care, and can affect public morale more adversely than deaths.

Should biological warfare become feasible and a serious threat, the pediatric problems involved would be those resulting from:

1. Present known infections or intoxications—many of which are now amenable to control by inoculation or to treatment by use of sulfonamides or antibiotics—or to neutralization by serums or antagonistic drugs.

2. Complications arising from known infections and intoxications.

3. Psychological or psychosomatic strain induced by fear of biological warfare which would affect older children rather than the younger or by fear induced by actually seeing or experiencing an attempt, abortive or successful, utilizing any of the methods discussed.

4. Malnutrition resulting from lack of adequate food supplies or inaccessibility to them or through loss of animals or their food supply by enemy-induced animal or plant infections. Further, continued longterm strain occasioned by fear or worry may cause malnutrition through persistent anorexia, nausea or vomiting.

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MEDICINE IS ARMING FOR ATOMIC DEFENSE

(Continued from Page 202)

formulating their plans. It was the opinion of all participants that a meeting of the sort sponsored by the Wayne County Medical Society was long overdue and the conclusion was that it has served a most useful and stimulating purpose. All were greatly encouraged. Although much needs to be done, a great deal has been achieved. As a matter of record, the group decided that a similar meeting every six months was most desirable. Before the conference was adjourned it was decided to hold another meeting in May, 1952, with the Chicago Medical Society as sponsor.

Perhaps the most heartening conclusion drawn from this conference is the fact that county medical societies throughout the major areas of the United States, each of which has a committee devoted to the effort, have taken an active and leading part in medical civil defense. Each society is co-operating closely with health department authorities in the development and implementation of planning. There are other civic agencies such as police, fire, welfare, and communications, to name a few, who are vitally interested and necessary in the complete plan. Their co-operation has been admirable. It is apparent that the governing body of each society recognizes the responsibility of organized medicine in this endeavor. A major problem is getting the individual physician-member to realize that without his full and active participation medical civil defense cannot function. If organized medicine does not do the job, there are other groups ready to step in and take over, to our detriment.

Remember, there are no experts—as yet—in Civil Defense.

MEDICINE AND MORTALITY

Medicine enters 1952 with justifiable pride in an astonishing record of reduced disease mortality and prolongation of human life. A recent quarter-century summary* shows, for example, a decline in over-all mortality amounting to 55 per cent for females and 42 per cent for males. Nor is this exclusively the result of improved infant and child health techniques. In the sixty-five to seventy-four age bracket, the mortality tumbled 25 per cent for males and 37 per cent for females. And when it comes to communicable diseases, the record is even more amazing. For instance, the death rate from communicable diseases in childhood has, in one quarter of a century, taken a 97 per cent fall! Even the "degenerative" disease category has shared in the falling death rate at all ages.

This makes us face 1952 with good heart and no little pride. But before we pat ourselves on our collective backs, it might be well to salute the many other workers in the health professions who have contributed to this gratifying record. Research scientists and dietitians, pharmacologists and surgeons, nurses and electronic engineers, public health officers and soil chemists, veterinarians and medical clinicians have all had a share in it. Much of the trail-blazing work in pharmacology and pharmacognosy has been done by the extra-ordinary American drug industry. Government too has helped, with money, protective legislation, clinical material and brain-power. It seems like a long distance from the test-tube and the guinea pig to the recovery of a dying child, but the connection is there. The magnificent progress of medicine is no idle boast, no empty propaganda, but rather a solid achievement translated into the fact that hundreds of thousands of citizens of all ages are alive now who would have been dead long since, were it not for modern medicine.

It looks as if 1952 is going to be a tough year in world polities and world economics. We doctors don't know much about either subject. And we suspect that the politicians and economists don't either. But in our own field—individual human health—we look forward to one more round of steady progress. May it be a happy new year to all the troops in our war against disease, death and injury!

**Statistical Bulletin* of the Metropolitan Life Insurance Company, 32:3 (Sept.) 1951.

MICHIGAN CLINICAL INSTITUTE

March 12-13-14, 1952

Sheraton-Cadillac Hotel, Detroit

Information of Practical Value in

Your Daily Practice

Care of the Cancer Patient

By Harry M. Nelson, M.D.
Detroit, Michigan

A SERVICE PROGRAM which attempts to give aid to the patient with cancer must have the co-operation and approval of the medical profession. There is today a wholesome understanding among the physicians as to our purpose and our need for each other. Old suspicions are subsiding, perhaps in the face of a new threat, but whatever the reason, the American Cancer Society welcomes the doctor's growing awareness that we are not a thing apart from them but, on the contrary, are providing them with an opportunity for the expression of a community of action against cancer, without which its control will be long delayed.

At the present there is a greater appreciation of the importance of cancer in medieal practice and a more widespread recognition of the doctor's social responsibilities to participate actively in its control than ever before.

Every community is faced with the problem of caring for the individual with long-term illness or the individual who requires terminal care. The sick man does not for the moment see the necessity for progress in medical science. He is primarily interested in humanitarian rather than scientific impulses.

The American Cancer Society program of lay and professional education is aimed, with increasing success, at uncovering and eradieating malignant disease in the early stages, and the research program intends nothing less than the ultimate elimination of cancer by discovering its cause and cures; there remains the very real problem about what to do for the person who has cancer today. Service to the cancer patient in need is, I believe, the most sustaining element in all that we do. It will not advance our knowledge of cancer's causes or bring about more effective treatment—research will do that. It will not save the most lives—education will do that. But at the present moment we will do well to give these patients kindly, sympathetic care as long as required.

This brings up the question as to what is the best method of managing the chronically ill with cancer. We, as a voluntary health agency, cannot provide adequate care to the approximately 4,500 people who die each year in our division. There are at all times in Greater Detroit approximately 1,200 terminal eases which require attention. We must plan and work with the medical profession in order that the suffcrer may obtain the best possible hospital and homc care.

The greatest needs in Detroit at the present time are more registered and practical nurses. Several of our large, approved hospitals which have complete radiological, laboratory and surgical facilities for taking care of all types of cancer patients have vacant beds, a tragic situation caused by lack of personnel.

The experience of the American Cancer Society throughout the United States indicates that whcre additional hospital beds must be provided, and nurses are available, there is no reasonable substitute for direct expansion of the present hospitals. For a substitute located at a distance would obviously be unsatisfactory and inhuman.

It would be more expensive to maintain since it would be necessary to keep in this kind of hospital all that is now provided in the general hospital. Competent physicians who have a selected interest in the various categories of disease should be encouraged as scientists to study their special problems through to the end. It seems, then, that it is sound planning to provide two beds in the present hospitals—the place we can still find so many of our challenging clinical problems—rather than to provide one bed in the general hospital and one bed in a terminal-care hospital at a distance. We should never place an osbtacle between the patient and the physician, and distance is certainly an obstacle. The trend is away from special hospitals and toward the absorption of specialties by the general hospital so that group medical care may be applied on a broad medical basis no matter where the patient happens to be located. It is becoming more definite that the care of the acute and the chronic must be united in a general hospital on a continuing basis as long as the need for a hospital bed can be proven. More and more physicians are willing to support and relieve hopeless, helpless cancer patients to the end.

It seems quite evident that the patient who can be safely cared for in his home should remain there to allow a more profitable use of beds by those who need them. In some instances a pro-

From the annual report given to the Southeastern Michigan Division of the American Cancer Society.

gram of home care can be offered by financial subsidy under extension service, through the hospital or a voluntary agency. The burden of care during illness which does not require the highly concentrated hospital facilities is returning in large part to its point of origin, the home. Thus the way to achieve individualization of care for the patient is often within the bosom of his family.

Because we believe one of the greatest needs in patient care today is trying to solve the nursing problem, the American Cancer Society has carried out in the past two years an experiment with the Visiting Nurse Association in Detroit. This organization has been granted $13,000 for a study in the training and use of practical nurse students in home care of patients with cancer. This experience has shown that practical nurses, when properly taught and supervised, have an important job to do in a public health nursing agency which carries a bedside nursing program. Patients with long-term illness, and their families, have mental and physical health needs which a public-health nurse can help them to meet. But the patient's need for nursing care is often so great that the nurse's time and energy are consumed and public health nursing aspects are neglected. Through assigning these cases to student practical nurses, more concentrated consecutive service was possible, and the professional nurse, relieved of responsibility for actually giving care, was available to see and give attention to medical, dental, dietary, recreational and vocational needs of the patient and of other members of the household. Families temporarily relieved of part of the burden had a chance to see what more complete care meant to the patient, and sometimes showed themselves to be more teachable and responsible than they had been considered. Patients were sometimes found to possess strengths not previously recognized. Sometimes remarkable progress toward improved family health, not previously considered possible, was made through the combined efforts of the professional and practical nurse. This was possible only when the role of each worker was completely understood, accepted by both and adequately filled. While this program is small, it is a good beginning, and we should encourage other organizations to aid in providing more nurses for home care and hospital care.

The program of home care which was started in the Montefiore Hospital in New York, January 1, 1947, is a model which we hope many divisions of the American Cancer Society will follow. During the first two years the New York City Cancer Committee granted $80,000 for its continuance. The average census during 1948 was 53.5 patients. They have been able to take care of many very sick patients in their own home and provide them with a high level of medical care. The patient benefits by being in a more friendly atmosphere and having the benefit of individualized care. The patient who is suited for home care, and who has at his disposal the facilities which can be provided for him, is much better cared for than he could be in any hospital regardless of the relative cost. The cost of the Montefiore home care is about one-quarter of the cost of hospital care.

Through our research, education, early detection, diagnosis, treatment and follow-up programs, there will be fewer cancer patients who will require terminal care. In addition to that, many patients formerly regarded as terminal can be treated by newer methods and rehabilitated. There are, then, three important objectives in a service program which aims to assist the patient with advanced cancer:

1. Utilize full community resources in state and county cancer *service* activities.

2. Assist present institutions in the establishment of cancer clinics and cancer diagnostic clinics.

3. Develop in co-operation with physicians a more comprehensive program of home care.

MSMS

Esophagitis is probably the most important precancerous lesion of the esophagus.

* * *

Gastric polyps may become malignant.

* * *

Achlorhydria should be recognized when attempting to decide if small ulcers of the stomach are benign.

* * *

Among precancerous lesions of the colon, polyps in general and chronic ulcerative colitis in particular seem to offer the greatest potential danger.

* * *

Thousands of women's lives would be spared each year if they would submit to a reading of their cervical cytology.

* * *

When ovarian tissue is suspected of malignancy at the operating table, radical and extensive surgical procedures should be carried out. A total hysterectomy is definitely preferred to the subtotal procedure.

Hematoma of the Rectus Abdominis Muscle During Pregnancy

By Melvin S. Dennis, M.D.
Detroit, Michigan

HEMATOMA of the rectus abdominis muscle during pregnancy is apparently an uncommon condition. Torpin in 1943 collected twenty-seven cases from the literature and added one case of his own, making a total of twenty-eight. To date, only thirty-four cases have been recorded in the literature. This condition no doubt occurs more frequently than is indicated by these figures, but because of its obscure nature and self limitation is not recognized.

The etiologic factors of hemorrhage into the rectus abdominis muscle are generally considered to be:

1. Trauma during pregnancy such as coughing, sneezing, vomiting or violent exercise causing overstretching of the muscle and rupture of the vessels. This is probably the most common cause.

2. Intrinsic disease of the muscle from infections, such as influenza or typhoid fever, arteriosclerosis or blood dyscrasia.

3. Idiopathic causes.

Multiparity seems to be a definite etiologic factor of this condition. Of thirty-one reported cases, Thomas found only three primagravidas and twenty-four multigravidas. In twenty of the cases he found that the condition occurred after the thirtieth week of pregnancy, suggesting that overstretching of the rectus muscle is possibly a factor.

The diagnosis of this condition is seldom made. Adam reports only nine of thirty-two cases correctly diagnosed prior to surgery. Depending upon the location of the hematoma, it is frequently misdiagnosed as other intra-abdominal disease such as twisted ovarian cyst, degenerated fibroid, ruptured appendix, abruptio placenta, ruptured uterus, or gall-bladder disease. The diagnosis would undoubtedly be made more often if the condition was kept in mind. A careful history is important in arriving at a correct conclusion since in the majority of cases reported there was a history of some trauma such as coughing, sneezing, straining or a fall. A large number of minor cases go undiagnosed as a rule because of the obscure nature of the pain and the speed with which they recover. Usually the pain goes by the name of muscle strain, and within a few days it subsides and the correct diagnosis is not made.

The treatment must be decided by the severity of the case. Thomas believes the conservative treatment is only justified so long as the general condition is good, and there is no increase in the size of the tumor or of the abdominal pain. The majority of authors favor the surgical treatment which consists in opening the rectus sheath, removing the clot and ligating the bleeding vessel. If there has been no extension into the peritoneal cavity, there is no indication for exploration of the abdominal viscera. If the wound is dry and no infection is present, closure may be done without drainage, but if there is much bleeding, it is best to drain. Antibiotics should be employed to counteract infection.

Torpin found a mortality rate of 15 per cent and suggested that perhaps half of the infants died. This figure, of course, included many cases that probably died because of no blood replacement.

Case Report

Mrs. A. G., a forty-five-year-old negro woman, was admitted to Herman Kiefer Hospital obstetrical pavilion on July 23, 1947. She was a para 4, gravida 6. Her last baby was a 5-pound stillborn male delivered in November, 1945. She previously had two spontaneous abortions of unknown cause. Her last menstrual period began December 29, 1947. The patient gave a history of having hypertension for twelve years and syphilis since 1934 with intermittent treatment until 1940. During her pregnancy she developed some increase of her usual exertional dyspnea and ankle edema but no other toxemia symptoms. Her chief complaint on admission to the hospital was pain in the abdomen and cough. One week before admission she developed an upper-respiratory infection with an associated cough. She noticed some soreness in the abdomen during the week following the onset of the cough, but the pain was never severe enough to necessitate bed rest or medical advice. On July 22, following a paroxysm of coughing, she experienced a sudden "burning pain" in the right side of her abdomen. The pain increased in severity and was aggravated by further coughing, causing her to come to the hospital for relief.

Physical examination on admission revealed a well-developed, obese, colored woman, appearing acutely ill. Her temperature, pulse and respirations were normal, but her blood pressure was elevated to 200/90. There was some enlargement of the heart. A soft systolic murmur was audible at the apex and pulmonic areas, and

frequent ectopic beats were heard. The abdomen was rounded and obese, and there was marked tenderness to palpitation over the entire right side. A poorly demarcated, firm, tender, fixed mass was felt on the right side extending from 4 centimeters above the symphysis pubis to 5 centimeters from the right costal margin. The mass was apparently not connected to the uterus which seemed to move independently of the mass on change of position. The fetal heart tones were audible faintly in the left lower quadrant and were timed at 160 per minute. The fetus was unengaged and was palpated in a transverse presentation. There was no tenderness on palpation of the uterus or the left side of the abdomen, but she did seem to experience more pain on attempting to raise her head from a flat position. There was slight pitting edema of the ankles and legs. The pelvic measurements were normal. Laboratory studies revealed a 3-plus albuminuria with occasional granular casts and white blood cells per high-power field. Her blood count on admission was 3,370,000 red blood cells with 62 per cent hemoglobin and a leukocyte count of 15,000. Sedimentation rate and blood chemistry studies were within normal limits. An electrocardiogram revealed only extra systoles. X-rays of the abdomen were taken on July 25 and August 8, and revealed the bones of a fetus about eight months of age in a transverse presentation. The placenta was not visualized. The clinical impression at this time was eight-month gestation complicated by hypertensive toxemia, hematoma of the rectus abdominis muscle, and transverse presentation. The patient had some clinical improvement with bed rest and sedation, but the pain in the right side of the abdomen continued. On August 9, cesarean-hysterectomy was done under general anesthesia. A 4-pound 2-ounce male infant in poor condition was delivered from a transverse presentation and expired seven hours after birth. A hematoma measuring approximately 25 cm. in length and 10 cm. in breadth was found to occupy the right rectus sheath. No attempt was made to evacuate the hematoma, but 15 cc. of dark hemolized blood was aspirated with a large needle.

Her recovery from this operation was uneventful. On August 18, lateral x-rays were taken of the abdomen in an attempt to outline the hematoma, but no mass could be visualized separate from the other soft tissue of the abdominal wall. On August 23, the right rectus sheath was opened under general anesthesia and approximately 1000 cc. of clotted and hemolized blood was removed from the lower two-thirds of the rectus sheath. No active bleeding vessels were found. A pack was placed in the lower end of the incision which was removed in 24 hours. The patient had an uneventful recovery, the incision healing without infection. On discharge from the hospital September 2, the abdomen was soft with only a moderate amount of induration over the area of the hematoma.

Summary

A case of hemorrhage into the rectus abdominis muscle during pregnancy is reported.

The etiologic factors are briefly discussed.

Due to the rarity of the condition it is frequently misdiagnosed as some other intra-abdominal condition.

Operation is the usual recommended treatment since conservative treatment always carries the risk of more bleeding from additional trauma.

Early and correct diagnosis of the severe type of rectus hemorrhage is emphasized in order to prevent maternal mortality.

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THREE TOP UNIVERSITIES IN MICHIGAN AMONG LARGEST IN NATION

Michigan's three largest educational institutions—the University of Michigan, Michigan State College and Wayne University—all moved up in the national rankings during the past year.

The status of the Michigan schools was revealed in the annual report on full-time and total enrollments made by Dr. Raymond Walters, president of the University of Cincinnati.

In terms of full-time enrollment, the University of Michigan ranks as the fourth largest college in the country with an enrollment of 17,035. Michigan State College is ninth with 12,219 full-time students.

Last year, Michigan was seventh with 18,912 students and MSC was tenth with an enrollment of 13,692. No other Michigan institutions were listed among the top twenty-five colleges.

In terms of total enrollment, including part-time students, the University of Michigan ranks eighth with 19,685 students. Wayne University is fourteenth with 17,384 and MSC is twentieth with 13,837.

The decline in enrollments, reflected by the three Michigan institutions, was general throughout the country.

"The decline in enrollments reduces the income from tuition fees," Dr. Walters said, "and is heightening the effects of inflation which now imperil all of American education."

The report gave the following as "big ten" among American universities in terms of full-time enrollment:

1, University of California, 34,883; 2, Minnesota, 18,282; 3, Illinois, 18,036; 4, Michigan, 17,035; 5, New York University, 16,858; 6, Ohio State, 16,583; 7, Wisconsin, 16,142; 8, Columbia, 13,849; 9, Michigan State, 12,219; 10, Indiana, 11,752.—*AP, December 29, 1951.*

Surgical Treatment of Pain

By John Martin, M.D.
Chicago, Illinois

PAIN, being a symptom, is never treated directly by surgery unless the primary source of the pain cannot itself be removed. When it becomes necessary to treat pain directly, there are several definitely planned operations, based strictly upon an application of the anatomy of the nervous system, which may be applied safely for the treatment of intractable pain.

Because the nervous system is anatomically so organized that functional units are discretely placed, the accurate surgical application of a knowledge of such functional anatomy may be used for the control of pain by intercepting those neural pathways which conduct certain sensory impulses from the source of irritation to the location of conscious interpretation within the brain.

Very often the patient who is considered to need surgical relief from intractable pain is in a state of extremis. Often his outlook for life is very poor, as in the patient with a pre-terminal carcinoma. Often other extensive surgery has already been done, and analgesic drugs may have been given to the point of addiction. In such patients, the cessation of pain by any means is a welcome change for both the patient and all others concerned with him. But all patients with intractable pain are not suffering a malignant disease, so that if freed of the pain life could resume its normal course. In such a person it is important that the relief from pain be obtained with little or no secondary effects upon the person's otherwise normal self.

The surgical treatment of pain is best considered by a review of the few procedures of choice, rather than the almost endless list of possible pain states which are encountered.

1. *Peripheral nerve section* is rarely done. Most peripheral nerves serve a mixed sensory and motor function, and one would hesitate to sacrifice the motor component. Furthermore, most afflictions of individual peripheral nerves are successfully treated by the proper surgery locally where pain is a part of the disability. Under no circumstances should peripheral nerves to an extremity be cut, for to do so would be to destroy important tactile, proprioceptive, and other types of perception. Since peripheral nerves lie distal to the dorsal spinal ganglia they can and do regenerate, which may result in a recurrence of the pain, disagreeable paresthesias, painful neuromas, and phantom phenomena.

2. *Rhizotomy* is the intraspinal severance of the dorsal spinal root between the spinal cord and the dorsal spinal ganglion. In such an operation, therefore, one may selectively cut only the sensory components of the peripheral nerves to any selected number of dermatomes, and because of the anatomical site of the section regeneration can never occur. Again, such a procedure should never be done to the extent that an entire extremity is sensorily denervated. Rhizotomy is effective only for somatic pain, never for pain arising from visceral sources, unless, if done for the latter, the operation is extended over excessively wide levels. Rhizotomy is very useful for the control of persistent pain such as sometimes is present in the incisional scar of an old thoracotomy. For instance, if pain persists along thoracic segments seven and eight on the left side, dorsal spinal roots six, seven, eight and nine on the left could be severed with complete and permanent relief from the pain. Because of the anatomical overlap of the sensory supply from dermatome to dermatome, it is always necessary to cut the next highest and lowest dorsal roots above and below the dermatomes in which pain is expressed by the patient. In the instance of intractable pain about the neck, shoulder and face, as is sometimes present in carcinoma in those regions, sensory rhizotomy of the upper cervical roots on the involved side, together with section of the sensory root of the trigeminal nerve, will give complete and lasting relief. Thus rhizotomy is particularly useful for the relief of intractable pain of a somatic nature involving the neck and trunk. It is proper to add that when intractable pain develops along the course of one or several intercostal nerves, due to the effects of surgery, deep x-ray therapy, injury, or other causes, surgical severance of the nerves or their injection with alcohol, seldom gives lasting relief, and the recurrent pain may be more annoying than was the original.

Presented at the Eighty-Sixth Annual Session of the Michigan State Medical Society, Grand Rapids, September 28, 1951.

3. The operation called *cordotomy* consists of an incision within the spinal cord itself, with severance of the dorsal and ventral spinothalamic tracts, such incisions being made bilaterally and five to six segments above the highest level of pain. These tracts conduct the impulses of pain, touch, and temperature as they enter from the periphery, through the dorsal spinal roots, on their way upward toward the brain, and they exist as well delimited anatomical pathways within the antero-lateral quadrants of the spinal cord. The operation does not destroy the all-important proprioceptive senses, and may, if performed high in the cervical cord, be applied for the control of high thoracic pain. However, cervical cordotomy, particularly above the level of the origin of the phrenic nerves (which is cervical cord segments 3, 4 and 5), is not a safe procedure, the level of choice for cordotomy being at approximately thoracic cord segments two and three. Obviously, this is a more complicated and serious operation than rhizotomy, but it is done for more serious reasons. It may be used for the control of either somatic or visceral pain, and it is the operation of choice in most patients with intractable pain such as arises from abdominal or pelvic carcinoma, malignant tumors of the spine, sacrum or lower extremities, or for tabetic crises. Neither rhizotomy nor cordotomy should be done for the control of pain in a phantom extremity after amputation.

4. It may be that pain comes into consciousness in the thalamus and not the cortex of the brain, the cortex only serving to regulate it in degree. Pain is a primitive phenomenon, and logically it should have no accurate representation in the phylogenetically new cerebral cortex. Nevertheless, *ablation of the specific sensory cortex* has been done for the control of phantom limb pain, and the reports of the results vary from excellent to poor with only temporary relief. There is always such a large functional element in the pain of a phantom limb that the results of surgery for its control are difficult to interpret no matter what form of surgery has been employed. In this operation, performed under a local anesthesia, the post-central gyrus and adjacent parietal lobe is exposed, and the cortex is explored by electrical stimulation until the conscious patient complains of a reproduction of/or increase in his phantom pain. The gray matter for the corresponding limb is resected by "cold" sub-pial dissection. Three of five patients of my own so treated had immediate and lasting relief from their phantom extremity.

5. There are those patients for whom none of the already mentioned operations might be considered proper. This is especially true in the patient whose ultimate prognosis is not good, though life may be expected to continue for an indefinitely long time. If such a patient has become deeply addicted to drugs, or if there is an extreme state of tension, concern, and anxiety with the pain, then one of several methods of attacks upon the antero-medial nucleus of the thalamus may be employed. Such *thalamic destruction* may be carried out unilaterally or bilaterally, many excellent results having been obtained with the unilateral operation alone.

Surgical attack upon the thalamus was first devised as a treatment in certain of the psychoses, the purpose being to overcome the fears and anxieties of the patient. The cell bodies of the fibers leading to the antero-medial nucleus of the thalamus lie in the cortex of the antero-medial portion of the frontal lobe, and by the operation of resection of such specific cortical areas, sometimes called "topectomy," the desired depressive effect on the thalamus may be obtained. The same effect may be obtained by the original, equally effective, less complicated, less dangerous, and more popular operation of lobotomy, or, more properly, leucotomy, in which selected areas of the non-vascular white matter anterior to the lateral ventricle are severed under direct vision through trephine openings. A variation of leucotomy is done in some clinics by the euphemistically termed "ice-pick" method, wherein a sharp, pick-like instrument is passed through the upper conjunctival fold, through the thin roof of the orbit, and into the frontal lobe, where the white matter is severed by moving the handle of the instrument through the proper degrees in a coronal plane. Personally, I would not recommend this procedure. A more recent elaboration of the technique of thalamic destruction is through the use of a modified Horseley-Clarke stereotaxic instrument, which, when applied to the head, may be used to produce accurately placed electrolytic lesions within the antero-medial nucleus of the thalamus. This method is new, but it is a scientific approach of much merit and promise.

6. There are three specific types of primary

neuralgia wherein the pain is most severe, unrelenting, usually progressively disabling, and which have no known etiologic basis. These are, *trigeminal neuralgia, glossopharyngeal neuralgia,* and *sphenopalatine ganglion neuralgia.* The discussion of any one of these painful states would require considerable time to describe fully the clinical syndrome, the diagnosis, and the treatment. The pain of trigeminal neuralgia may be limited to the distribution of one, two, or all three branches of the nerve, and the only known permanent cure for this terrifying distress is section of the sensory root between the Gasserian ganglion and the point of entrance of the root into the pons. As in any other sensory rhizotomy, the nerve cut at this point cannot regenerate, but cut or injected with alcohol at any point distal to the ganglion, regeneration will always occur with renewed pain and paresthesias. The operation is conveniently done under a local anesthesia, or local anesthesia bolstered with a light general anesthesia for the moment of actual severance of the root, and it may be done regardless of the age of the patient. A supposed refinement of this operation is the severance of the descending trigeminal sensory pathway in the lateral surface of the medulla, near the olive, but this operation has never proved popular because of the many undesirable side effects of medullary disturbance which it has produced. Theoretically, section of the trigeminal root at that point destroys pain perception only, leaving undisturbed all tactile sense. Glossopharyngeal neuralgia is much less common than trigeminal neuralgia, but it is nonetheless severe. It is permanently cured, without any after effects whatsoever, by the intracranial section of this tiny nerve as it passes from its meatus in the antero-lateral wall of the posterior cranial fossa to the brain stem. Palatal or faucial numbness or weakness is never noted by the patient and rarely demonstrable by an examiner after the section of this nerve. Sphenopalatine ganglion neuralgia is a definite entity which can be proved by a therapeutic test of cocainization of the ganglion during an attack of pain and which can be cured by the destruction of the ganglion by surgical removal or by alcohol injection. It need never be confused with trigeminal neuralgia. If you wish to incur the ill will of a patient with such a pain, indicate to him that you have never heard of such an entity, or that text books pass it off as an indefinite sort of combination of intranasal pathology and functional distress, or that it was probably a figment of the imagination of a certain Dr. Sluder.

7. The intractable pain of angina pectoris, chronic pancreatitis, and certain peripheral vascular diseases such as Raynaud's phenomenon and thromboangiitis obliterans can be most satisfactorily and permanently stopped by the application of surgery to the proper segments of the autonomic nervous system. Often the organic changes resulting are of equal or greater benefit to the patient than the mere relief of his pain. But I should like to emphasize that in my opinion destruction of the autonomic nervous system for any reason must be considered carefully, for there seems at times to be a tendency to use such an approach as a panacea, or when nothing else seems to work. Based both on a knowledge of autonomic nervous system anatomy and physiology and clinical experience, such surgery, however, when properly selected and done with technical accuracy, has of recent years brought new hope and extended life to many severely afflicted persons.

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HUMAN BLOOD PRESSURE DETERMINATIONS

A revised guide for physicians in measuring human blood pressure, entitled "Recommendations for Human Blood Pressure Determinations by Sphygmomanometer," has been issued by the American Heart Association. It will shortly be available to physicians in booklet form through application to the Michigan Heart Association, 4421 Woodward, Detroit 1, Michigan.

The "Recommendations" booklet replaces the booklet "Standardization of Blood Pressure Readings," originally published by the Association in 1939. The revisions were drawn up by a committee appointed by the Council for High Blood Pressure Research of the American Heart Association, under the chairmanship of Dr. Carl J. Wiggers, Professor of Physiology at Western Reserve University School of Medicine, Cleveland.

In commenting on the publication of the "Recommendations," Dr. Wiggers said:

"The physician, and through him nurses and properly trained technicians, are being constantly kept informed of new discoveries which help to make blood pressure readings more accurate. The measurement of human blood pressure is still a comparatively new tool, the introduction of which is well within the memory of many of the older groups of practitioners. Recognizing that physicians were employing different techniques and criteria in measuring blood pressure, and too generally assumed that instruments sold were accurate, the American Heart Association in 1939 appointed a committee to crystallize the best available thought on the subject at that time by publishing a pamphlet entitled 'Standardization of Blood Pressure Readings.' This has resulted in more precise standardization of methods and has stimulated manufacturers to make improvements in apparatus."

"Since that time, more experience has been gained in laboratories and hospitals, resulting in even greater accuracy in measurement of human blood pressure. This has now been assembled in the new 'Recommendations.' "

First Use of Epinephrine (Adrenalin®) in Asthma

Wilfrid Haughey, M.D.
Battle Creek, Michigan

MY MOTHER SUFFERED very severely from asthma for a great many years. My father, Dr. W. H. Haughey, for several years had sent her to the Mackinac Island region the middle of August to escape the asthma. She was free from it in that region. My first year out of school, in 1906, she did not get started early enough, and developed an attack of asthma in such severe form that she was confined to bed. My father had done everything then known, with not much relief. She was getting so weak she could not raise her head, and we feared for her life.

Finally in desperation, my father asked me if there was not something I had been taught in school that could help. I remembered having seen one of the rhinologists use a new drug to relieve a stuffy nose, and mentioned it. We could not see any relation, but I reasoned that the asthma was a stuffiness of the bronchi instead of the nose, and what was good for one might be good for the other. I suggested that if we could apply the new drug, adrenalin®, to the bronchi it might help, but how to do it. We could not make a direct application, and a spray was clearly not indicated, for she could not inhale enough to carry the spray.

We succeeded in finding a bottle of the drug. It was marked for local application only, however, and that was not good. I remember making the suggestion that the only way to apply the drug to the bronchi would be by injection, and maybe that would not be helpful. However, after much discussion we decided to try. The next question was dosage. Up to that time, adrenalin had been used locally only. It was marked 1-1000, so we figured it might take quite a dose to get any results. We injected one hypodermic full, 20 minims.

This was done with fear and trembling, as we did not know what would happen, but we did know the patient was likely to die if something was not done. We explained this to her, but she begged for help at any cost.

We watched her. Within two minutes she quieted down, could breathe easily, and was perfectly happy. But we were not. We saw for the first time an anaphylactic reaction. She shook. She shook the bed, the house. She had a terrific chill, but she was breathing for the first time in days. This relief lasted for eighteen hours. When she became severely asthmatic again, she begged for another dose. After considerable hesitancy we decided to try again, but to use only half the previous dose. We knew it would not kill her, but feared for the shock to her nervous system from repeated reactions. The 10 minim dose threw her into a chill for just a few minutes instead of approximately an hour experienced from the first dose. The third dose was 6 minims, and that seemed to be about right to keep her comfortable for about twelve hours.

This occurred in August, 1906. In October of that year, the detail man from Parke-Davis came to the office on his regular visit and told us he had a new drug just being introduced, which would reduce swollen nasal mucous membranes. We told him of our experience. He promptly said the drug was not to be injected and was so marked on the label; however, he was going back to Detroit, and would report our findings. The next year Parke-Davis advertised the drug for the relief of asthma.

This we are positive is a Michigan First. No one had ever done it before, and we knew we were playing with fire, not knowing anything about the action of the drug when injected, or even if it could be injected. But the need was great, and we took a calculated chance, with results far beyond our expectations.

MSMS

BLUE CROSS-BLUE SHIELD COVERAGE AVAILABLE

Michigan Medical Service and Michigan Hospital Service will open enrollment again to members of the Michigan State Medical Society during the period of March 10 to April 10. The effective date of accepted applications will be May 1, 1952.

This is the one time of the year when members who are now enrolled may make changes in their contracts, add dependents, et cetera.

For the first time, the $5,000.00 family income limit plan of Michigan Medical Service will be offered to the members during this enrollment.

Each member and each enrolled office assistant will receive enrollment information by mail during the first week of March. Assistants of enrolled members are eligible for enrollment.

Know Your Government

By John B. Martin
Auditor General, State of Michigan
Lansing, Michigan

MR. CHAIRMAN and members of the House of Delegates, I am very glad to be here this morning to talk to you on the third element of your Formula For Freedom program, KNOW YOUR GOVERNMENT.

In Lansing, as your Auditor General, I see the problems of government coming across my desk daily, because most of those problems, in the last analysis, or in at least one analysis, are financial problems. So, sometimes I wonder whether, if we could apply some other formula, some other way of doing things, we could reduce them.

The other night when I got home I found my little daughter saying her prayers. I could hear her through the door. When she got through I said, "Suzie, you didn't finish. You didn't say 'God bless Mummy and Daddy.' You can add it if you want to."

There was a moment of silence, and then she said, "But I can't, Daddy; I've already hung up!"

In Lansing, and I am sure in Washington and other places where men struggle with the problems of government, we would like to be able to reach down and get a telephone and hold it to our ear and get some instructions from up on high as to what we ought to do about some of these tough questions. Of course, we can't do that. We have to solve them the best we can, with the best implements we have, with the honesty and integrity that we have in us, the best judgment we can apply, with the gathering of all the facts we can pull together, with all that we can do to give a right answer and produce the kind of government that people are entitled to.

There was a time when government was not very important in one sense. It was not very important to you and me and a lot of other people because it didn't seem to affect us very much. It was something rather remote. It was operated on a relatively small budget, and it did relatively few things. It provided relatively few services, and it just didn't affect people. So, occasionally they went to the polls and voted. Sometimes they took a good deal of interest in political campaigns, but government itself did not hit them very hard.

That isn't true today, and I don't have to elaborate on that. If you buy something, the prices that you pay are controlled. If you earn something, what you earn is controlled by what your taxes might be. If you do something—if you are a businessman and want some materials—you have to go to Washington for some papers that say you can have them. If you want to make something which has critical materials in it, you have to get a permit for that. If you are a farmer and want to plant crops, you will have to take an inventory of what the many aspects of the farm program may require you to do and may limit you in doing.

We are dealing with a big stake. As one of the previous speakers said, we are dealing with the whole question of freedom. It isn't just freedom in general terms—it may have been once upon a time—it isn't just freedom for the country to operate as it likes—it is your freedom and my freedom as individuals—the freedom of our country. I have travelled all over the state, talking to a great many groups, and I have observed that men in groups of this type are, generally speaking, the leaders in their communities. They provide the force and initiative and drive that gets things done in those communities. They lead hospital drives and Community Chests, and see that the community gets things done. But in one field they don't do very much leading, and that is in the field of government. Generally speaking, the leaders in our community, in Michigan and throughout the United States, are unwilling to lead in the field which is now almost more important than any other. They are unwilling to lead in the field of government.

I think we have a simple choice developing today. It is very clear. The more you study this picture, the clearer it becomes. It is a choice between those who believe that whatever is wrong with us, whatever does not work very well, can be solved by going to Washington for it, that it can be solved by bucking the problem on up the line to a group of Washington bureaucrats who presumably have some magic answer.

It is a struggle between that kind of thinking and those who believe that we will survive as a free nation only if we keep our free institutions,

Address delivered at the Formula for Freedom presentation before the House of Delegates, Michigan State Medical Society, Grand Rapids, Michigan, September 24, 1951.

our free professions and our free enterprise out of the hands of Federal bureaucrats.

All you have to do is to look around you to see this drive for control. You don't have to be a soothsayer or have any special insight as to what is happening. In business there is always a pressure from the Washington level to try, if they can, to put more controls on the decisions that business has to make.

Recently in the Defense Production Act there was a proposal that all business be licensed. Why? To enforce price controls. Why? Well, someone asked Michael DiSalle that question, and he said, "That is so if they don't do what I tell them, I can put them out of business." That is government of men, and not government of laws.

The same thing is true with agriculture—the whole attempt to subsidize the farm program. The same thing is true in the field of electric power. The same thing is particularly true (and I don't have to stress it because you are familiar with the fact) in the field of health. The whole Ewing plan as it is proposed is familiar to you.

The doctors throughout the states have made many, many speeches on the subject. Your Auxiliary has done a remarkable job in that regard, in educating the people as to what that particular threat is. To me that is the best illustration I know of concerning what is happening to this country and what is happening to you, and why you must not only know your Government but you must somehow or other begin to share it.

Someone said the other day, at a national meeting of a medical society, that the threat of socialized medicine had been beaten—that the program was dead. That was a very naïve statement, gentlemen. The threat of the program of socialized medicine, the threat of the Ewing plan, hangs over your heads just as heavily today as it did a year ago. Those things don't die. Sometimes they suffer a temporary defeat, but they are reborn in other forms.

There never was a time when you and the country had a bigger stake in trying to preserve a system of medical care which has produced more and better medical care for more people than any other system known in the world today, and no one ought to be carrying that fight harder than yourselves; and I know many of you are trying to do that very thing.

Certainly, if we are in our right minds, we aren't going to trade the kind of system we have for the sort of three-minute-per-patient medicine they have in England. If England wants to suffer along with it, that's all right. Certainly this country does not want that kind of program.

The answers don't lie in Washington. The answers lie in ourselves, in our local communities, in our states, in the job we can do with individuals to develop what one of our speakers has called a sense of responsibility for ourselves.

I think the answers lie probably in the kind of action some people have been trying to take through our local communities, through the states, to develop better training facilities for doctors and for nurses so that we can have an ample supply of them and so there won't be a shortage of that commodity.

The answers lie in providing better hospitals—not better hospitals built with money from Washington. If the necessary amount can't be raised in the local community and can't be provided from the state, and can't be provided by local individuals, there may be some grounds for help from above; but the job ought to be started and ought to be done, as far as we possibly are capable of doing it, in and by each local community throughout the country.

Of course, we need a lot of other things: We need better local public health programs. We need better care for the indigent. Nobody expects nor intends the people who can't provide for themselves to be allowed to die for lack of care. People are not obliged to have poor men's medicine because for some unfortunate reason they can't pay all they ought to pay. We are working forward on all those fronts of developing local health programs and facilities. Add to that the whole program of private medical health plan insurance, which now covers millions of people throughout this country. Those are the elements that make up the right way to handle this problem, as opposed to the wrong way of handling it through federal interference and through the use of federal power and federal control.

I picked up the Grand Rapids *Herald* this morning and noted a few figures in their lead editorial: 18,000, or about 88 per cent of all the doctors in Great Britain, are working for the Government. Almost all the pharmacists in Great Britain are working for the Government; 95 per ment of all the dentists in Great Britain are working for the Government.

When everybody gets on the Federal payroll, do you think we will have in this country the kind of government we have had? Not at all!! When everybody is on the Federal payroll, then everybody is dependent upon Washington and whatever the source of Federal power may be for a bonus or a hand-out.

If we can keep Federal bureaucracy out of this picture, if we can avoid the social nightmare Britain is struggling with, we can do it on our own initiative only if you men are willing to share in the problem of how to get good government—how to select good men.

Somebody said all these politicians are alike. They are not all alike. Some of them are good, honest, straight; and some of them are not. Some of them make promises they don't keep, and some of them keep the promises they make. There is a difference, and it is just an easy way of passing the problem off to say they are all alike.

We can have the kind of government you want. Generally speaking, you will get the kind of government you deserve; but you have to back the right kind of people. You have to take part in elections. You have to contribute. You have to do some work of your own. You have to feel free to talk about politics in your offices. Sure, it hasn't been done before, but this is a big stake. This is a stake in freedom for all of us!

You can call this thing that is happening anything you like—you can call it federalization, decentralization, government monopoly, socialism, dictatorship. Those names all have one common denominator, that is, central control of the lives and details of the lives of individuals. That is why government is important to you.

We are not yet in a socialized state. Our grandfathers would say we passed that point long ago. The aviators have a term: they call it "The point of no return." When you reach the "point of no return" on your outward flight, and go past it, you know that you have gone past the point at which you could have turned back and arrived safely home.

We haven't passed the point of no return in this country. If we had, there would be no point in my standing here, talking. We have not passed the point of no return. If we don't work, if we are not willing to sacrifice, if we are not willing to do something about it, the point will be reached and passed.

There is a little church out on the Maine coast, on a little island, a tiny little building built out of the timbers of ships that had been wrecked and forgotten and that had drifted up on the shore. If you go there someday, you will find an old man who will take you around. He will take you up the rocky little path that leads to it, and he will take you inside. At the end of each pew you will see a little iron hook. He will tell you about it.

He will say, "Mister, when they built this church there weren't any electric lights. When the first family came for the evening service they brought a lantern with them, and they hung it on that little hook. Say, Mister, you know, when that first lantern was hung, the place was kinda dim, but when all the families got here and all the lanterns were hung, then the church was bright with light!"

That's our program! If all of us are willing to bring our little light, however smoky, however dim it may be, and pool it together in the work of a great organization such as this, then not only your organization but the country, the state and all the world can be bright with light.

MSMS

SCIENCE WRITERS TO MEET WITH AMA

The annual meeting of the National Association of Science Writers, whose members prepare most of the medical stories for newspapers and magazines, will be held in conjunction with the AMA meeting in June. Heretofore, the science writers have been holding their annual session in conjunction with the annual meetings of the American Association for the Advancement of Science.

Since the science writers will be meeting with the AMA, the Lasker Award Committee also decided to hold its annual dinner for the writers during the AMA session. At this dinner, tentatively set for Tuesday evening, June 10, the Lasker Awards for 1951 for distinguished writing in the fields of medicine and public health will be presented. The two awards—one for a newspaper writer and one for a magazine writer—are identical and consist of $500 and a statuette of the Winged Victory of Samothrace.

The AMA will play host to the science writers at a dinner when their meeting is held in Chicago in June.

John L. Bach, director of AMA press relations, attended the writers' meeting in Philadelphia, December 28-29, 1951, at which time it was decided to switch the annual session of the AMA meeting site.—George F. Lull, M.D., Secretary, AMA.

Detroit Physiological Society

Meeting of October 18, 1951

Carbohydrate Metabolism and Energy Relationships in the Crystalline Lens

Charles E. Frohman and V. Everett Kinsey
Kresge Eye Institute, Detroit

It has been established that the lens contains both the flavoprotein and the cytochrome-cytochrome oxidase systems. The respiratory enzymes involved in these systems exist in much higher concentration in the epithelium of the lens than in the cortex and nucleus. The ratios of the concentrations of lactate to pyruvate in the different portions of the lens indicate that only in the epithelium does an appreciable amount of respiration take place, and that in the other portions of the lens the metabolism is chiefly anaerobic.

The amount of energy, presumably in the form of the high-energy phosphate bond, produced by the relatively inefficient anaerobic metabolism of the cortex and nucleus is insufficient to meet the requirements for the synthetic processes in these portions of the lens. It is hypothesized that the additional energy is supplied by diffusion of compounds containing the high-energy phosphate bond from the epithelium where they are formed through the more efficient respiratory process. The relative concentrations of compounds known to be involved in the transfer of high-energy phosphate (adenosine triphosphate and phosphocreatine) were shown to support the above hypothesis.

Effects of Reduced Blood Supply on Bone

Carl C. Coolbaugh
Wayne University College of Medicine

This investigation was supported (in part) by a research grant from the National Institutes of Health, U. S. Public Health Service.

In a series of normal, adult dogs the blood supply to one femur was interrupted by using one of three different types of surgical procedures, designed to interrupt vascular supply in varying degrees of severity.

Following surgery the animals were encouraged to carry on their normal aetivity for varying postoperative intervals. At sacrifice both the operated and non-operated femurs were removed. Each diaphysis was divided longitudinally into four sections corresponding to the anterior, posterior, medial, and lateral quadrants. From the compacta of these sections a sample at least 3.75 cm. in length was fashioned with a milling machine. The thickness and breadth of these milled samples were made to agree within one twenty-five-hundredth of a centimeter, (1/10,000th of an inch; 250 μ) as measured by a standard micrometer, over a span of 2.5 cm. in the middle of the sample. These samples were then used for the first part of the investigation, which consisted of measuring the tensile force of the bone on the basis of stress-deformation or strain per given force in pounds per square inch. The strain or stress-deformation over a one-inch span of the sample was measured by a Porter-Lipp extensometer in units of 0.001 of an inch. This was used in conjunction with a strain-gage type dynamometer. The tensile force was applied to the specimen along its long axis by a universal-materials-testing-machine which has an accuracy rating of 0.5 per cent.

For the second part of the investigation, the comparative normal and avascular bone density determinations, a sensitive density measuring device or densitometer was used. This densitometer, which was developed by Coolbaugh, Evans, and Lebow (Science, 114:182-185, 1951), consists of a radioactive source, a bone sample holder, and a Geiger-Muller tube. It is used with a scaling and counting chamber. A beta-ray emitter was chosen for the radioactive source because nuclear physicists have shown that the percentage transmission of beta rays by any material is proportional to the logarithm of the density of that material. Strontium-90, with a half life of 25-30 years, insures a constant source of radiation. The densitometer is so designed that the geometrical relationship of the radio-active source and bone sample remains constant.

Each day a laboratory background count was taken with the radioactive source removed from

the room. Next a count was taken with radioactive source in place (densitometer cassette) without a bone sample. Next, counts were taken using four standard strips of aluminum which measure 0.02, 0.03, 0.04, and 0.05 cm. in thickness. From these readings a graph was plotted on semilogarithmic single cycle graph paper with the sample area in gms/cm.^{2} as the abscissa and the intensity in counts/min. as the ordinate. This graph was then used as the standard reference graph for determining the bone densities. The numerical count obtained with a given bone sample was referred to the graph and the corresponding area read off in gms/cm^2. This figure, divided by the thickness of the sample in centimeters, gave a direct reading of the density in gms/cm^3.

The resuults obtained showed that following interruption of the blood supply of bone there is an initial postoperative interval of from 24 to 96 hours during which the density and modulus of elasticity of the compacta decreases. By the 5th day (120 hours) this decrease in density and modulus has practically disappeared, the avascular and normal values being about equal. From the 5th or 6th day onward there appears to be a reversal of the earlier process, with an increase in density and modulus of elasticity over and above the corresponding normal bone.

Even though the interpretation of bone-density changes is usually carried out on the basis that the density of bone is primarily dependent upon its mineral content, which would obviously involve the fundamental process of bone calcification, yet it is not possible at this time to explain completely the density changes noted with decreased blood supply to bone.

Chemical analyses and *in vitro* calcification studies for the identification of a possible calcification-inhibitory substance produced in avascular bone are being carried on at the present time by the author, and it is hoped that the explanation will be forthcoming.

Hypophysial Anatomy and the Stress Reaction

John D. Green
Wayne University, Detroit

Some of the evidence for the nervous mediation of the stress reaction was presented with special reference to the author's own work on neurohumoral control.

Meeting of November 15, 1951

Certain Endocrine Aspects of Sterility in Women

Charles S. Stevenson, M.D.
Wayne University College of Medicine, Detroit

General clinical experience seems to point to mild degrees of hypothyroidism as being the most common dysfunction in sterile women. The next most common endocrine defect appears to occur in connection with corpus luteum function. This defect is chiefly manifested by evidence of inadequate progestational change in the endometrium and may be the result of faulty gonadotropin stimulation of the ovary or of faulty response of the ovary to an apparently normal gonadotropin stimulation. There may be a deficiency in estrogen production by the ovaries as well as in progesterone production. Estrogen deficiency is chiefly manifested by prolonged and irreguluar intermenstrual periods, and a quantitative decrease in menstrual flow and duration, as well as sterility.

A study of endometrial biopsy specimens, taken about two days prior to the expected onset of a mensis, has revealed that 80 per cent of the sterile women in this study appeared to be ovulating but only one-third of the group showed adequate secretory or progestational change in the endometrium. Twenty per cent of the women were not ovulating.

The treatment consists of replacement therapy, giving whole desiccated thyroid gland tablets by mouth in appropriate daily dosage and, in those patients who give evidence of only progestational phase inadequacy, 10 milligrams of "buccal" progesterone should be administered morning and night after meals starting on the 16th to 18th day of the cycle and ceasing on the 27th day of the cycle. For those women whose intermenstrual period is appreciably longer than the usual 28-30 days and in whom the endometrium may give evidence of inadequate proliferation, as well as inadequate progestational change, a course of grad-

ually increasing doses of oral estrogen is advised, starting on the 4th day of the cycle, being maintained at maximum dosage from the 20th through the 23rd day, and rapidly being decreased to the original small dose by the 26th day, with none being given on the 27th day. Conjugated equine estrogens are believed to be very satisfactory for this purpose and the usual starting dose is 0.625 milligrams daily, the maximum daily dose being roughly five times this amount. It is recommended that this cyclic therapy be given for three consecutive months.

Studies on Epidermal Regeneration

Hermann Pinkus, M.D.
Detroit Institute of Cancer Research and Wayne University College of Medicine, Detroit

A method is presented by which a graded proliferative stimulus can be applied to human epidermis. Previous attempts at stimulating epidermal proliferation fall in two groups. Either a defect was set and the healing of the wound was studied, or natural conditions under which epidermal hypertrophy occurs were simulated. Electricity, changes in temperature, chemical irritation, friction, running in tread mills have been used for the latter purpose. Most experiments were done on animals, the epidermis of which differs in various respects from human epidermis. The methods can not be conveniently applied to human skin, or they set up complicated and uncontrollable conditions.

By applying transparent pressure-sensitive adhesive tape to the skin, Wolf† removed a single superficial layer of horn cells for microscopic study. It was found* that if this process is repeated, the entire horny layer can be stripped off step by step without undue damages to the underlying living epidermal cells. Scotch Tape® was applied to the volar surface of the forearm, patted on, and peeled off. It took from 20 to 30 strips to remove most of the horny layer. Biopsies taken at various intervals from ½ to 96 hours after stripping showed greatly increased mitotic activity starting as early as 24 hours after the stimulus. In one case 4 per cent of the living epidermal cells were found undergoing mitosis at 72 hours. It is planned to compare features of this benign and self-limited proliferation to carcinogenesis. It is expected that the strip method may be applied to various physiologic problems, such as the role of the horny layer in loss of heat and water, in absorption of chemicals, in electric resistance, sensory perception, et cetera.

†Wolf, J.: Das Oberflächenrelief der menschlichen Haut. Ztschr. f. mikr-anat. Forschung, 47:351-400, 1940.
*Pinkus, H.: Examination of the Epidermis by the Strip Method of Removing Horny Layers. J. Invest-Dermat., 16:383-386 (June) 1951.

The Arterial Blood Supply of the Human Stomach

John Reid Brown and John William Derr
Detroit

The arteries of the stomach have been restudied by latex injections of fresh human autopsy specimens. Injections were carried out with all vessels intact, after which the relative importance of the left and right gastric and right and left gastroepiploic arteries was determined by injecting each after ligation of the other three. Resulting specimens, cleared, demonstrate the abundant anastomoses within the gastric wall and the relative proportions of the blood supply which are or can be contributed by each of these vessels. The results are of great interest in relation to operative procedures upon the stomach.

Meeting of December 20, 1951

Paper Chromatography as a Rapid Method for Survey of Enzymes

John F. R. Kuck, Jr.,
Wayne University, Detroit

A tissue extract is made by grinding with sand and an equal amount of buffer, and then centrifuging. Aliquots (2 to 3 ml) of the supernatant are put into flasks with 2 to 8 micromoles of substrate. Two controls are used: a water blank containing no substrate which serves to indicate the normal level of metabolic products; and an inactive blank made by adding 2 micromoles of substrate to an inactivated sample which serves as a semi-quantitative standard for comparison with the test samples. After incubation the samples are freed of protein and made up to 1 to 2 ml. Aliquots (.05 ml) are subjected to paper chromatography along with appropriate reference solutions. The disappearance of the substrate in the test samples as compared with the inactive

blank is an indication of its enzymic conversion. The appearance of new products, or increases in products normally present at levels shown by the water blank, is an indication of the pathway of the enzymic conversion. The method is applicable to a survey of liver tissue for the presence of enzymes acting upon cystic acid, since it and the expected metabolic products, alanine or taurine, are all ninhydrin-reactive substances.

Heat Processing and its Implications in Nutrition

M. Iacobellis, L. J. Schroeder and A. H. Smith
Wayne University College of Medicine, Detroit

This investigation was undertaken to re-evaluate possible nutritive damage to milk and milk products incurred during commercial heat processing. Samples of commercially pooled whole raw milk were frozen, while other samples from the same source were processed and converted into evaporated milk and whole milk powder by the Pet Milk Co. In addition to these commercially processed milks, raw milk from the Borden Co. was autoclaved at 10 and 15 pound pressure for 15 to 30 minutes in our laboratory.

The experimental subjects used in this investigation were four adult female dogs and nitrogen balance studies were the criteria of possible deleterious change.

It was observed that (1) under the experimental conditions employed commercial heat processing as used in the preparation of evaporated and dried whole milk does not decrease the nutritive value of the protein constituents: (2) that autoclaving whole raw milk at 10 or 15 pounds pressure for 15 or 30 minutes has no detrimental effect on milk protein; (3) that the digestibility and biological value of milk protein does not change if milk is kept in frozen storage for five months.

To explain the beneficial effect of heat on the milk protein as contrasted to the deleterious effects of the same heat conditions on other food proteins, the same experiments were carried with "Starlac" which is obtained from high quality fresh whole milk by removing 97.5 per cent of H_2O and 99 per cent of fat with the hope of finding in these two factors the clue for the difference in results. The "Starlac," therefore, was autoclaved at 15 pounds for 30 minutes dry and reconstituted with water at different concentrations. It was observed that "Starlac" autoclaved without addition of any water kept the dogs in marked negative nitrogen balance, while "Starlac" which was autoclaved in the presence of H_2O kept the dogs in positive nitrogen balance.

From these experiments, we could conclude that although the interaction of proteins and carbohydrates is known to decrease the nutritive value of proteins when subjected to heat, such an interaction does not seem to be in evidence when these two components of food are subjected to heat in aqueous medium under the present restricted conditions of concentration and of time and degree of heat processing.

Metabolism of Sulfone Drugs

A. J. Glazko, W. A. Dill, L. M. Wolf and J. Strong
Parke, Davis and Company, Detroit

The absorption, distribution and excretion of a number of diaminodiphenylsulfone (DDS) derivatives was studied in animals, with particular attention to M-52 (4-allylamino-4′-aminodiphenylsulfone). With DDS, Promin, M-52, Diasone and Sulfetrone given orally to rats, highest concentrations of drug were observed in the liver and kidneys, with lower concentrations in the spleen, lungs, muscle and heart. In all cases lowest concentrations were found in brain tissue. DDS appears to be absorbed and excreted more readily than any of the substituted sulfones tested. Clinical subjects on continued daily dosage of M-52 maintain fairly constant blood levels over a 24-hour period. Excretion of M-52 is slow, with about one-third of a given dose excreted in the urine and two-thirds in the feces over a period of several days.

Two dimensional paper chromatograms of rat urine after the administration of DDS derivatives revealed the presence of some unchanged drug, considerable free DDS produced by hydrolysis of the substituted derivatives *in vivo,* and several unidentified metabolites. One of these appears to be a glucuronic acid conjugate of DDS which is unstable in acid solution, breaking down to form DDS. Chromatography of blood serum from patients on M-52 indicates that some free DDS is present, as well as unchanged drug. It is suggested that the slow excretion of DDS derivatives, coupled with slow hydrolysis in the body to form DDS, offers a valuable means of maintaining blood levels of DDS over long periods of time with a minimum of side reactions.

President's Page



Doctor William Beaumont

Beaumont Memorial Restoration Begins

To the medical profession of Michigan has been given the privilege of restoring the old American Fur Company Store on Mackinac Island. By now, all doctors of medicine in Michigan should be acquainted to some degree with the historical importance of this old store, where William Beaumont first saw his famous patient, Alexis St. Martin. It is hoped that all members of the Michigan State Medical Society will avail themselves of the opportunity to contribute something to this memorial. In doing so, all will feel a noble pride in having a part in developing a medical shrine which will stand for all time to come.

Otto O. Becke

President, Michigan State Medical Society

Editorial

POLITICS UNADULTERATED

ABOUT SIX or eight months ago, President Truman made an announcement that if the medical profession would produce a national health program as good or nearly as good as his he would get behind it and try to make it work. He completely ignored the fact that the medical profession and the hospital group had the Blue Shield and Blue Cross plans in operation, doing a very satisfactory service for all who wish them. Approximately half of the total population of the United States now participate in these plans, in spite of the nearly twenty-five millions of people who are under the various government health services.

Since this promise, and as an additional spur to socialization, the American Fabian enthusiasts, the counterpart of those responsible for the socialism of Britain, are still very active. One of the latest plans proposed by our Government, Oscar Ewing's old age hospitalization program, promising complete hospital care for those over sixty-five, would accomplish the socialization of another fairly large segment of the population. Those over sixty-five are a rapidly increasing percentage, and their inclusion in the Government-sponsored category, Oscar claims, can be done without a dollar's extra cost, because it has suddenly been determined that the Social Security funds *are adequate to cover all these new costs.* Oscar fails to report that the Social Security funds have not been allowed to accumulate, but have been used by Government for ordinary going expenses, and whenever an account is paid by the Federal Security Agency the sum must be raised by a new tax contribution. When this suggestion was made a few months ago, it was not completely accepted, but has recently cropped up in one of Mr. Truman's utterances, with the explanation that there would be no extra cost.

Not long ago, Governor Warren of California announced himself as a candidate for President on the Republican ticket. He also has repeated his suggestion of socialization of medicine as one of his ambitions. He does not have the confidence of the Doctors of Medicine in his own State, but he is accepted as one of the men who must be reckoned with in the forthcoming election. He has tried his scheme in California without success, but he is unconvinced.

Another effort toward the same objective has just been announced. The President, on December 29, 1951, announced the appointment of a Commission on the Nation's Health Needs. The objectives are not too clearly stated. The Chairman is Dr. Paul Magnusson, orthopedist of Chicago, formerly head of the Veterans Bureau.

Another Emergency

Giving the health professions scant consideration, the President in effect has declared a National Health Emergency, and has appointed a lay commission of men to study the health needs of the nation, including his own national compulsory plan, as a defense measure, and to report a program within a year or earlier if possible.

As appointed, this was a commission of fifteen, containing a few doctors of medicine who are in independent practice (one of whom, Gunnar Gundersen of the AMA Trustees, promptly refused to act), with sufficient bureaucrats and socially minded individuals to assure a complete smothering of the conservative, workable, but independent American ideologies.

The President directed the commission to enquire into and study the following:

1. Present and prospective supply of physicians, dentists, nurses and other medical people and the ability of schools to provide what is needed.
2. The ability of local public health units to meet the demands of civil defense requirements.
3. Problems created by the shift of workers to defense-production areas which would require relocation of medical personnel.
4. How existing and planned medical facilities meet present and prospective needs.
5. Present research activities in the field of health and the research program needed.
6. The effect on maintaining health standards of actions taken to meet long-range military, civil-defense and veterans requirements.
7. The adequacy of private and public pro-

grams designed to provide ways to pay for medical care.

8. How much the Government should contribute to local governments for health purposes.

The President's attempt, by the appointment of another commission, to take the issue of health out of the 1952 political arena has been unmasked and shaken by the Cline-Gundersen statements.

Not Interested

It is not clear to us whether the President is proposing this new commission as a part of the administrative reorganization authority allowed him by the legislation following the Hoover Commission report. He, however, has announced it as an Emergency Defense Program, and might attempt to assume the authority of creating his national compulsory health plan on this basis. We can do no better in presenting the attitude of the medical profession than to repeat the announcement published quite generally in the public press Wednesday, January 2, 1952:

American Medical Association Head Rips Truman Health Plan as "Brazen"

President Truman's newly appointed commission on the nation's health needs received a second blast of criticism yesterday when Dr. John W. Cline, president of the American Medical Association, described the commission as "another flagrant proposal to play politics with the medical welfare of the American people."

Earlier Dr. Gunnar Gundersen of La Crosse, Wisconsin, a trustee of the association, refused to serve as a member of the commission. He charged the Presidential body was packed with advocates of Truman's socialistic compulsory health insurance plan and was timed and inspired politically.

Shocking Proposal, Cline Says

In a statement he issued, Dr. Cline charged that the commission "to be financed from emergency funds allocated for national defense is a shocking attempt to give White House sanction to the brazen misuse of defense emergency funds for a program of political propaganda, designed to influence legislation and the outcome of the 1952 election."

"There is no health emergency in this country to require such an investigation," Dr. Cline continued, "or to justify the use of defense emergency funds by such a commission. The health of the American people never has been better, as all competent authorities know, and greater progress is being made in providing medical care for all who need or desire it than any other time in the nation's history.

"In the face of such circumstances, any attempt to whip up an asserted health 'emergency' as an excuse to create another tax supported commission is an outrageous abuse of public authority.

"President Is Confused"

"It is clearly apparent from President Truman's statement, in which he has the bad grace to insist the people are 'confused,' that he still refuses to accept public rejection of his socialized medicine program and hopes to use this new commission to propagandize for it.

"It is the President who is confused, not the people. Congress, when it reconvenes, should put a quick end to this misuse of national defense funds for a useless commission, and for highly questionable political purposes.

"Dr. Gundersen's refusal to serve came in the form of a telegram to Dr. Paul W. B. Magnuson, Chicago orthopedic surgeon. Gundersen said his name had been released without his approval and before he had seen an official statement of the commission's objectives."

CIVIL DEFENSE

WAYNE COUNTY Medical Society has arisen to the necessity for constructive action in preparing for the Atomic or other disaster which any major American city must anticipate. Their Civil Defense and Disaster Committee headed by Max L. Lichter, M.D., held meetings extending over two days of the serious storm conditions, and produced a direct program. In this issue of THE JOURNAL, we are happy to present the chairman's report.

The March number of THE JOURNAL, which last year was devoted to the Atomic Energy problem, and which this year is designated to carry on with treatment, use in medicine, avoidance of injuries, et cetera, will publish many of the papers prepared by Dr. Lichter's committee. We hope that throughout the year we may be privileged to present new evidence, results of study, reports or complete papers bearing on this very real problem with which medicine must prepare to cope.

We congratulate Dr. Lichter and his committee and thank them for a project well executed.

MORE MICHIGAN FIRSTS

WE HAVE BEEN talking of Michigan Firsts in the field of economic and administrative medicine, for several years, but there are undoubtedly many firsts in the field of scientific medicine, which contain a story both instructive and interesting. Also, if some of these stories are not told, they will be forever forgotten.

On another page, the editor has told one such

story, of the first use of a drug of the epinephrine type Adrenalin®, the only one known then) in the treatment of asthma. We have two or three other similar stories, and have been promised one or two more. If any of our members know of such a story, we beg you to submit it. The story will be published, and we know will not only add to our collective knowledge but will confirm in our minds the fact that, in Michigan, medicine has always been a progressive profession.

May we have your story of a Michigan First?

"STAND YE IN THE WAYS"

WHAT SHALL it profit a physician to gain his professional freedom from socialistic planners, if he lose his professional soul to hospital corporations? And to what avail do we unite to study and make recommendations to insure the best medical practice in hospitals and under medical insurance plans, if our recommendations and requirements are ignored or circumvented by our colleagues and hospitals authorities? And are there those amongst us who will help to save our black sheep who have wandered amid the thistles and thorns of compromise? And what is this all about, anyway?

Doctor, we are talking about Michigan Medical Service, other insurance plans, many Michigan hospital administrations, the AMA and College of Surgeons recommendations, and many of our brethren in radiology and pathology. The bald facts follow: When Michigan Medical Service was organized, the principle was laid down and accepted that MMS would make payments only to physicians. This was done in support of the principles evolved and enunciated by medical organizations and to assure sound and continued physician interest and participation in the plan. This was and is good, and Michigan can take pride in the fact that this action has been cited nationally as an example of Blue Shield Plan administration at its best.

Unfortunately, however, this principle did not fit in with the preconceptions and prejudices of many Michigan hospital administrations and a small minority of physicians. In most Michigan hospitals, the above principle has been circumvented in the case of radiologists and pathologists by the execution of assignments of Blue Shield fees to the hospital by the physician concerned. These men have transferred their just claims upon MMS fees over to their hospitals.

The fact that Michigan physicians, in establishing MMS, wished it to be otherwise and that the AMA and American College of Surgeons recommended otherwise has not counted. Assignments have been executed, in fact, in face of the American College of Surgeons inspired requirement present in most hospital staff pledges that a physician shall not permit others to collect fees for him. In some cases, the assignments were made by a predecessor but enforced by pressure upon the present radiologist or pathologist when he became a staff member.

In some of the hospitals, certain of these specialists have made such assignments simply because "they couldn't be bothered" to collect the fees themselves. Now, we will admit that it is at least questionable whether members of the profession in Michigan have a legitimate concern in what a colleague does with his fees after he collects them. We do have a valid and potent interest in Michigan Medical Service however, and any other Blue Shield Plan which may use MMS as a model, and this claim allows us very definitely to insist that our few other worldly brethren come down to earth long enough to receive the MMS fees due them. The principle of payments only to physicians was established for the protection of the public and the profession at large. To stand by and permit it to be breeched by hospital pressure or professional ennui is unthinkable.

Where do we go from here? Back to our hospitals and radiologic and pathologic colleagues to find out whether a portion of a free physician's birthright has been signed away. If so, let us change it.

"Stand ye in the ways, and see, and ask for the old paths, where is the good way, and walk therein."—Jeremiah VI, 16.

S. W. DONALDSON, M.D.

MSMS

GIANT HAZEL NUTS

Filberts, more commonly known as hazel nuts in the East, have been placed on sale in New York which are twice as large as the ordinary ones. They are grown in Oregon. That state and Washington are declared to be the only region in the world outside of the Mediterranean countries where this nut can be raised profitably on a commercial basis.

Michigan M.D.'s Restore Beaumont Memorial

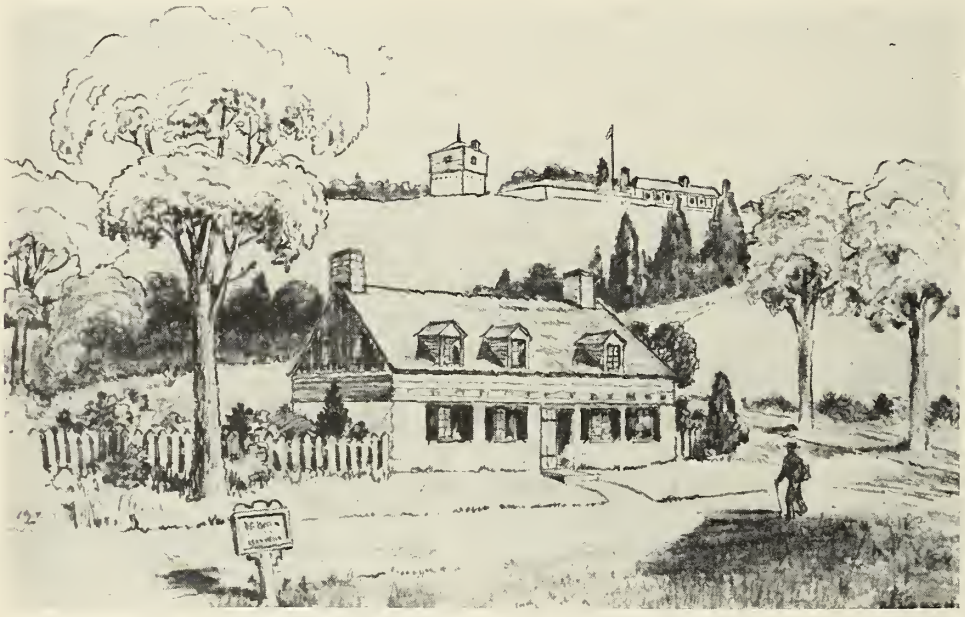
The ugly rumble of a musket crescendoed through the boisterous voices of trappers and traders crowded into the American Fur Company's store on Mackinac Island. As the sound echoed against the stone walls of the building, a startled young French-Canadian voyageur grasped his left side and crumpled to the hob-nail scarred floor. The voyageur's name was Alexis St. Martin.

Dr. William Beaumont, the medical officer of Fort Mackinac, was hastily summoned by a motley group of fur trappers. The doctor did what he could to repair the gaping wound in St. Martin's side even though he was certain the young voyageur could not live through the day.

But it was a day of destiny—June 19, 1822—a day for the world to remember.

For Doctor Beaumont and St. Martin had been brought together. And St. Martin lived with a hole in his side! St. Martin lived with a gastric fistula through which Doctor Beaumont could study the action of the stomach's digestive process.

The story of Doctor Beaumont's research is an epic of medicine. His experiments on the gastric juices are monumental in the history of medicine. With painstaking care Doctor Beaumont recorded fifty-one inferences uncovered in his experiments. While his laboratory equipment was crude, his observations and interpretations were keen and



Proposed Beaumont Memorial Building

From the vision of artist and architect, backed by exhaustive, documented research, the building portrayed in the artist's sketch can be turned into stone and mortar. It is proposed that a replica of the American Fur Company store stand once again on the spot marking the historical beginning of Doctor Beaumont's famed contribution to medical science. Inside this store a museum will preserve the memory of that period in the early 19th Century which became so important to modern medicine. This living memorial, this shrine of stone and wood can rise from the decay of time to proclaim to all the never-ending quest for scientific truth. And the Medical Profession of Michigan, through its generous contribution in the year 1952, can make tangible, for all to see forever, the labors of Beaumont and all other Doctors of Medicine who have brought Health and Long Life to the people of these United States.

clear—mileposts in experimental medicine. These observations were passed on to other men of science—doctors of medicine—so that more of them might know more about the mysteries of the human body.

The conclusions made by Doctor Beaumont are rated alongside Harvey's discovery of the circulation of blood. His observation of the gastric juices is one of the foremost medical achievements in a profession consecrated to the eternal hope that more may know.

Resolution

WHEREAS, Dr. William Beaumont began his pioneering work in physiology at Mackinac Island, Michigan, in 1822, and

WHEREAS, the first observation of his famous patient, Alexis St. Martin, was made by Dr. Beaumont in the American Fur Company's trading post, now known as the Early House on Mackinac Island, and

WHEREAS, through the generosity of Parke, Davis & Company, Detroit, the Early House was acquired several years ago by the Mackinac Island State Park Commission as the first step in plans to convert this historic building into a permanent shrine to the memory of Beaumont, with maintenance to be assumed by the Park Commission, and

WHEREAS, such a monument to the imperishable research of Beaumont would constantly remind the thousands of people who visit Mackinac Island annually that a free medicine is always a progressive one, eternally endeavoring to improve its science and its service to the public; therefore, be it

RESOLVED: That the Michigan State Medical Society assume responsibility for developing the Beaumont Memorial on Mackinac Island, and that the House of Delegates authorize The Council and the Woman's Auxiliary to the Michigan State Medical Society to inaugurate a drive for funds among the Michigan State Medical Society members and its friends, to complete the work of transforming the Early House into a medical landmark for posterity; the collected funds to be deposited with the Treasurer of the Michigan State Medical Society; and be it further.

RESOLVED: That contributions in this campaign be on a voluntary basis with the names of all donors inscribed permanently in the Beaumont Memorial, and that the work be completed, if at all possible, in 1952 in order to commemorate the 130th anniversary of Beaumont's important discovery.

This Resolution was adopted by the Michigan State Medical Society House of Delegates at its Annual Session of September 24-25, 1951, in Grand Rapids.



The old, decaying American Fur Company Store, Mackinac Island

On this site at Mackinac Island, the blast of a musket saved a million lives.

Here is the location of the American Fur Company store where Alexis St. Martin received the wound which gave Dr. William Beaumont the opportunity to observe and record the gastric juices in operation. Since 1822, the outline of the building has changed from a fur company store . . . to a house . . . to a nonentity. Even the contour of the land is different. It is unrecognized by the thousands who pass it by without a glance.

Yet it could become a landmark of the medical profession.

It could be a spot to which the people of Michigan would point with pride . . . pride in the achievements of their Doctors of Medicine!

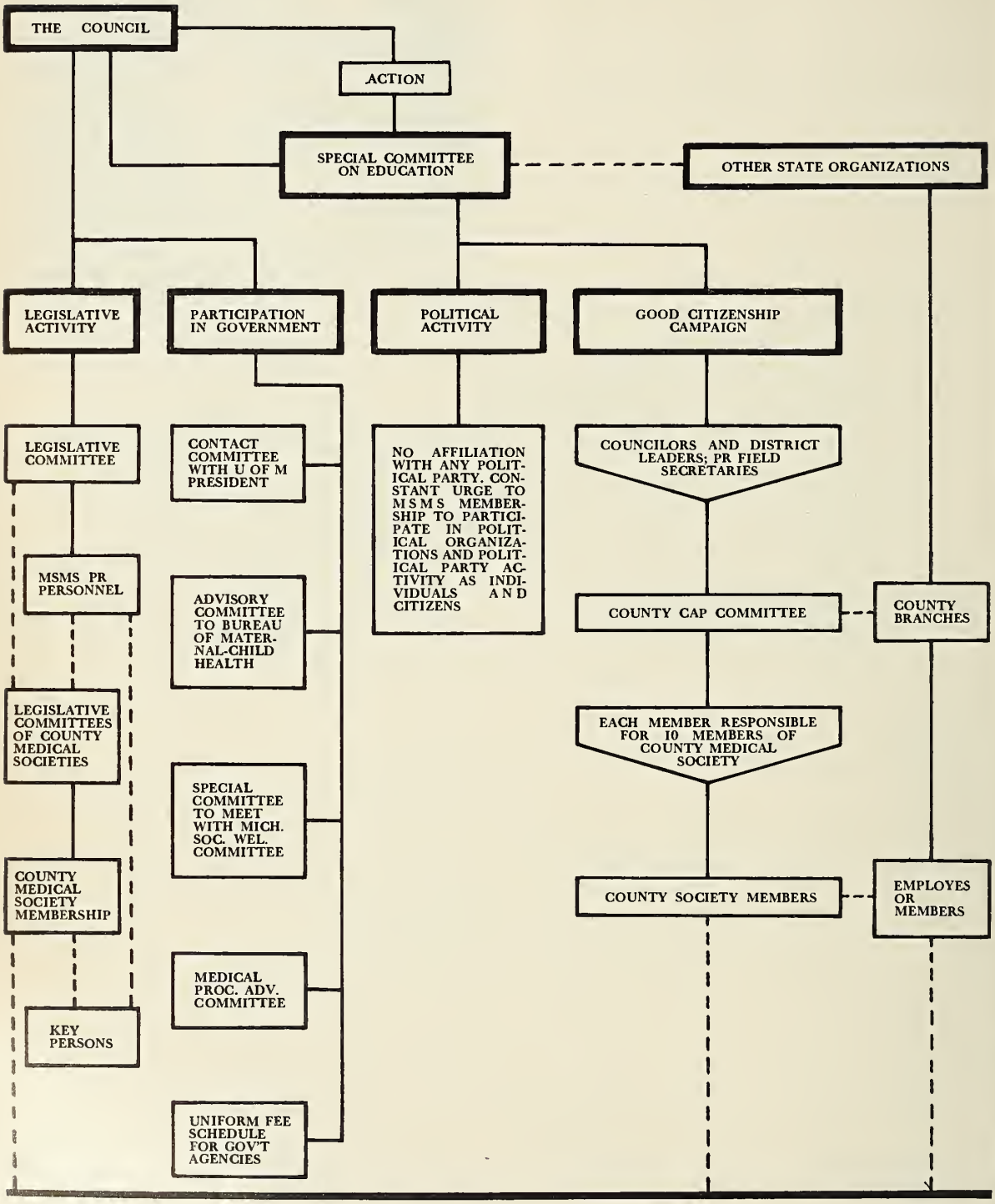
It will also serve as a reminder to all who visit the location on Mackinac Island that the medical profession is striving constantly to advance the science of medicine.

Today these advances in research begin in a completely equipped, modern laboratory. It was not so in the days of Doctor Beaumont. A kitchen was his laboratory and his tools were crude—a magnifying glass, a pair of scales, a gum-elastic tube. For an incubator Doctor Beaumont used either his armpit or a pan of warm water.

But despite these handicaps, Beaumont accomplished a great feat of research and brought more honor to his profession and fame to medicine in this state and throughout the universe.

Every Michigan Doctor of Medicine is invited to share in this shrine of honor, by individual subscription to the Beaumont Memorial Restoration.

Know Your Government



FORMULA FOR FREEDOM

A Formula that Works for All

(Part III)

Know Your Government

The Know Your Government element of the Formula For Freedom requires four basic types of study and activity on the part of organizations and persons. These are:

1. A constant scrutinizing of the local, state and national legislative and administrative bodies and the exercise of influence on the laws or regulations to be established by these bodies so that the decisions made by them will be in consonance with the American ideals of freedom.
2. Participation in governmental projects to the end that these projects will return to the people maximum value for tax money invested and also so that the project cannot be deviated from its original purpose by subversive influences.
3. Political activity toward the end that policies and candidates of political parties are assisted or defeated depending upon their possibilities for contributing to progress within the American concept of freedom and private enterprise.
4. Good Citiznship work toward the end that a maximum vote is gained and a maximum interest be maintained by the public in maintaining good government.

These are essentials in a republic if it is to survive and serve the people without the placing of controls which restrict freedom of self government.

The medical profession is discharging its obligations under this element of the Formula For Freedom as indicated below. The greatest difficulty involved is the maintenance of both a sustained interest and a constant desire to improve upon our program.

1. *Legislative Activity.*—The Legislative Committee of the MSMS maintains a constant liaison with the state and national legislatures and with state and national officials. This is done both directly through personal contact and through secondary contact via MSMS employes and the American Medical Association. Bulletins from both national and state societies constantly inform the county medical societies, the county medical society legislative committees and the individual members. Of equal importance is the return flow of information and assistance starting with the individual member. This work continues under the Formula For Freedom plan with particular attention to medical and health matters but not to the exclusion of matters of general civic moment. By such means doctors of medicine know their government and can be a definite force in helping others to be equally knowledgeable.

(Turn to next page)

2. *Participation in Government.*—Scores of contacts with federal and state governmental agencies are made each year by the MSMS. The society's representatives attend Michigan Day in Washington, D. C. A joint committee with the Michigan State Board of Registration in Medicine studies mutual problems, the Michigan Health Commissioner attends meetings of The Council, three MSMS Advisory Committees aid the Michigan Department of Public Instruction. A liaison committee works with the University of Michigan President and close working relationships have been developed with Wayne University. Advisory committees work with the Michigan Social Welfare Commission and the Michigan Crippled Children Commission. Services are offered and rendered to the Governor, the Michigan Civil Service Commission, the Selective Service System. Close observation is given opinions of the Attorney General, the White House Conference on Children and Youth, the "Little Hoover Commission" reports and various federal agency programs such as the EMIC. County and District Medical Societies are carrying out similar liaison and advisory services in county and local government.

This constant participation in governmental activities continues to increase under the Formula For Freedom plan as the necessity grows for guidance of government by professional organizations which are private enterprise minded. Many errors have already been avoided which would have constricted the freedom of the people as well as the medical profession.

3. *Political Activity.*—Although no affiliations by the MSMS or any other medical society is made with any political party the Formula For Freedom plan strongly recommends to the MSMS membership that it participate in political organizations and political party activity as individuals and as citizens, the effect of enlightened, civic minded and learned individuals actively participating in political work can be of great value, for political participation is a bedrock essential for the maintenance of freedom in a republic.

4. *Good Citizenship.*—The MSMS organized the "Co-operation with the American People" program for the purpose of carrying on a campaign to actively promote the policies and positive projects of freedom in America and gain a maximum vote by the people in general and primary elections. This program has two general directions: the first is organization within the profession to obtain maximum effort by every member, and through every member to the general public. The second is a joint effort with other ancillary medical organizations and other professional organizations; with business interests having special and financial interests in the health field and with organizations with like philosophies re private enterprise. The use of all types of communication media as well as personal and organizational contact is used in this program.

The Formula For Freedom plan continues this CAP program as a basic essential in the Know Your Government element.

Both the administration of the CAP program and the urge to political action are carried out by the Special Committee on Education. The work of the Legislative Committee is integrated by the membership of the Legislative Committee chairman on the Special Committee on Education. The Liaison activities are carried out directly by the separate committees and the MSMS Executive office. The entire effort, of course, is under the direct supervision of The Council.

The entire Formula For Freedom plan is being offered in its basic outline to other organizations who, if they accept the principle, will of necessity carry out the program in conformance with their own organizational structure. However, the Formula For Freedom is only a formula and unless its elements are combined and activated it has no force toward Freedom. That is the challenge of and to the medical profession today.

Wayne University Medical School



In October, 1951, foundations for the Wayne University College of Medicine Medical Science building were being poured.

Wayne University has been awarded $200,000 in grants for the expansion of its computing machine laboratory.

General Motors Corporation contributed $150,000 for a digital computer, first machine of its kind in the Midwest.

It will be built by the Burroughs Adding Machine Company which will contribute $100,000 worth of services.

A $50,000 grant from the Ford Motor Company will be used for the laboratory's operating expenses.

The new "mechanical brain" will enable Wayne to offer a complete instructional program in large-scale machine computation.

It will solve problems of vibration, noise and structural strength in automobiles at a great saving in manpower and expense.

The University asked the Legislature, at the January session, for $2,550,000 to complete the Medical Science Building.

The foundation and part of the first floor of the structure have been built with the $1,000,000 granted by the last Legislature.

The eight-story building is rising in a lot bounded by Mullett, Clinton, Hastings and Rivard. So far, the builders haven't been plagued by the steel and other material shortages.

It is expected to be completed in time for registration in September, 1953.

The new facilities will help ease the shortage of doctors. The Medical School will be able to teach 400 students a year, instead of the current 256.

No additional enrollments will be accepted until the building is completed, however, university officials said.

The Legislature has set a limit of $3,550,000 on the amount it will contribute toward the Medical Science Building.

Inflation has boosted the original cost estimates to approximately $4,000,000. It is expected that the difference of about $450,000 will come from local funds.

The old Medical Science Building at Gratiot and St. Antoine will be retained for its laboratory facilities.

Leo H. Bartemeier, M.D., Detroit

President, American Psychiatric Association

With an A.B. degree at the age of nineteen, Bart had no idea what he wanted to do with it, so he continued to study. He was well on his way toward his Ph.D., working in experimental animal psychology, when he decided to go into medicine. So he left the laboratories and entered Georgetown University Medical School.

He worked his way through medical school by managing the fraternity house, clerking at night in a hotel, typing notes and lectures for his fellow students, working in the laboratory at Garfield Hospital. In his junior and senior years he lived and worked in Children's Hospital, Washington, D. C.



While at Children's Hospital he met Dr. J. C. Montgomery, who was about to leave Washington for Detroit and work in the Henry Ford Hospital. He urged Bart to take the examinations and try for a position as an intern at Ford's. He did so and began his career in the Motor City.

Bart thought he would specialize in pediatrics. He changed his mind, or maybe it should be said "postponed" his work with children until many years later. After serving as resident in the Henry Ford Hospital, he worked as assistant to the Physician in Chief, and it was Dr. Frank Sladen's interest in the psychiatric aspects of various medical problems which influenced Bart to seek further training. So he went to Hopkins where for two years he worked in Diseases of the Mind and of the Nervous System under Dr. Adolf Meyer at the Phipps Psychiatric Clinic. He returned to Detroit where he has remained.

A testimonial dinner in honor of Leo H. Bartemeier, M.D., President of the American Psychiatric Association, will be held at the Sheraton-Cadillac Hotel, Detroit, on Wednesday, March 12, at 7:00 p.m.

Bart is conscientious and honest with himself and in dealing with others. He has an unusual amount of energy, determination to excel, and endless patience in his work. Many days he will spend fourteen hours in his office—and then work until one or two o'clock in the morning on correspondence, committee reports, agendas or lectures. He loves to teach. He has written and published many scientific papers. He was Secretary of the American Psychoanalytic Association and for four years was Secretary of the American Psychiatric Association. He studies continually. When at home, he gets up every day at 5:00 a.m. and sees his first patient at 6:15 a.m. On Sunday he has a "long" sleep until 6:00 a.m. Even on that day he works.

Bart has an amazing memory, even to remembering birthdays and anniversaries. To prove this paragon is human, he generally leaves his Christmas shopping until December 24!

Maybe Bart's early desire to work with children urged him to lend his assistance in the establishment of the Cornelian Corner, a young organization which is helping this generation of mothers and fathers to have a better understanding of the needs of their new offspring.

Besides the work of the Cornelian Corner, Bart has been for some time Chairman of the Macy Foundation Conference on the problems of infancy and childhood. He spent the summer of 1950 in Ireland advising the Irish Government about the possibility of establishing psychiatric services for children. Each year he finds new opportunities for study and work in this field of Mental Health.

When Bart talks about his hobbies, one realizes

(Continued on Page 262)

James Milton Robb, M.D., Detroit

President, American Academy of Ophthalmology and Otolaryngology

"Bob" . . . "Bobbie" . . . "Jim" . . . "Milt" . . . Take your choice. His multitude of friends do.

Doctor Robb came from the land, born in 1884 in the Owen Sound area, Ontario. At eight years of age, he informed his family that he was "going to be a doctor and a good one." Whether his decision was based on inherent urge, or the seeming hardships of farming, remained to be seen. There were no tractors then, and threshing machines blew bearded chaff up one's pants legs and through his shirt at a rapid rate. Strange incidents sometimes shape vocational choice. Health tragedies in the family are not among the least of these in formative years, and a boy of eight can be so impressed as to decide: "I am going to be a doctor and a good one," and all that the declaration implied has come to pass.



At nineteen he came to Detroit to study medicine, but found he was too young to be enrolled, so he took a job at the Acme White Lead and Color Works as bookkeeper. His characteristic "prone to action" made it difficult to keep him from mixing paint instead of keeping the books. He is still that way—doesn't want even to look at the ledger. He demonstrates that in medicine to give service to the people and lots of it happily and efficiently makes the doctor's social security adequate.

A year of mixing figures and paint, and he entered the Detroit College of Medicine (Wayne University), graduating as valedictorian in 1908. A colleague in later years, while watching him perform a radical mastoid operation and not knowing "Milt's" scholarship, remarked: "How strange that the valedictorian of a graduating class in medicine never amounts to much as a doctor." Doctor Robb let the man be happy in his thought and kept on operating. He continues the studious habits of his college days. College work was intermixed with riding the ambulance for the old Red Cross Hospital and externship at Harper Hospital where he later interned.

Among the influences that shape a medical graduate into a good doctor, Doctor Robb admits the power of dynamic personality of his preceptors: Theodore McGraw, Henry Carstens, Sr., Angus McLean, Don M. Campbell, Eugene Smith, E. L. Shurly, Daniel Laferte, Preston Hickey, E. A. Chapoton, Neil Hoskins. These and others turned the tide. After two years of assistantship with Doctor Campbell, the young surgeon's quest carried him through studies at the University of Vienna, then two years in practice, and then away again, this time to London to the Golden Square Ear, Nose, and Throat Hospital, and to Moorfields, where the first World War overtook him.

In 1922, he qualified by examination to practice in Saskatchewan, for a license to practice somewhere in the British Empire was essential to his next hoped-for step in further surgical preparation. He then proceeded to Edinburgh, where after months of study and grilling he qualified for the degree of Fellow of the Royal College of Surgeons in 1922. He is a Fellow of the American College of Surgeons, and a member of all of the local and national otolaryngological societies. And now, he is President of the American Academy of Ophthalmology and Otolaryngology, one of the best organized of postgraduate teaching institutions.

Preparation for excellence in surgery came first.

A dinner honoring the President of the American Academy of Opthalmology and Otolaryngology, J. M. Robb, M.D., will be held at the Detroit Athletic Club, Thursday, March 13, 1952, at 6:30 p.m.

On being asked one day for some criteria evidencing possible surgical skill in a doctor of medicine, he mentioned two characteristics:

"First, the good surgeon on examining a possible surgical case will hope that an operation may not be necessary, but if it is necessary, that he might be the one to have the great privilege of doing the operation. And second, *work*. Other things being equal, good surgery develops through much experience and this requires seeing many patients."

As an assistant of Doctor Robb for several years, I was expected to meet him at the hospital not later than 7:15 in the morning. After surgery was over, we proceeded to the office, going through the day heavily except for lunch, leaving the office at 7:00 p.m. for dinner at the D.A.C. (before he was married), and then making house or hospital calls often into the night. There were no half days off until Sunday at 1:00 p.m. The week started over again at the hospital at 7:15, Monday morning. Why such a schedule? "Except one sees many people at their convenience, one will not have enough surgery to be good at it." Just that, and it was final.

And then after twenty years in the midst of heavy practice, to exemplify the essentials and the importance of organized effort within medicine, and to the end of the public needs in his home community and state, he became President of the Wayne County Medical Society, and later of the Michigan State Medical Society. During these terms many significant developments were initiated which space here does not allow to be catalogued.

He thought, in those years of preparation and the development of a large practice, that he was pretty skeptical of women . . . "all women," but one day he met the lovely Virginia Yerger, daughter of the Prosecutor of Shelby County, Memphis, Tennessee, and he was not so "tough" after that. His influence and the satisfactions of his life have doubled. James, Elisabeth, David, and Virginia are the children.

As Professor and Head of the Department of Otolaryngology at the College of Medicine of Wayne University, and Chief of the Division at Receiving and at Harper Hospitals, he has proved his influence as a teacher. His characteristic of forever being early instead of late finds him on hand daily at 7:00 a.m. at Harper where he joins the interns and residents at breakfast. By these men in informal conference, he is welcomed as "The Chief of the Dawn Patrol." He exemplifies purpose, and among his essential purposes is the training of young men to distribute good medical care. From morning until night, he demonstrates that "there is a job to be done," and that it must be done well. In this, he may well be characterized as "selfless." He has a consciousness of "what is vital," and the concept is contagious without its being obvious, for his depth of humor puts his message across unknown to the recipient until said recipient awakens to the fact later. Here is a personality that is never negative.

It is difficult to sum up the subject of this sketch in this short space, but the word that does it best perhaps is that here is a man of stature. While they call him "Bob" . . . "Bobbie" . . . "Jim" . . . and "Milt" . . . the profession and the public appreciate this friendly man as "Doctor Robb," Master of the situation. He portrays no pious mien but he lives the concept that "He who would be the master must be the servant." Dr. Duncan Campbell said of him yesterday, "He is a good man to go down the river with."

"Doctor Robb," we salute you.

R. H. P.

THE TAXPAYER PAYS

The average American will give the Government twenty-nine weeks' more pay out of his working life as a result of the higher Federal taxes which took effect November 1.

The Commerce Clearing House, a business and tax law analyzing agency, made that estimate. It defined its average American as twenty-nine years old, married and the father of two, earning $4,300 a year.

Under the old tax structure, the organization said, he could expect to pay $34,743 in taxes during his working years. Under the new rates he can add at least $2,420 for a total of $37,163 during his working life.

This "average man" will have $67.22 less spendable income a year as a result of the new taxes, the organization said.

If he works until he is sixty-five, it added, he will pay in taxes a sum equal to his entire earnings for more than eight and a half years.

These tax figures include excise, real estate, state and local taxes as well as income taxes.



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for use when oral administration is difficult or impractical —when more prompt action is desired

Banthine—a true anticholinergic drug with an adequate range of safety—is now made available to the medical profession in parenteral form, for use intravenously or intramuscularly in those conditions characterized by nausea and vomiting, when oral medication cannot be retained and when a prompt action is desirable.

Through its anticholinergic effects, Banthine inhibits excess vagal stimulation and controls hypermotility.

In Peptic Ulcer—the value of the oral form of Banthine is now well established. However, edema in the ulcer area may indicate parenteral Banthine until the healing processes have reduced the edema.

In Pancreatitis—it has been found that parenteral Banthine relieves pain, effects a fall in blood amylase and produces a general improvement in the patient's condition.

In Visceral Spasm—it inhibits motility of the gastrointestinal and urinary tracts.

Parenteral BANTHĪNE is supplied in serum-type ampuls containing 50 mg. of Banthine powder. Adult dosage is generally the same as with Banthine tablets.

ACCEPTED COUNCIL ON PHARMACY AND CHEMISTRY AMERICAN MEDICAL ASSOCIATION

RESEARCH IN THE SERVICE OF MEDICINE **SEARLE**

Michigan's Department of Health

Albert E. Heustis, M.D., Commissioner

Provisional reports for the first ten months show that in 1951 Michigan had the highest birth rate and the lowest death rate in its history.

Approximately 170,000 babies were born in Michigan in 1951, an all-time high. Less than nine persons per thousand died during the year, shaving a fraction off the previous low death rates of nine per thousand in 1949 and 1950.

* * *

To help meet the mounting demands for blood and blood products, the Laboratories of the Department have put into operation a new mobile unit, making two mobile blood collecting units the Department has in the field. The new unit was financed by contract with the American National Red Cross.

Blood is collected in Michigan by the Department's procurement units, American National Red Cross Regional Centers, Michigan military establishments, prison hospitals and by hospital blood banks in Michigan. This blood is procured for four purposes: (1) whole blood for the armed forces in Korea, (2) plasma and derivatives for the armed forces and for national defense, (3) plasma for civilian use, and (4) whole blood for civilian use.

Forty-seven local hospital blood banks now send their outdated blood to the Department's laboratories to be processed into plasma, immune serum globulin and normal serum albumin. These products are then returned to the various hospitals.

* * *

The Division of Laboratories performed a record 1,146,296 diagnostic tests during the past year to assist physicians in identifying disease, and produced and distributed 3,315,354 doses of serums and vaccines for the prevention, diagnosis or treatment of illness in Michigan people.

* * *

Vital records of the Department show that 701 persons in the State committed suicide in 1950. Of these 78 per cent were males.

The most common means of suicide among males was firearms, accounting for 47 per cent of the male suicides. Among the women, poisoning was the most common method, accounting for 34 per cent of female suicides. The second choice for both men and women was by hanging or strangulation, which accounted for 28 per cent of the female and 22 per cent of the male suicides.

* * *

The Department is urging vaccination of dogs against rabies at this time. In Michigan, there is usually an increase in rabies among animals during January and February, reaching a peak in late winter and early spring.

* * *

Fluoridation of public water supplies as an effective measure of preventing tooth decay in children was endorsed by the State Advisory Council of Health at a recent meeting. The Council urged the Michigan Department of Health to take all possible steps to promote its adoption in municipalities throughout the state. A total of nineteen Michigan communities are now adding fluorides to their water supplies, and 11 others have plans approved, awaiting installation of equipment or delivery of chemicals.

* * *

Two of the Department's most popular pamphlets have been revised by the Section of Nutrition. "What to Eat Before and After the Baby Comes" has been brought up to date in the light of the latest research on nutrition in pregnancy. Physicians and nurses have found this publication a useful aid when working with expectant mothers, either individually or in mothercraft classes. The new material was approved by the Committee on Maternal Health of the Michigan State Medical Society.

"As Your Little Child Eats—So Will He Grow" reviews the food needs of the preschool child and gives suggestions for preparing the little child's food. Physicians and nurses have found it useful to mothers and others caring for young children. The material was approved by the Child Welfare Committee of the Michigan State Medical Society.

Physicians may obtain copies of the leaflets from the local health departments or from the Section of Nutrition, Michigan Department of Health.

* * *

Classes for expectant parents are growing in popularity and the Maternal and Child Health Section of the Department reports an "unprecedented" demand for them. A recent survey shows that forty-four sets of classes are being held in thirty-one communities in the state. New classes are being added each month.

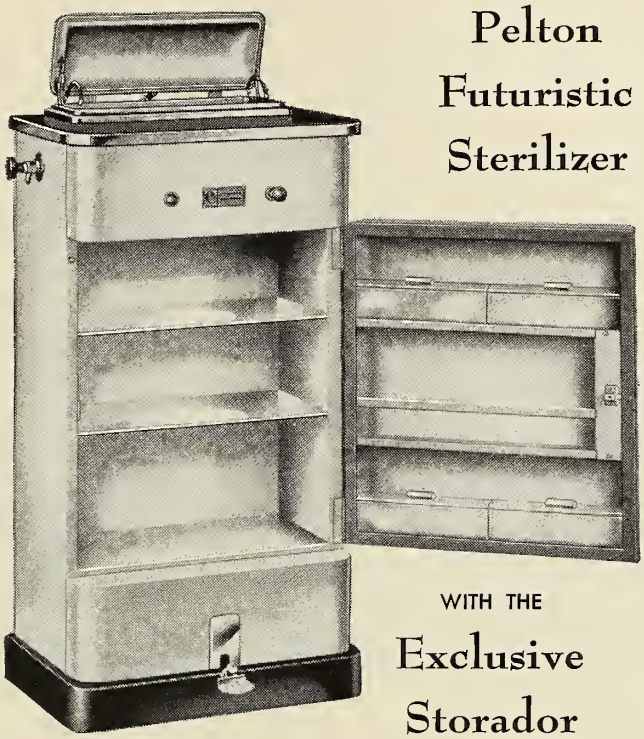
* * *

Grace Eldering, Sc.D., is now chief of the Western Michigan Section of the Laboratories in Grand Rapids and an Associate Director of the Division. She succeeds Pearl Kendrick, Sc.D., who has resigned to devote full time to teaching at the University of Michigan where she is Resident Lecturer in the School of Public Health, teaching laboratory practice in the Department of Epidemiology.

Dr. Eldering was assistant to Dr. Kendrick for many years and also served in the Lansing and Powers Laboratories.

* * *

Harold Bishop has been appointed acting director of the Eaton County Health Department to serve until a full-time director is appointed.



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In Memoriam

CHARLES D. AARON, M.D., of Detroit, died December 3, 1951, at the age of 85.

Dr. Aaron was graduated from the University of Buffalo School of Medicine in 1891. He later studied at the Universities of Berlin, Giessen, Vienna, Wurzburg, Paris, London and Heidelberg.

Dr. Aaron was senior house physician and surgeon at Harper Hospital, after his arrival in Detroit in 1891. He was city physician of Detroit from 1893 to 1895. A specialist in gastroenterology, he was certified by the American Board of Internal Medicine.

Dr. Aaron was a member of the Wayne County Medical Society and a Fellow of the American College of Physicians.

WILLIAM F. ACKER, M.D., of Monroe, died November 9, 1951, at the age of seventy-two.

Doctor Acker served the city of Monroe for the last forty-eight years as a general practitioner. He was graduated from the Detroit College of Medicine in 1901 and interned at Harper Hospital, Detroit. Later he was chief of interns on the staff of Harper Hospital before entering general practice in Monroe in 1903 where he also served as county and city physician. He was chief of staff at Mercy Hospital, Monroe, 1935-1936.

Dr. Acker was honored at the 86th Annual Session of the Michigan State Medical Society in September, 1951, by membership in the "Fifty-Year Club."

During World War I, Dr. Acker was a captain in the Medical Corps.

Dr. Acker is survived by his wife, Marie; a daughter, Mrs. David E. Collier, of Tokyo, Japan; a son, Robert, a chief hospital corpsman at Mare Island, Vallejo, California, and three grandchildren.

CHARLES C. BILODEAU, M.D., of Kalamazoo, died December 5, 1951, at the age of forty-one.

For the past year, he had practiced medicine and surgery in Kalamazoo. Previous to that, Dr. Bilodeau had practiced in the East after receiving his medical degree in 1936 at Columbia University College of Physicians and Surgeons in New York City.

Dr. Bilodeau was a member of the Kalamazoo Academy of Medicine and the Kiwanis Club.

He is survived by his wife, Dorothy; two children, Harrison and Cynthia, of Springfield, Massachusetts; and two brothers, George, of Maine, and Francis, of New Jersey.

VANNY H. DUMOND, M.D., of Bay City, died December 4, 1951, at the age of sixty-four.

For the past thirty-eight years he served the community of Bay City as a physician and surgeon. He was graduated from the Detroit College of Medicine in 1910 and interned at Harper Hospital, Detroit.

Dr. Dumond was active in the committee work of the Michigan State Medical Society. He was a past president of the Bay-Arenac-Iosco County Medical society and on the staff at Mercy and General Hospitals, Bay City. He was a First Lieutenant in World War I.

He is survived by his wife, Florence; a brother, Walter Dummond, M.D., of Florida; three sisters, Mrs. William Campbell, of Cleveland, Mrs. D. Roy Merrill, of Detroit, and Mrs. May Graham, of Windsor, Ontario.

THOMAS N. HORAN, M.D., of Detroit, died December 1, 1951, at the age of forty-nine.

Dr. Horan was a pioneer in the use of photography in diagnosis. He was graduated from the University of Michigan Medical School in 1926 and interned and served his residency at Harper Hospital, Detroit, where he was a member of the staff during the years of his practice.

He was a diplomate of the American Board of Internal Medicine, and Assistant Professor of Clinical Medicine at Wayne University College of Medicine. He was a former resident physician at Cranbrook.

Dr. Horan was a member of the American College of Physicians, the Detroit Academy of Medicine, the Wayne County Medical Society and the Detroit Medical Club.

During World War II, Dr. Horan served as a lieutenant colonel in the Harper Hospital unit in North Africa and Italy. He was in the armed forces from 1942 to 1946.

He is survived by his wife, Elizabeth; a daughter, Rosemary; a son, James; his mother, Mrs. James Horan; and a brother, David, of Ridgewood, New Jersey.

Burial was in Woodlawn Cemetery, Detroit.

DAVID S. JICKLING, M.D., of Flint, died November 3, 1951, at Hollywood, Florida. He was seventy-five.

For the past forty-five years he served the community of Flint as a general practitioner. Previous to that, he practiced in Traverse City after his graduation from the University of Michigan Medical School in 1901.

He is survived by his wife, Adah.

JOSEPH B. KASS, M.D., of Detroit, died November 3, 1951, at the age of sixty-five.

For the past thirty-five years he practiced in Hamtramck and Detroit. Previous to that, Dr. Kass served as a medical consultant to the Mexican railroads. He was graduated from the University of Texas Medical School in 1913. He entered the medical school shortly after his arrival in the United States from Russia.

Dr. Kass was generous with contributions to charity and to such institutions and organizations as the Detroit Symphony Society, the Detroit Institute of Arts, the Metropolitan Opera Association, the University of Texas, the Academy for Jewish Research, the Jewish Publica-

(Continued on Page 242)

Outstanding results with Furacin

Reasons for the clinical effectiveness of Furacin© include: a wide antibacterial spectrum, including many gram-negative and gram-positive organisms — effectiveness in the presence of wound exudates — lack of cytotoxicity: no interference with healing or phagocytosis — water-miscible vehicles which dissolve in exudates — low incidence of sensitization: less than 5% — ability to minimize malodor of infected lesions — stability.

Furacin preparations contain Furacin 0.2% brand of nitrofurazone N.N.R. dissolved in water-miscible vehicles.

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(1)


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68 year old patient suffered third degree burns of face, arms and torso. See illustration (1) above. Fine-mesh gauze, *impregnated with Furacin Soluble Dressing* was applied next to the burned surface—and covered with wet pressure dressings. Dressings were changed daily. Illustration 2 shows patient, after skin grafting, 6 months later.

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MEDCOTRON STIMULATOR MODEL 50

For the stimulation of innervated muscle or muscle groups . . . In rehabilitation therapy, ancillary to treatment by massage . . .



The Medcotron Stimulator, Model 50, operates on 110 volt, 50 to 60 cycle alternating current. The current generated by the apparatus is non-sinusoidal alternating current. Output circuits have no direct connection to the power supply. The maximum voltage output is from 15 to 18 volts R.M.S. The protective mechanism consists of a 1 amp. line fuse that will open, should a short circuit ever occur.

By means of the Medcotron Pad Electrodes the current from the Stimulator is applied to individual muscles or groups of muscles, with comparative freedom of discomfort to the patient. Control of stimulation is attained by the operator regulating the type of stimulus provided, and the voltage and frequency of the current.

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Jackson, Mich.

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(Continued from Page 240)

tion Society, the Jewish Teachers Seminary, the United Hebrew Schools, the United Jewish Folk Schools and Brandeis University.

THOMAS C. MC INTYRE, M.D., of Detroit, died November 6, 1951, at the age of seventy-five.

He had practiced in Detroit for the past forty-seven years after graduating from the Detroit College of Medicine in 1904.

Besides his wife, Hattie, he is survived by two sons, Yale and Thomas, and a daughter, Mrs. Shirley Kukuk. He also leaves a sister and two grandchildren.

GEORGE C. STUCKY, M.D., of Charlotte, died November 26, 1951, at the age of sixty-two.

Dr. Stucky was director of the Eaton County Health Department for the past thirteen years and director of the Ingham County Tuberculosis Sanatorium from 1925-1938.

He was graduated from the University of Michigan Medical School in 1923, and served his internship at Ford Hospital in Detroit.

Dr. Stucky was a member of the Michigan and National Trudeau society, past president of the Michigan Health Officers association, and was a fellow of the American College of Physicians, the American Public Health association, and a former director of the National Tuberculosis Association.

Surviving are the wife, Juliette; two sons, Harry Stucky, of Dexter, and George Stucky serving with the U. S. Army in Germany, and three daughters, Mrs. Jack Foster, of Hastings, Mrs. Clark Griffin, of Ann Arbor, and Betsy, at home.

ARCHIBALD B. WICKHAM, M.D., formerly of Detroit, died October 27, 1951, at the age of seventy-five in Phoenix, Arizona.

Following his graduation from the Detroit College of Medicine in 1904, Dr. Wickham became a resident physician at the Solvay Hospital, now known as the Delray Industrial Hospital. The next year he entered general practice in Detroit. He turned to the study of diseases of the chest in 1918 and attended the Trudeau Tuberculosis School as well as Harvard Medical School. He also served in the TB division of the Detroit Department of Health. Dr. Wickham established the Eastlawn Tuberculosis Sanatorium in Northville.

Dr. Wickham was a member of the American Trudeau Society and had fellowships in the Michigan Tuberculosis Association and the American College of Chest Physicians.

He moved to Phoenix, Arizona, in 1948. He is survived by two daughters: Mrs. Harold Roehm and Mrs. Dean Davis.

Seventy per cent of brain tumors are in the supratentorial areas.

* * *

The commonest symptoms of brain tumors reported by the patient are headaches, disturbances of vision, nausea and vomiting, personality changes, seizures, unsteadiness and weakness of limbs.

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Baker's Modified Milk supplies 3.5 to 4 grams of milk protein per kilogram of body weight per day when the total feeding is 2½ fluid ounces of normal strength dilution** per pound of body weight. The milk protein in Baker's also provides adequate amounts of all the essential amino acids.

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The carbohydrates in Baker's Modified Milk are lactose and dextrose. The dextrose which requires no digestion is readily assimilated. The lactose is slowly digested and absorbed. This combination of sugars is less likely to lead to digestive disturbances than if a single sugar were used. The carbohydrate content (7% at normal dilution**) provides adequate calories to spare the protein for its normal function of tissue building and repair.

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The fat-carbohydrate ratio (approximately 1:2) is adequate to insure proper fat metabolism. The butter fat has been replaced by other fats containing less of the undesirable very low and very high molecular weight fatty acids. The added fats have also been selected to provide adequate amounts of the essential unsaturated fatty acids.

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Baker's Modified Milk contains an adequate mineral content with the calcium-phosphorus ratio falling within the optimum range (1.3 to 1). Since cows milk contains only a trace of iron, sufficient iron ammonium citrate has been added to supply 7.5 milligrams of iron per quart of normal dilution.**

VITAMINS

Baker's Modified Milk supplies adequate amounts of all recommended vitamins except Vitamin C.

These are the reasons why infants thrive on Baker's Modified Milk—a nutritionally adequate* formula.

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Made from Grade A Milk (U.S. Public Health Service Milk Code) which has been modified by replacement of the milk fat with vegetable and animal fats by the addition of carbohydrates, vitamins and iron.



POWDER and LIQUID

*When fed in normal quantities, provides amounts of proteins, vitamins (except C), minerals and essential unsaturated fatty acids equal to or exceeding the daily recommended allowances of The Food and Nutrition Board of the National Research Council.

**Dilute with equal parts of water.

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. NEWS MEDICAL

President Truman's campaign for Socialized Medicine has taken a new turn with the creation of "The President's Commission on the Health Needs of the Nation," which will be financed with National Defense funds and which, significantly, has been set up to function only for a one-year period—the election year of 1952.

Mr. Truman, in an adroit political maneuver designed to make it appear that the American Medical Association acquiesced in the creation of this new propaganda agency, appointed Dr. Gunnar Gundersen of La Crosse, Wisconsin, a member of the AMA Board of Trustees, to the Commission. Dr. Gundersen, whose name was used without his consent, promptly resigned from the Commission, in a sharply worded statement which characterized the agency as "an instrument of practical politics."—National Education Campaign, January 4, 1952.

* * *

A summer camp for diabetic children will be opened for the fourth season under the auspices of The Chicago Diabetes Association, Inc., from July 1, 1952 to July 22, 1952 at Holiday Home, Lake Geneva, Wisconsin.

In addition to the regular personnel of the camp, there will be a staff of dietitians and resident physicians, trained in the care of diabetic children, furnished by The Chicago Diabetes Association.

Boys and girls, aged eight to fourteen years inclusive, will be accepted at a fee of $120.00 (which covers the three-week camping period and transportation from Chicago). Fee reductions may be arranged when considered necessary.

Doctors of Medicine are requested to notify parents of diabetic children and to supply the names of children who would like to attend camp. Applications may be obtained from, and inquiries should be addressed to: Service Unit, Chicago Diabetes Association, 110 South Dearborn Street, Chicago 3, Illinois.

Limited capacity requires prompt application.

* * *

Congress has made $82.5 million available for grants to be distributed to states on a per capita income population ratio in connection with the Hill-Burton hospital construction program.

The status of the hospital construction in Michigan, is as follows:

Completed and in operation: 18 projects at a total cost of $14,365,423 including federal contribution of $5,169,016 and supplying 943 additional beds.

Under construction: 15 projects at a total cost of $17,362,073, including federal contribution of $6,652,900 and designed to supply 1,022 additional beds.

Approved, but not yet under construction: 5 projects at total cost of $2,083,155, including $995,683 federal contribution and designed to supply 153 additional beds.

MICHIGAN INDUSTRIAL HEALTH DAY MAY 7

The program of the third Michigan Industrial Health Day, to be held at Flint on Wednesday, May 7, 1952, will be published in the March number, JMSMS. The scientific meeting will be held at Hurley Hospital, and the dinner will be featured at the Durant Hotel, Flint. For extra copies of the program write: O. J. Preston, M.D., President, Michigan Association of Industrial Physicians and Surgeons, 300 N. Chevrolet Ave., Flint, or P. J. Ochsner, M.D., Secretary, 215 Verlinden, Lansing.

* * *

Paul de Kruif, of Holland, Michigan, well known author and writer, was elected an Honorary Member of the Ottawa County (Michigan) Medical Society on December 7, 1951. The resolution presented to the County Medical Society at the time of Dr. de Kruif's election read as follows:

"WHEREAS, Dr. Paul de Kruif, a native son of Ottawa County, born in Zeeland, Michigan, has brought fame to himself and to this community by his outstanding ability as a medical writer, and

"WHEREAS, Dr. Paul de Kruif has distinguished himself for his services and attainments in medicine and the allied sciences, and

"WHEREAS, Dr. Paul de Kruif has rendered other services of unusual value to organized medicine and the medical profession, therefore be it

"RESOLVED, That Dr. Paul de Kruif be elected as an Honorary member of the Ottawa County Medical Society."

* * *

Frank C. Witter, M.D., of Detroit, was honored by the Surgical Staff of Highland Park General Hospital at a dinner held at the Detroit Golf Club on November 28. The occasion commemorated Dr. Witter's retirement as Chief of the Surgical Department of the Hospital, a position he held for thirty years.

Dr. Witter will continue in the private practice of surgery.

* * *

Ferdinand Cox, M.D., of Jackson, has been appointed to the Board of Appeals of State Selective Service, according to announcement of Colonel W. J. Myers, Lansing.

(Continued on Page 246)



Presenting

The Continental Professional Plan

OF ACCIDENT & SICKNESS INSURANCE

EFFECTIVE and OPERATING FOR

Members of your State MEDICAL PROFESSION

DESIGNED EXCLUSIVELY
By CONTINENTAL CASUALTY COMPANY
One of the Oldest and Largest Stock Casualty Companies in the World

A Few of the Many Outstanding Features

- ★ **Monthly benefits for both accident and sickness payable FROM FIRST DAY — Minimum claim 7 days.**
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Renewal is guaranteed to individual active members of the profession regardless of age, so long as the premiums are paid in accordance with the terms of the contract and the plan continues in effect for the members in your designated territory.

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NOW available to all eligible members in active practice and under 69 years of age. Plans A or B available to female members under age 65.

SICKNESS BENEFITS	PLAN AA	PLAN A	PLAN B
PAYS.. A Monthly Indemnity for total disability during first year, whether house confined or not, ...**From First Day**	**$ 300.**	**$ 200.**	**$ 100.**
PAYS.. Total Monthly Indemnity First 2 Years...	**5400.**	**3600.**	**1800.**
ACCIDENT BENEFITS			
PAYS.. A Monthly Indemnity for total disability during first year**From First Day**	**300.**	**200.**	**100.**
PAYS.. Total Monthly Indemnity First 2 Years...	**5400.**	**3600.**	**1800.**
PAYS.. Monthly Indemnity for partial disability up to 13 weeks**From First Day**	**120.**	**80.**	**40.**

The Cost is Low

	PLAN AA	PLAN A	PLAN B
Annual	$138.00	$92.00	$46.00
Semi-Annual	69.50	46.50	23.50

ADD $5.00 TO FIRST PREMIUM ONLY

OPTIONAL BENEFITS	PLAN AA	PLAN A	PLAN B
Monthly Hospital Indemnity may be added up to for $6.00 per $100 Hospital Benefits payable for One to 90 days — Each disability.	**$ 450.**	**$ 300.**	**$ 150.**
Accidental Death and Dismemberment Indemnity up to.. Added for $2.00 per $1000.	**7500.**	**5000.**	**2500.**

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(Continued from Page 244)

Partial Reimbursement for Collecting Dues—All component county and district societies of Michigan may retain as a dues collection fee a sum equal to 1 per cent of the MSMS and of the AMA dues which are collected in the year 1952 (i.e. 1 per cent of $70.00, if both the MSMS and AMA dues are certified, or 1 per cent of $45.00 if only the MSMS dues are certified).

* * *

Income tax deduction for expenses incurred in taking postgraduate courses.—The AMA has initiated correspondence with the U. S. Bureau of Internal Revenue regarding a review of the 1921 ruling which denied deductions to doctors of medicine for expenses incurred in taking postgraduate courses. A report to our membership in JMSMS will be made from time to time as the matter progresses.

* * *

Selection of Michigan's Foremost Family Physician.—Notification was given by the Michigan State Medical Society to the Secretaries of all component county and district societies of Michigan on January 7, 1952, that county societies have the privilege of nominating a doctor of medicine for this top honor among Michigan's medical men and women. The deadline for nomination of candidates for "Michigan's Foremost Family Physician" is May 15, 1952. Nominees are to be certified to the MSMS Council, P.O. Box 636, Lansing.

* * *



R. S. Sykes, D.D.S.

The Sykes Lecture, established in 1948 through a grant from R. S. Sykes, D.D.S., of Muir, Michigan, annually presents outstanding authorities to discuss diagnosis of tumors. The first lecture was given by Frederick A. Coller, M.D., Professor of Surgery, University of Michigan Medical School, Harry S. N. Greene, M.D., Professor of Pathology, Yale University School of Medicine, delivered the second (1949) lecture; William Lewis Brosius, M.D., of Detroit, gave the 1950 lecture, and Evarts A. Graham, M.D., of St. Louis, Missouri, gave the 1951 lecture.

Lauren V. Ackerman, M.D., Professor of Surgical Pathology and Pathology, Washington University School of Medicine, St. Louis, Missouri, will deliver the fifth Sykes Lecture, a feature of the 1952 Michigan Clinical Institute. This year's lecture is scheduled for Thursday noon, March 13, 1952, in the English Room of the Sheraton-Cadillac Hotel, Detroit.

* * *

The American College of Physicians announces a postgraduate course in Internal Medicine, to be held at the University of Michigan Medical School, Ann Arbor, April 14-18, 1952, under the directorship of Cyrus C. Sturgis, M.D. Maximum registration is sixty; fees for ACP members, $30.00 and for non-members $60.00. This course has been arranged for the week preceding the 33rd Annual Session of the College at Cleveland. For full information, write E. R. Loveland, Executive Secretary, 4200 Pine St., Philadelphia 4; for hotel accommodations write Michigan Union, Mr. Frank C. Kuenzel, Manager, Ann Arbor.

* * *

The American Academy of General Practice will hold its 1952 scientific assembly in Atlantic City, March 24-27, according to Mac F. Cahal, Executive Secretary, Kansas City, Missouri. The question of "Problem Drinking" will be featured in a symposium; also on the program will be a discussion of the relationship of the general practitioner and the public. Progress in Medicine will be outlined by six outstanding authorities. Other subjects covered will be obstetrics, anemia, and orthopedics.

All sessions of the Assembly, including the banquet and the scientific and technical exhibits, will be held in the Atlantic City Convention Hall.

* * *

The Fifth Annual Postgraduate Course in Diseases of the Chest sponsored by the Council on Postgraduate Medical Education and the Pennsylvania Chapter of the American College of Chest Physicians and the Laennec Society of Philadelphia, will be presented at the Warwick Hotel, Philadelphia, Pennsylvania, March 24-28, 1952.

A program covering the entire field of heart and lung disease is being arranged. Dr. Chevalier L. Jackson, Philadelphia, President of the American College of Chest Physicians, is chairman of the postgraduate course committee.

Physicians interested in attending the postgraduate course are invited to communicate with the Executive Offices, American College of Chest Physicians, 112 East Chestnut Street, Chicago 11, Illinois.

* * *

"Formula for Freedom" nights are being scheduled during the months of January, February and March by many Michigan county medical societies. Magnificent co-operation has been received in response to the offer of the MSMS to supply speakers who would introduce and explain the 1952 MSMS Public Relations plan to county medical society members.

As of press time, the following schedule had been developed:

Kalamazoo Academy of Medicine, Kalamazoo, December 18, 1951
Kent County, Grand Rapids, January 15, 1952
Saginaw County, Saginaw, January 22, 1952
Mecosta, Osceola, Lake Counties, Big Rapids, February 5, 1952
Shiawassee County, Owosso, February 12, 1952
Clinton County, (combined with Shiawassee County)
Washtenaw County, Ann Arbor, February 14, 1952
Muskegon County, Muskegon, February 15, 1952
Gratiot-Isabella-Clare, Mt. Pleasant, February 19, 1952
Sanilac County, (combined with St. Clair County)
Calhoun County, Battle Creek, March 4, 1952
St. Clair County, Port Huron, March 18, 1952
Bay-Arenac-Iosco Counties, Bay City, March 19, 1952
Genesee County, Flint, April 22, 1952

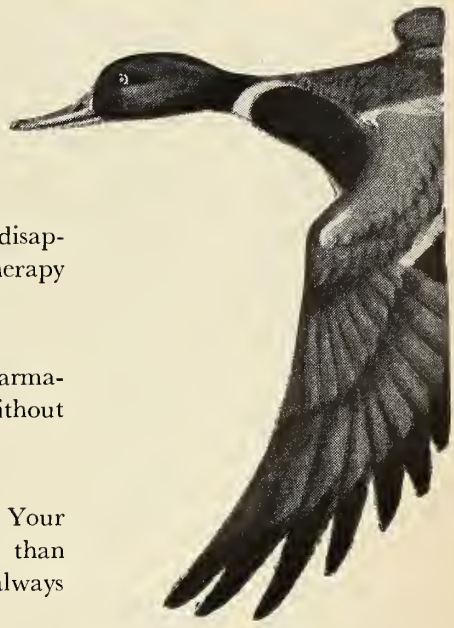
(Continued on Page 248)





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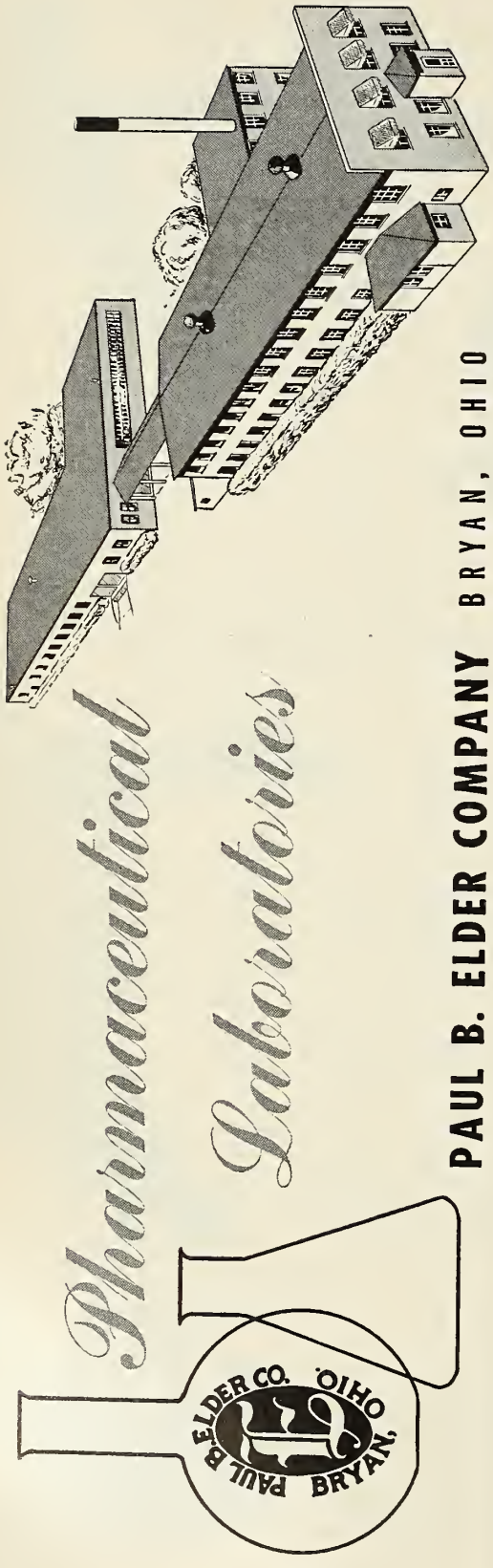
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(Continued from Page 246)

Several invitations have been extended by county medical societies of the Upper Peninsula and plans are being considered in an attempt to co-ordinate these into a series of meetings or a single large meeting in order to present the best possible program to all doctors of medicine in that area.

At the meeting of the Kalamazoo Academy of Medicine members of the Woman's Auxiliary and many guests were in attendance to hear a program under the chairmanship of President-elect R. J. Hubbell, M.D., Kalamazoo; MSMS President Otto O. Beck, M.D., of Birmingham outlined the Beaumont Memorial Restoration. MSMS Secretary L. Fernald Foster, M.D., of Bay City, State Treasurer D. Hale Brake of Lansing, and MSMS Public Relations Counsel Hugh W. Brenneman of Lansing developed the administrative outline and policy of the Formula for Freedom.

Arrangements for the program in Kent County included Senator Carlton H. Morris, Kalamazoo, Dr. Foster and Mr. Brenneman presenting similar addresses to those at Kalamazoo. In succeeding programs, various officers of the MSMS plus state officials will participate.

* * *

Single AMA membership level proposed at Los Angeles Clinical Session. The elevation of all AMA members to fellowship status to achieve a single membership classification within the Association was proposed in a resolution submitted by Louis A. Buie, M.D., Rochester, Minnesota, chairman of the AMA's Standing Committee on Constitution and By-Laws. This would eliminate present "Member" and "Fellow" levels. The resolution must lie over until June, 1952, for final action. The Kentucky delegation introduced a resolution that any AMA member who had not paid AMA dues in 1950 or before be permitted to join the AMA without penalty upon payment of 1951 dues. The House approved a substitute version, however, giving the secretary of the AMA authority to negotiate with each state society as to means of correcting misunderstandings relative to 1950 dues. At the same time the AMA is to make further efforts to clarify membership status and publicize this information to the profession.

* * *

The AMA Board of Trustees authorized another $500,000 contribution to the American Medical Education Foundation for unrestricted use by the nation's medical schools. The Foundation was started one year ago by an AMA donation of the same size. About $250,000 has been collected by solicitation of U. S. physicians, considerably short of the million dollar goal.

* * *

The AMA will spend $250,000 on its national education campaign during 1952, with Whitaker-Baxter being retained on a part-time basis.

* * *

Internships discussed by AMA: A proposal that any plans for approval of internships include quota assignments based on a survey of facilities for adequate training, and bearing a relation to the number of students graduated and applying for internships, was referred to

the AMA's advisory committee on internships which is expected to complete a study of the matter in about a year.

* * *

Hospital Accreditation.—The six AMA representatives who will serve on the Joint Commission for the accreditation of hospitals in the United States and Canada are: Gunnar Gundersen, M.D., LaCrosse, Wisconsin; Dwight H. Murray, M.D., Napa, California; Julian P. Price, M.D., Florence, South Carolina; Stanley R. Truman, M.D., Oakland, California; Herman G. Weiskotten, M.D., Syracuse, New York, and Rolland J. Whitacre, M.D., East Cleveland, Ohio.

The Canadian Medical Association representative is: E. K. Lyon, M.D., Leamington, Ontario. Other Associations having representation on the Joint Commission are the American Hospital Association (6), the American College of Surgeons (3), the American College of Physicians (3) and the Canadian member of the American Hospital Association (1).

* * *

The National Society for Crippled Children and Adults (Easter Seals) will hold its 1952 convention at the Fairmont Hotel, San Francisco, October 25-30.

* * *

Facts About AMA Dues for 1952

1. American Medical Association membership dues for 1952 are $25.00.

2. Fellowship dues for 1952 have been abolished.

3. American Medical Association membership dues are levied on "active" members of the Association. A member of a constituent association who holds the degree of Doctor of Medicine or Bachelor of Medicine and is entitled to exercise the rights of active membership in his constituent association, including the right to vote and hold office as determined by his constituent association, and has paid his American Medical Association dues, subject to the provisions of the By-Laws, is an "active" member of the Association.

4. American Medical Association membership dues are payable through the component county medical society or the constituent state or territorial medical association, depending on the method adopted locally.

5. Commissioned medical officers of the United States Army, the United States Navy, the United States Air Force or the United States Public Health Service, who have been nominated by the Surgeons General of the respective services, and the permanent medical officers of the Veterans Administration and the Indian Service, who have been nominated by their Chief Medical Directors, may become Service Fellows on approval of the Judicial Council. Service Fellows need not be members of the component county or constituent state or territorial associations or the American Medical Association. They do not receive any publication of the American Medical Association except by personal subscription. If a local medical society regulation permits, a Service Fellow may elect to become an active member of a component and constituent association and the American Medical Association, in which case he would pay the same membership dues as any other active member and receive a subscription to *The Journal of the American Medical Association.*

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Despite its social significance, the treatment of excessive drinking is recognized today as essentially a medical problem.

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All of our treatment is carried on under strict medical supervision. Each case is treated individually and—we do not use conditioned reflex therapy in any of its forms, such as alcohol reactors, nauseants, etc.

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6. An active member of the American Medical Association may be excused from the payment of American Medical Association membership dues when it is deemed advisable by the Board of Trustees, provided that he is partially or wholly excused from the payment of dues by his component society and constituent association.

The following may be excused in accordance with this provision: (a) members for whom the payment of dues would constitute a financial hardship as determined by their local medical societies; (b) members in actual training but not more than five years after graduation from medical school; (c) members who have retired from active practice; (d) members who have reached the age of 70, on request, and starting January 1 following the 70th birthday, and (e) members who are called to active duty with the armed forces (exemption begins July 1 or January 1 following entrance on active duty). The last two categories are excused from AMA dues regardless of local dues exemptions.

7. Active members of the American Medical Association are not excused from the payment of American Medical Association membership dues by virtue of their classification by their local societies as "honorary" members or because they are excused from the payment of local and state dues. Active members may be excused from the payment of American Medical Association membership dues only under the provision described in Paragraph 6 above.

8. American Medical Association membership dues include subscription to *The Journal of the American Medical Association.* Active members of the Association who are excused from the payment of dues will not receive *The Journal* except by personal subscription at the regular subscription rate of $15.00 a year.

9. Members may substitute one of the special journals published by the Association for *The Journal* to which they are entitled as members.

10. A member of the American Medical Association who joins the Association on or after July 1 will pay membership dues for that year of $12.50 instead of the full $25.00 membership dues.

11. An active member is delinquent if his dues are not paid by June 1 of the year for which dues are prescribed and shall forfeit his active membership in the American Medical Association if he fails to pay the delinquent dues within thirty days after the notice of his delinquency has been mailed by the Secretary of the American Medical Association to his last known address.

12. Members of the American Medical Association who have been dropped from the Membership Roll for nonpayment of annual dues cannot be reinstated until such indebtedness has been discharged.

13. The apportionment of delegates from each constituent association shall be one delegate for each thousand (1,000), or fraction thereof, active members of the American Medical Association as recorded in the office of the Secretary of the American Medical Association on December 1 of each year.

* * *

Frank C. Witter, M.D., retiring after thirty years as chief of surgery at Highland Park General Hospital, was recently honored at a dinner given by his colleagues at

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the Detroit Golf Club. He will continue in private practice.

A graduate of the University of Michigan medical school in 1906, Dr. Witter started practice as chief surgeon at Lockwood Hospital, Petoskey. He came to Detroit in 1918 as a surgeon at Harper Hospital and an instructor at the Detroit College of Medicine.

A charter member of several honorary societies, Dr. Witter was named to the Detroit Medical Hall of Fame in 1933.

* * *

Michigan Authors

John M. Sheldon, M.D., of the Allergy Section of the Department of Internal Medicine, spoke on "Modern Concepts in the Management of Bronchial Asthma," at the Forty-fifth Annual Meeting of the Southern Medical Association at Dallas, Texas, November 5 through 8.

James L. Wilson, M.D., of the Department of Pediatrics and Communicable Diseases, took part in a symposium on "The Physiology and Disturbances of Respiration in Children," at the American Academy of Pediatrics which met October 20 to 25 in Toronto. Dr. Wilson also participated in a seminar on "Diagnosis and Treatment of Bulbar and Respiratory Complications in Poliomyelitis," sponsored by the National Foundation for Infantile Paralysis at the American Academy.

R. W. Waggoner, M.D., of the Neuropsychiatric Institute, conducted a symposium on "The Sexual Psychopath" at the Third Annual Mental Hospital Institute at

Routine chest x-rays on admission to general hospitals pay off. This is the experience of New York State in a program that screened the chests of 195,751 patients admitted to general hospitals in the state outside of New York City from May, 1947, to January, 1950.

The yield of suspected tuberculosis in this program was found to be twice as high among general hospital patients (20 per thousand x-rayed) as it is in the general population.

Especially significant are the results of this program in the detection of non-tuberculous conditions in the thorax—especially among older people. The number of suspected non-tuberculous conditions revealed for all ages (141 per thousand x-rayed) was seven times as high as the tuberculous conditions detected.

The comparison of findings on tentative diagnosis per thousand x-rayed for older adults in contrast with young adults follows:

	Tuberculous	Non-tuberculous
Ages 15-44	12.1	66.3
Ages 45 and over....	36.4	286.5
All ages.....	20.3	141.2

—MICHIGAN TUBERCULOSIS ASSOCIATION

Based on "Chest X-rays on Admission Pay Off—"—Siegal, Plunkett and Hilleboe. *The Modern Hospital*, July, 1951.

Louisville, Kentucky, October 15 and 16. On October 19 and 20, Dr. Waggoner attended the meeting of the Central Neuropsychiatric Association at Minneapolis, at which time he was elected President of the Association for 1951-52. Next year's meeting will be held in Nashville, Tennessee.

Reed O. Dingman, M.D., Oral Surgeon in the University Hospital, addressed the American Society of Plastic and Reconstructive Surgery on November 1 at Colorado Springs. His subject was "Iliac Bone Cranioplasty." At the meeting of the American College of Surgeons in San Francisco, November 7, he spoke on "The Management of Fractures of the Mandible."

Carl V. Weller, M.D., of the Department of Pathology, gave the John A. MacGregor Memorial Lecture for the Faculty of Medicine of the University of Western Ontario, London, on October 12. Dr. Weller's subject was "The Causes of Cancer."

Harold F. Falls, M.D., of the Department of Ophthalmology, presented a paper entitled "Further Evidence for the Inheritance of Retinoblastoma," at the 20th annual meeting of the American Society of Human Genetics held at the University of Minnesota, September 10-12, 1951.

Samuel J. Levin, M.D., F.A.C.A., and Selma S. Moss, M.D., F.A.C.A., of Detroit, are authors of an article, "Repository Penicillin Injections in Allergic Children," published in *Annals of Allergy,* July-August, 1951.

E. H. Steffensen, M.D., and **J. Kekara, O.T.**, of Detroit, are authors of a paper, "ACTH, Intermedin and Cortisone in the Treatment of Retinitis Pigmentosa," in The *American Journal of Ophthalmology,* December 1951.

Paul Van Portfleet, M.D., and **F. Bruce Fralick, M.D.**, of Ann Arbor, are authors of an article, "The Inflammability of Plastic Eye Glass Frames," in the *American Journal of Ophthalmology,* December, 1951.

R. Glenn Smith, M.D., and **Miles Gullickson, M.D.**, Rockford, Illinois, and **Darrell A. Campbell, M.D.**, of Ann Arbor, are authors of an article, "Some Limitations of Lumbar Sympathectomy in Arteriosclerosis Obliterans: Early Results in One Hundred Consecutive Cases," published in *Archives of Surgery,* January, 1952.

Fred W. Whitehouse, M.D., of Detroit, is the author of an article, "Aureomycin and Penicillin in Canicola Fever," published in *The Journal of the American Medical Association,* January 5, 1952.

"Observations on Effect of Drugs upon Intestinal Intubation" by **Meyer O. Cantor, M.D.**, and **Harold P. McGinnes, M.D.**, of Detroit, was published in the November, 1951, issue of *Gastroenterology.*

* * *

The seventh annual National Rural Health Conference will be held in the Shirley-Savoy Hotel, Denver, February 28, 29 and March 1, 1952. There will be about 700 in attendance—medical, farm, civic and agriculture education leaders. The theme will be "Help Yourself to Health." The program will include: Charley J. Smythe, M.D., Director of Graduate Education at the University of Colorado, Denver, formerly of Michigan and a fre-

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quent contributor to this JOURNAL; John R. Rodger, M.D., of Bellaire, member of the Committee on Rural Medical Service of the Michigan State Medical Society; and Paul A. Miller, of Lansing, Extension Specialist of the Michigan State College.

* * *

Medical Schools get another $500,000 from AMA.— Dwight H. Murray, Napa, California, chairman of the Board of Trustees, announced at the opening session of the House that the AMA was contributing another half million dollars to the American Medical Education Foundation, which has been raising funds within the medical profession during the last year for the unrestricted use of the nation's medical schools.

The Foundation was founded at the meeting of the AMA in Cleveland in December, 1950, at which time the Board of Trustees announced an appropriation of a half million dollars as the nucleus of a fund to be raised by the medical profession to assist medical schools. In addition, the AMA is underwriting the total expenses involved in raising the funds.

Approximately $640,000 has been turned over to the schools so far.

* * *

Proceedings of the House of Delegates have been published in *The Journal of the AMA*. Scores of resolutions were introduced and the House and the reference committees handled the load of work in fine fashion.

The Board of Trustees recommended to the House a substitute report for adoption in place of the previous reports on hospitals and the practice of medicine (the Hess Report). The House in turn adopted the report without a dissenting vote.

This substitute report was entitled "Guides for Conduct of Physicians in Relationships With Institutions." It retained the principles enunciated in the former reports, but with certain deletions and additions designed to clarify the situation. Copies of the substitute report were distributed to members of the House.

Other actions taken by the House included:

A resolution protesting against "the promulgation of any regulation by the Selective Service System under which students of chiropractic may be deferred under the Universal Military Training and Service Act of 1951."

A resolution clarifying House action last June which called for a congressional investigation of the teaching of "collectivism in our schools."

A resolution calling for a comprehensive survey by the AMA to determine the sources of funds, both public and private, now available for medical research.

A resolution authorizing the Board of Trustees to appoint a special committee to handle the complex problem of medical care for war veterans.

A resolution authorizing the AMA to make a survey to determine the number of "deaths of small children and infants resulting from the ingestion of household products not labeled as poisonous."

Approval of a report by the AMA Council on Medical Service which outlined plans to assist state medical associations in developing programs designed to bring physicians into communities in need of medical services.

Approval of the Board of Trustees' appointment of six



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AMA representatives who will serve on the joint commission for the accreditation of hospitals in the United States and Canada. The six are: Rolland J. Whitacre, M.D., East Cleveland, Ohio; Herman G. Weiskotten, M.D., Syracuse, N. Y.; Julian P. Price, M.D., Florence, S. C.; Dwight H. Murray, M.D., Napa, Calif.; Gunnar Gundersen, M.D., La Crosse, Wis., and Stanley R. Truman, M.D., Oakland, Calif.

* * *

Thirty doctors' wives are notaries public now.

Purpose: To administer the loyalty oath to a couple of thousand physicians on whom the burden will fall if Detroit is hit by an A-bomb.

William Brinkman, Office of Civilian Defense, pointed out that all civilian defense workers must take the oath before getting the ID (identification) cards.

The wives are led by Mrs. Claire L. Straith and Mrs. T. Grover Ames. Well aware of the amount of moving around that doctors do, the wives will try to reach as many as possible by stationing teams of women at each hospital in Wayne County.

* * *

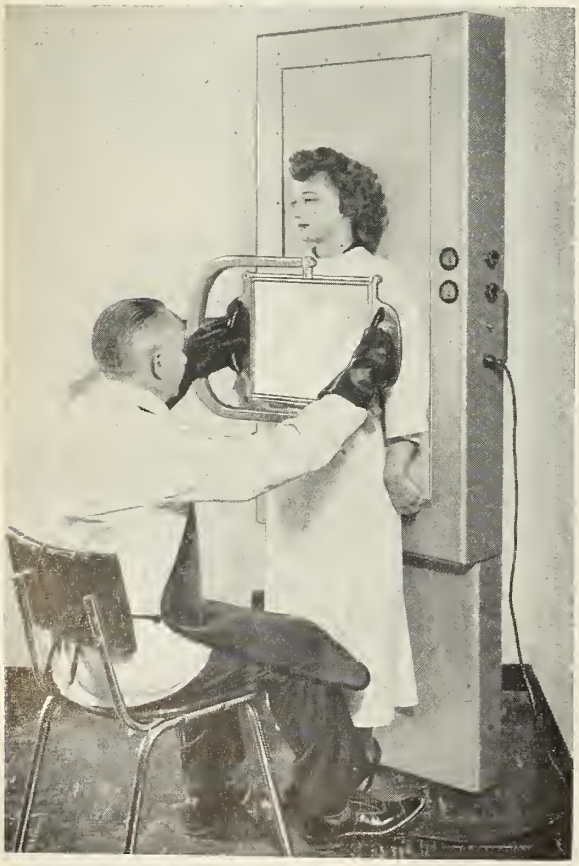
E. Dwight Barnett, M.D., of Detroit, left December 28, 1951, to assume his new duties as Director of the Institute of Administrative Medicine at Columbia University. Dr. Barnett came to Michigan as assistant to Stewart Hamilton, M.D., Director of Harper Hospital, and upon Dr. Hamilton's death was made Director. He also succeeded Dr. Hamilton as a member of the Board of the Michigan Hospital Service, and soon advanced by his outstanding ability to the presidency of the Board of MHS. Dr. Barnett was also elected to the Board of Directors of Michigan Medical Service, and has rendered invaluable service. He has been a nationally recognized leader in the field of voluntary hospital and medical service. On September 19, 1951, at the annual meeting of the American Hospital Association, he was elected to the Board of Trustees.

Columbia University in planning to establish The Institute of Administrative Medicine, offered the directorship to Dr. Barnett. Finally, he decided to accept, resigned as Director of Harper Hospital, but decided to serve out his term as president of Michigan Hospital Service. Michigan has lost a valuable physician, but Columbia University has gained an excellent administrative officer.

* * *

September State-Wide Non-Group Enrollment Campaign.—Final results of the first State-wide Direct Enrollment Campaign show that almost 90 thousand per-

(Continued on Page 256)



ANNOUNCING THE NEW "Spacesaver" Verticle Fluoroscope

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Maximum Output 15 Milliamperes—85 Peak Kilovolts Fluoroscopic Rating 5 Ma at 85 PKV

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Hurley Hospital—Flint, Michigan
Wednesday, April 9, 1952

Scientific Program
9:30 a.m.-5:00 p.m.

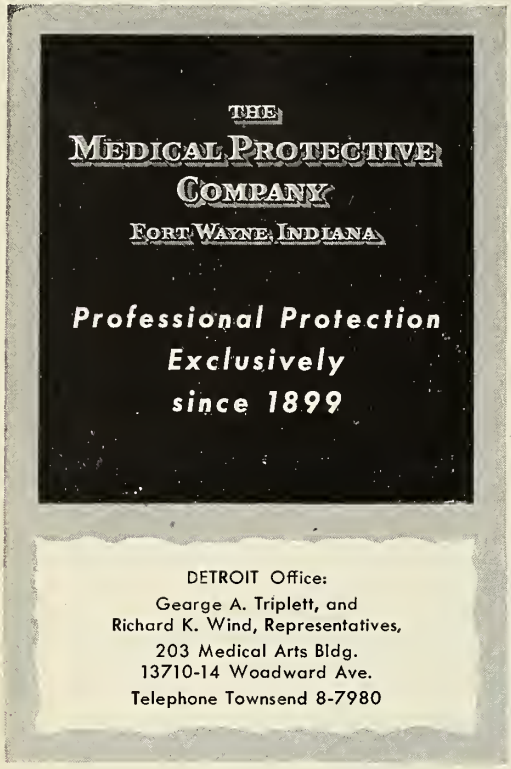
"The Leukemic States: Their Malignant and Non-malignant Aspects in Relation to Prognosis and Treatment"
CHARLES A. DOAN, M.D.—Dean, College of Medicine
Ohio State University, Columbus, Ohio

"Cancer Problems of Specific Interest to the Surgical Pathologist"
WILLIAM J. BOYD, M.D.—Emeritus Professor of Pathology
University of Toronto
Professor of Pathology
University of British Columbia, Vancouver, B. C.

"Cutaneous Malignancies"
PAUL A. O'LEARY, M.D.—Chief of Section on Dermatology
Mayo Clinic, Rochester, Minn.

"Recent Developments in Cancer Research"
CORNELIUS P. RHOADS, M.D.—Director
Sloan-Kettering Institute and Memorial Hospital, New York, N. Y.

One-Hour Tumor Conference
R. ARNOLD GRISWOLD, M.D.—Professor of Surgery
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Surgical Technic, Surgical Anatomy and Clinical Surgery, four weeks, starting March 3 June 2.
Surgical Anatomy and Clinical Surgery, two weeks, starting March 17, June 16.
Surgery of Colon and Rectum, one week, starting March 3, April 7.
Gallbladder Surgery, ten hours, starting April 21.
Basic Principles in General Surgery, two weeks, starting March 31.
Breast and Thyroid Surgery, one week, starting June 23.
Esophageal Surgery, one week, starting June 23.
Thoracic Surgery, one week, starting June 2.
Fractures and Traumatic Surgery, two weeks, starting February 4.
GYNECOLOGY—Intensive Course, two weeks, starting February 18, March 17.
Vaginal Approach to Pelvic Surgery, one week, starting March 3, March 31.
OBSTETRICS—Intensive Course, two weeks, starting March 3, March 31.
MEDICINE—Intensive General Course, two weeks, starting May 5.
Electrocardiography and Heart Disease, two weeks, starting March 17.
Gastroenterology, two weeks, starting May 19.
Hematology, one week, starting June 16.
UROLOGY—Intensive Course, two weeks, starting April 28.
Ten-Day Practical Course in Cystoscopy starting February 18, March 3, and every two weeks.
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General, Intensive and Special Courses in All Branches of Medicine, Surgery and the Specialties

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sons enrolled in the Blue Cross and Blue Shield Non-Group Plans.

In addition to the enrollment in the Non-Group Plans, the Group Enrollment Department reports that the average monthly enrollment of small groups of 5 to 25 employees more than doubled during the month of September.

A few highlights of the Campaign show that as many as 10 thousand persons enrolled in one day and that the daily average for the month was almost 3 thousand persons, or more than two persons enrolling every minute of every working day. Of the total Non-Group applications received, three-fourths came from residents of the area served by participating hospitals in Detroit, Pontiac, Flint, and Mt. Clemens. Including all previous campaigns, there are almost 125 thousand persons enrolled in the Non-Group Plans. This total is divided about the same as the Michigan population figures, that is, half in the Detroit-Flint-Pontiac area and the balance in other areas throughout the state.

ENROLLMENT RESULTS BY AREA

Area	Including the Following Towns	Non-Group Members
1	Detroit - Flint - Pontiac - Mt. Clemens	64,552
2	Lansing - Jackson - Ann Arbor - Monroe	6,908
3	Battle Creek - Kalamazoo - Benton Harbor - Niles	2,472
4	Grand Rapids - Muskegon - Holland - Ludington	5,733
5	Saginaw - Bay City - Port Huron - Mt. Pleasant	4,062
6	Grayling - West Branch - Alpena - Rogers City	898
7	Manistee - Traverse City - Petoskey - Cheboygan	1,000
8	Upper Peninsula	2,128
		87,753

Future Non-Group campaigns will likely be conducted on an annual state-wide basis.

* * *

The annual meeting of the **Michigan Pathological Socicty** was held at the University Hospital in Ann Arbor, on December 8, 1951. In addition to the business meeting, the program consisted of a Slide Seminar on "Diagnostic Problems, Interesting and Unusual Cases." W. A. Stryker, M.D., of Wyandotte, was elected president, and James G. Christopher, M.D., of Detroit, president-elect. C. Allen Payne, M.D., of Grand Rapids, was re-elected secretary-treasurer. The next meeting is scheduled on February 9, 1952, at Henry Ford Hospital, the program to be devoted to clinical pathology.

* * *

The Second National Cancer Conference, sponsored by the American Cancer Society, National Cancer Institute and American Association for Cancer Research, will be held at the Netherland Plaza Hotel, Cincinnati, Ohio, March 3-5, 1952.

Two general sessions will be held daily at which will be discussed cancer of the lung, prostatic and bladder neoplasms, the value of chemotherapy and radiation therapy, treatment of melanoma and gastrointestinal cancer and relation of steroids to cancer production.

In addition, seven clinical panels will be devoted to cancer of the breast, head and neck, female genital tract, gastrointestinal tract, genitourinary tract, lung and lymphomas and leukemias.

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Acknowledgment of all books received will be made in this column, and this will be deemed by us as full compensation to those sending them. A selection will be made for review, as expedient.

AN ATLAS OF NORMAL RADIOGRAPHIC ANATOMY. By Isadore Meschan, M.A., M.D., Professor and Head of the Department of Radiology, University of Arkansas School of Medicine, with the assistance of R. M. F. Farrer-Meschan, M.B., B.S. (Melbourne, Australia). 1044 illustrations on 362 figures. Philadelphia: W. B. Saunders Co., 1951. Price $15.00.

This new book is not just another book, but one which fills a very considerable gap that has long existed. Not many of us are good artists, and it is often impossible to convince men not trained in the field of radiology that certain shadows actually do represent a specific structure in the body. The correlation of the radiographs with good anatomical drawings is an excellent way to accomplish the teaching. This has been done in detail and the amount of care that has gone into the book is evident at first glance.

Every one in medicine should benefit from careful study of the sections of this book which pertain to their particular field.

The physical aspects of the book are done in the usual manner of Saunders' books. Need more be said?

G. T. P.

SURGICAL PRACTICE OF THE LAHEY CLINIC. By members of the Staff of Lahey Clinic, Boston. 784 illustrations on 509 figures. Philadelphia: W. B. Saunders Co., 1951. Price $15.00.

This book is a revision of the original volume published ten years ago. It brings up to date the cumulative surgical experience of the staff of the Lahey Clinic. Emphasis is placed on standardized operative procedures. Although one may object to this method of presentation it does have great value when used for the training of young surgeons. This book is heartily recommended to all surgeons. Without it, no surgical library would be complete.

J. W. H.

THE SPECIALTIES IN GENERAL PRACTICE. Edited by Russell L. Cecil, M.D., Professor of Clinical Medicine, Emeritus, Cornell University Medical College, New York City. Articles by: William A. Barnes, M.D.; Douglas D. Bond, M.D.; Charles G. Child, III, M.D.; R. Cannon Eley, M.D.; John M. Flumerfelt, M.D.; Edmund P. Fowler, Jr., M.D.; Louis M. Hellman, M.D.; Charles H. Herndon, M.D.; Chevalier L. Jackson, M.D.; Hugh J. Jewett, M.D.; George M. Lewis, M.D.; R. Townley Paton, M.D.; Arthur W. Proetz, M.D., and L. Ramsay Straub, M.D. Philadelphia: W. B. Saunders Co., 1951. Price $14.50.

Dr. Cecil as editor of this volume has assembled very satisfactory treatises on the various specialties with which the general practitioner comes most in contact. There are fourteen well-known collaborators, several in some fields. The first three chapters are minor surgery, orthopedic surgery, and fractures and dislocations. Next fol-



low urology, diseases of the anus and rectum, gynecology, obstetrics and pediatrics. These are ably presented, well illustrated and occupy 491 of the 818 pages. Ophthalmology, diseases of the nose and throat, diseases of the larynx, bronchi and esophagus, and otology are extremely well presented in the next 140 pages. There is an abundance of illustrations, and some special subjects of extra importance such as blindness from glaucoma, cataract, get special consideration. Incidentally, Townley Paton, in his article on ophthalmology, speaks of two ionometers, and gives the American instrument, the McLean, a good boost. Many writers ignore that instrument in favor of the Schitz which is not a direct reading affair. Two chapters on dermatology and syphilis, and psychiatry, complete the book. A sixty-page detailed index is a real asset to the book.

KEY TO MEDICAL TERMINOLOGY, Unit One. By Queena Hazelton. Second edition. Dallas, Texas: American Association of Certified Medical Secretaries, 1951.

This is a supplemental text in medical word-combining forms for medical secretaries, medical record librarians, nurses, corpsmen, and premedical students.

Professional nomenclature is made easy for the average high school graduate in the Intensive Exercises giving pronunciation and also shorthand outlines for the difficult terms used in the solid matter drilling the word-combining forms listed at the beginning.

Difficult words are given special treatment, to make them intelligible, and shorthand symbols are suggested. This little book is part of a course of training.

UNTOWARD REACTIONS OF CORTISONE AND ACTH. By Vincent J. Derbes, M.D., F.A.C.P. Associate Professor of Medicine, Tulane University of Louisiana School of Medicine; Head of Department of Allergy, Ochsner Clinic; Visiting Physician, Charity Hospital of Louisiana at New Orleans; and Staff Member, Foundation Hospital, New Orleans, Louisiana, and Thomas E. Weiss, M.D., Instructor in Medicine, Tulane University of Louisiana School of Medicine; Member of Department of Medicine, Ochsner Clinic; Visiting Physician, Charity Hospital of Louisiana at New Orleans; and Staff Member, Foundation Hospital, New Orleans, Louisiana. Springfield, Illinois: Charles C Thomas, 1951. Price $2.25.

This attractive little soft leather covered book contains a good chapter on the physiology of the drugs. Administration causes structural changes in some of the organs of internal secretion also leading to a chapter. Actions on the cardiovascular system and in infections are mentioned. Changes in the musculoskeletal system and in skin, subcutaneous and mucous parts are considered. Probably the most important part of the book is a long list of references, including J. W. Conn of Michigan University in the *Journal of Clinical Endocrinology,* 10: 825, 1950; O'Donnell, W.M. and Fajans, S.S. in *University of Michigan Medical Bulletin,* 16:169-172, 1950.

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STATISTICS FOR MEDICAL STUDENTS and Investigators in the Clinical and Biological Sciences. By Frederick J. Moore, M.D., Associate Professor of Experimental Medicine, University of Southern California School of Medicine and Frank B. Cramer, B.A., Research Fellow, and Robert G. Knowles, M.S., Research Associate Department of Experimental Medicine, University of South California School of Medicine. Philadelphia: The Blakiston Co., 1951. Price $3.25.

The science of statistics is a growth from mathematics, and calculus. It is an attempt to find reason and rhythm from a mass of figures and facts which of themselves are baffling. There is a science to the matter, and this book is an exposition of the application of the science to medical studies and research. Five stages of the study are covered: (1) several articles on variation and the normal curve of error; (2) fitting the normal curve of error to the data; (3) sampling distributions and tests of significance; (4) the problem of non-normal distributions; and (5) general aspects of the design of experiments and presentation of results. The appendix devotes twenty pages to tables and formulae used in statistical calculations. For a student doing experimentation and analyzing results, this book should be a great help.

CLINICAL ALLERGY. A Practical Guide to Diagnosis and Treatment. By Samuel J. Taub, M.D., F.A.C.P., Professor of Medicine and Chairman of the Department of Allergic Diseases, the Chicago Medical School; Professor of Medicine Cook County Graduate School; Attending Physician Cook County, Columbus and Mt. Sinai Hospitals. Second edition, revised and reset. New York: Paul B. Hoeber, Inc., 1951. Price $4.50.

This author has given us a very readable treatise on Allergy. His style is pleasing, easy to read, and entertaining at times. The publishers have done an excellent job, too, in that the book is well printed with good type, adequately spaced for easy reading, and on non-glossy paper. Such a book one can enjoy. In the chapter on asthma, the author says bronchial asthma is a misnomer. He credits John Foyer, an English physician, with a "Treatise on Asthma," in 1698, in which he described his own symptoms. He described two types, one a continual asthma, and one he called idiopathic and suggested its cause as "the constriction of the bronchi and bladders of the lungs by windy spirits." Status asthmaticus is the cause of most asthma deaths. About three pages are devoted to its consideration and treatment, including Cortisone, which gives good results. Disturbances of the skin due to allergy, drug allergies, blood transfusion, allergic reactions, serum sickness, and miscellaneous conditions are reviewed. We like the book.

THE BATTLE FOR MENTAL HEALTH. By James Clark Moloney, M.D. New York: Philosophical Library. Price $3.50.

The author has presented his views in a cloth-bound booklet of less than 100 pages. He is of the opinion that we are a nation of emotionally unstable people. To corroborate his beliefs, he has included statistics on the number of cases, cost and care of the psychotics, psychoneurotics, alcoholics, drug addicts and criminals that help to make up our population. As a charter member of the Cornelian Corner organization for infant mental hygiene, he strongly favors their beliefs, consisting of: less maternal fear of pregnancy, breast feeding, obstetrical rooming-in care, permissive child rearing and the promotion of relaxation in mothers to further mental health. All these problems should be of interest to physicians and especially obstetricians and pediatricians. Also possibly hospital administrators and obstetrical nurses should find it thought provoking. And if the Cornelian Corner group should have the method to avoid the instability and maladjustment that are making up a large proportion of our population, then we should all be interested.

G. K. S.

PENICILLIN DECADE. 1941-1951. Sensitizations and Toxicities. By Lawrence Weld Smith, M.D., Medical Director, Commercial Solvents Corporation; Ann Dolan Walker, R.N., former editor, *Trained Nurse and Hospital Review*. Washington, D. C.: Arundel Press Inc., 1951. Price $2.50.

This is a book of small articles occupying sometimes a page, sometimes more, about sensitizations and toxicities of penicillin as observed during the ten-year period just ending. These include urticaria, contact dermatitis, allergic reactions, serum sickness, anaphylaxis, exfoliative dermatitis, and a long list of kindred reactions or manifestations. Following the text is a list of 342 papers and references.

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ANTIBIOTIC THERAPY. By Henry Welch, Ph.D. Director, Division of Antibiotics, Food and Drug Administration, Federal Security Agency of the United States Government, and Charles N. Lewis, M.D., Medical Officer, Division of Antibiotics, Food and Drug Administration, Federal Security Agency of the United States Government, foreword by Chester S. Keefer, M.D., Wade Professor of Medicine, Boston University School of Medicine, Chairman Committee on Medicine and Chairman, Committee on Chemotherapy of the National Research Council. Washington, D. C.: The Arundel Press, Inc., 1951. Price $10.00.

In the past ten years, the treatment of infectious diseases has been so completely changed by the advent of the antibiotics that any new and complete summary of the information now available is welcome and should be of distinct value to the student and the busy physician. The amount of information that is available is tremendous and to present this in a concise, though reasonably complete form, has been a herculean task. Prior to this text, there has been no single volume encompassing the whole field of the available antibiotics. If for no other reason, this fact should make the book of marked importance.

The first part deals with the isolation and development of the antibiotics. The second part deals with each antibiotic individually, including antimicrobial spectrum, pharmacology and dosage forms. At the start of each chapter there is a photograph and biographical sketch of the discoverer of that particular antibiotic. This is especially well done. The antibiotics covered are as follows: Tyrothricin, Penicillin, Streptomycin and Dehydrostreptomycin, Bacitracin, Aureomycin, Chloramphenicol, Terramycin, Polymyxin, Neomycin, Mycomycin, Viomycin, and Subtilin. The third and last part discusses the treatment of specific diseases and in most instances recommended dosages are given. Also, the use of the various antibiotics in these individual diseases is summarized. This makes this text of particular value in quick reference for specific therapy. At the end of each chapter an adequate bibliography is appended.

As is readily seen, there is a tremendous amount of information in this book, and we believe it represents an excellent summary of the properties and uses of the antibiotics as of today. Since the treatment and prevention of infectious diseases comprise a large portion of the practice of medicine, then the active practitioner will find great help in this worthwhile text.

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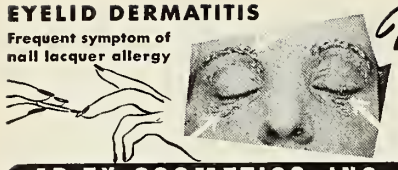
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LEO H. BARTEMEIER, M.D.

(Continued from Page 234)

that under the serious mask of this busy man, there lies a love of fun and an adventurous spirit. He used to fish but of late has turned to stamp collecting, gardening, and taking pictures—really good pictures, movies and stills. He ties these hobbies in with a collector's appreciation of art and literature. When Bart is taking pictures, nothing else is important: he trails behind sightseeing groups; he is always the last one to board the bus; he stops his guide on the most dangerous curve on the mountain for "just one shot of this view," keeping his family in a constant state of jitters!

He enjoys laboring in the garden. His own yard is beautiful—the envy of all neighbors who, of course, join in enjoying it. There are bird feeders in the yard—which Bart keeps filled; one is outside his study window and the red birds come each year for the feed they know is waiting for them.

Because of the many meetings he has attended, he has a valuable collection of stamps. In his travels as President of the International Psychoanalytic Association, as a member of a commissioned group sent by the Surgeon General of the United States to study combat exhaustion in the European Theatre in World War II, as a consultant for the World Health Organization, as a member of the Executive Board for the World Federation for Mental Health, he has made contacts with stamp dealers in Europe and has friends all over the world who know of his hobby and who are trading with him or buying for him.

Bart hasn't many gray hairs on his head. Perhaps that is due to the joy he has in his work and the great love and care that daily come his way from a close-knit family composed of an admiring wife (who has been ministering to his wants for thirty years) and two fine daughters—not to mention the light of his life—grandbaby Ann.

Bart used to say he would retire at fifty-five. Wife Bess says proudly, with a slightly wistful note: "I used to believe him. He is now fifty-seven and has no intention of even slowing down."

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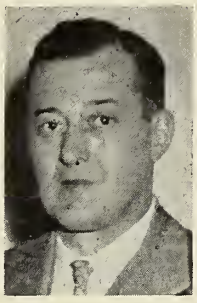
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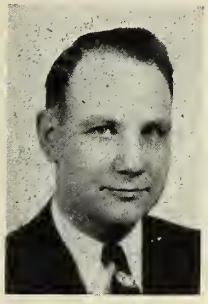
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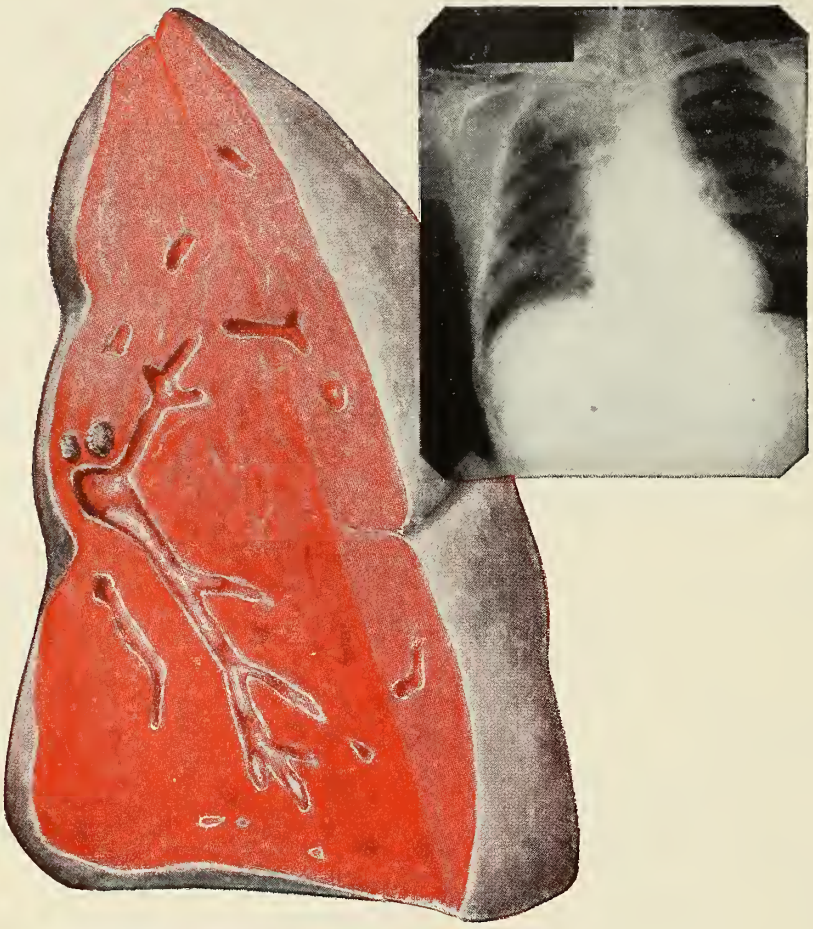
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ACCEPTED COUNCIL ON PHARMACY AND CHEMISTRY AMERICAN MEDICAL ASSOCIATION

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Michigan Foundation for Medical and Health Education, Inc., Sponsors Successful Rural Health Conference

"Court of Public Appraisal" Attracts Wide Interest

Adequate progress is being made in Michigan's Health programs!

This was the verdict of the jury in a court of public appraisal which highlighted the fifth annual Michigan Rural Health Conference at the University of Michigan.

The trial, staged in a realistic manner with Circuit Judge James R. Breakey, Jr., presiding, was witnessed by 250 people. The conference was sponsored by the Michigan Foundation for Medical and Health Education, Inc., with 94 cosponsors including the University and the Michigan Health Council.



"Court of Public Appraisal" in Session

Judge Breakey *(second from left)* and jury *(center rear)* hear testimony of A. C. Furstenberg, M.D., Ann Arbor. *(Right foreground)* L. F. Foster, M.D., Bay City, and J. K. Altland, M.D., Lansing, confer with defense attorney J. Joseph Herbert, as Warren B. Cooksey, M.D., Detroit *(extreme right)* observes.

Under questioning by Defense Attorney J. Joseph Herbert of Manistique, five defendants representing as many areas of responsibility for Michigan's health established these facts:

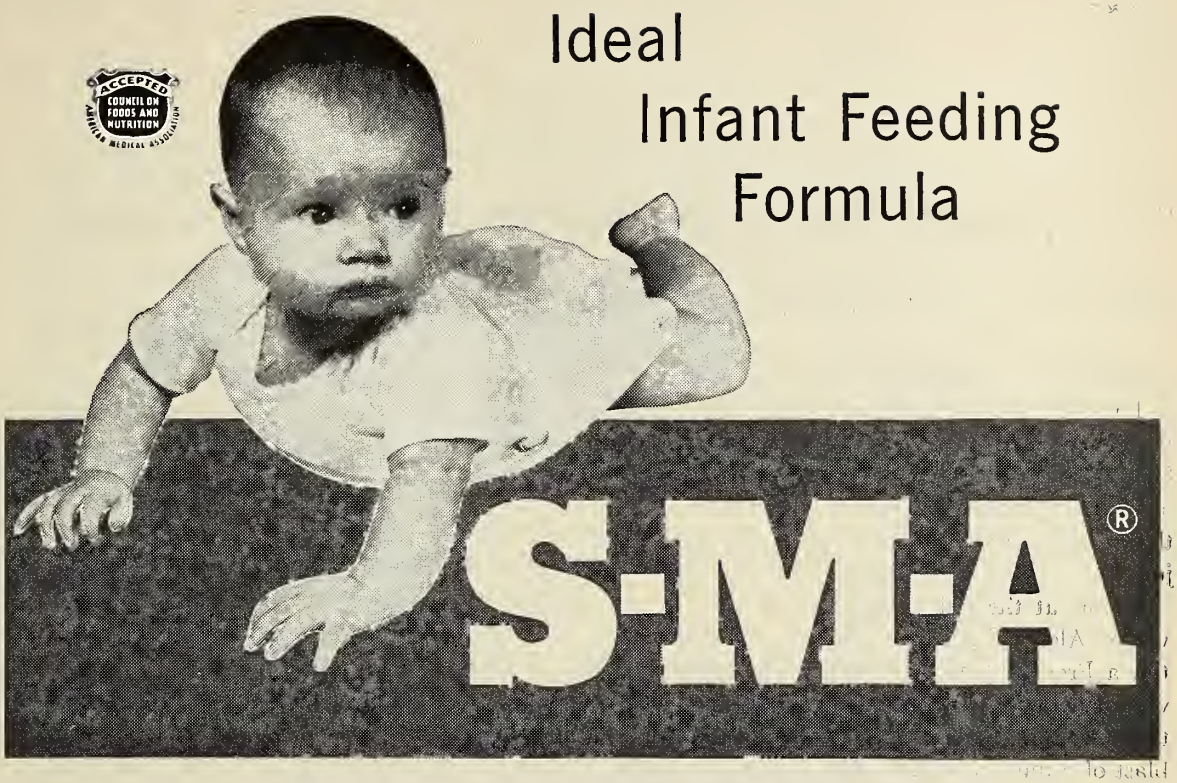
- The average Michigan citizen lives to be 69, nineteen more years than fifty years ago.
- Eight per cent of Michigan's population does not benefit from a local health department but this is because 12 counties have not voted funds to support such departments.
- Education of medical students has vastly improved. Lectures are now supplemented by bedside training and hours of instruction have more than doubled.
- Improved transportation, better drugs and modern techniques permit one doctor to give more and better care than two doctors in 1930.
- Individual consumers of health are co-operating to the best of their knowledge and ability.
- Voluntary health organizations are seeking more efficiency and have established procedures aimed at preventing the wasting of solicited funds.
- Doctors are not opposed to public health programs and have not attempted to keep down the number of doctors.

Charged with "failing to make adequate progress in discharging their responsibilities to the public," representatives from five major areas of responsibility in health were called to the stand. The jury, picked at random from the registration slips, after hearing the testimony brought in a verdict of "not guilty" after 18 minutes deliberation.

Michigan medicine contributed generously to the success of the conference. Appearing on the two day program were, A. C. Furstenberg, M.D., Ann Arbor, Dean School of Medicine, U. of M., Chairman, E. I. Carr, M.D., Lansing, President Michigan Foundation for Medical and Health Education, Rudolf Noer, M.D., Detroit, Assistant Dean, College of Medicine, Wayne University, John R. Rodger, M.D., Bellaire, Warren B. Cooksey, M.D., Detroit, President United Health and Welfare Fund, L. Fernald Foster, M.D., Bay City, Secretary, MSMS, and J. K. Altland, M.D., Lansing, Michigan Department of Health. Warren R. Mullen, Saline, Michigan, Sr. Student, College of Medicine represented the Medical Student on the program.

The annual Michigan Health Council Awards were presented by John B. Martin, Jr., Grand Rapids, Auditor General, State of Michigan, Chairman Awards Committee and the Banquet Address was presented by Dr. Harlan H. Hatcher, President of the University of Michigan.

More than fifteen County Medical Societies sent delegates. Members of the Woman's Auxiliary to MSMS and the Washtenaw County chapter, served as hostess.



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Unmatched in similarity to healthy mother's milk, S-M-A provides all essential food elements, including vitamins and minerals well in excess of recommended daily allowances.

S-M-A is an economical formula.

Only water need be added. Since the addition of nutritive elements is unnecessary, *the initial cost is the whole cost.* And the whole cost of the complete S-M-A formula is *less than 1¢ per ounce.*

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"That More May Know"---Help Build the Beaumont Memorial

Campaign to Restore Historical Building Begun

The Michigan medical profession has assumed the important task of restoring the American Fur Company store on Mackinac Island—scene of the historical event which gave Dr. William Beaumont the opportunity to discover the action of gastric juices.

It was at the old Fur Company store in 1822 where Alexis St. Martin, a French-Canadian voyageur, was accidentally wounded by the blast of a musket which tore a hole in his side. When the wound healed, it formed a fistula through which the workings of the stomach could be observed.

Doctor Beaumont, a young surgeon serving at Fort Mackinac, treated St. Martin's wound and later conducted experiments on the voyageur with the hole in his side. The discoveries from these studies are rated an outstanding contribution to medical science.

Otto O. Beck, M.D., Birmingham, President of the Michigan State Medical Society, launched the campaign to restore the Beaumont Memorial at the annual County Secretaries-Public Relations Conference in Detroit, January 27, 1952.

Doctor Beck stated that the Beaumont Memorial Restoration should be a project supported exclusively by Michigan doctors of medicine and the Woman's Auxiliary to the Michigan State Medical Society. Approximately $40,000 must be raised by personal subscription—to construct the Fur Company store as it originally existed in the early Nineteenth Century.



Otto O. Beck, M.D., Birmingham, MSMS President, reveals plans of the Beaumont Memorial Restoration project to members of the Woman's Auxiliary to the Michigan State Medical Society. The MSMS Beaumont Memorial Restoration Committee, in charge of this 1952 program, is headed by A. H. Whittaker, M.D., Detroit.

Pictured conferring *(left to right)* are Mrs. Robert S. Breakey, Lansing, Woman's Auxiliary President; A. H. Whittaker, M.D.; Mrs. Walter S. Stinson, Auxiliary First Vice President; MSMS President Otto O. Beck; and Mrs. William G. Mackersie, Detroit, Auxiliary President-Elect.

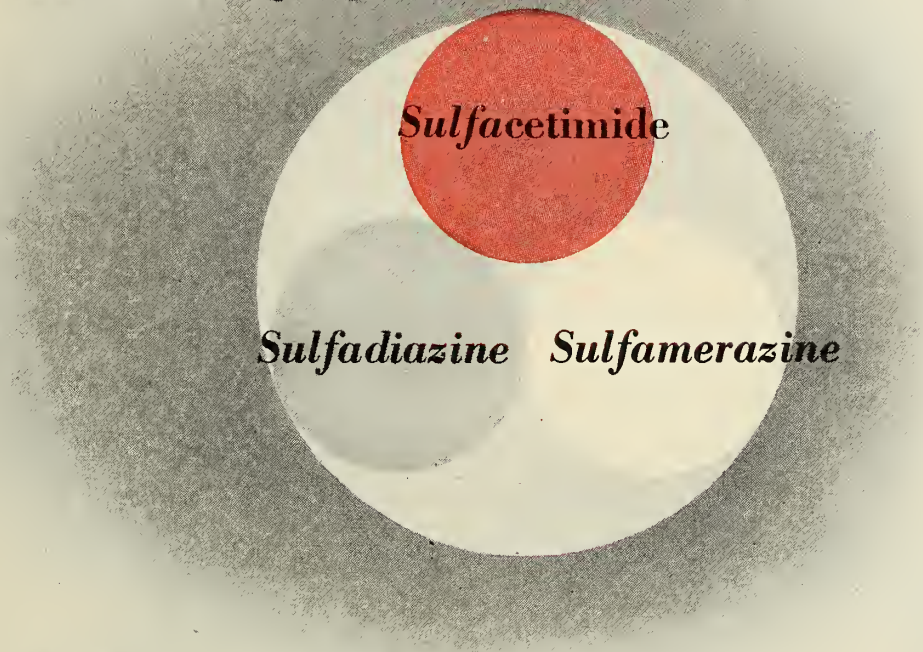
A letter from Doctor Beck has been sent to every member of the Michigan State Medical Society asking for contributions to make possible this historic shrine to medicine. An attractive brochure on the Beaumont Memorial project, entitled "That More May Know" was enclosed in the letter.

The Woman's Auxiliary is shouldering its share of the campaign with energy. Mrs. Robert S. Breakey, Lansing, enthusiastic and untiring President of the Auxiliary, prepared a second letter which she sent to all Auxiliary members seeking distaff support. The immediate response from the Beck and Breakey letters has been most encouraging.

All of the active direction of the campaign is under the supervision of the Beaumont Memorial Restoration Committee headed by A. H. Whittaker, M.D., Detroit.

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For greater clinical safety plus the advantages of more rapid absorption, better tissue distribution and faster therapeutic effect.

TRICOMBISUL Tablets, 0.5 Gm. total sulfonamides, each tablet containing 0.166 Gm. of sulfa*cetimide,* sulfadiazine and sulfamerazine.

TRICOMBISUL Liquid, 0.5 Gm. total sulfonamides (0.166 Gm. each of sulfa*cetimide* [solubilized], sulfadiazine and sulfamerazine) per teaspoonful (4 cc.).
*T.M.

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Formula For Freedom Nights

At County Medical Societies

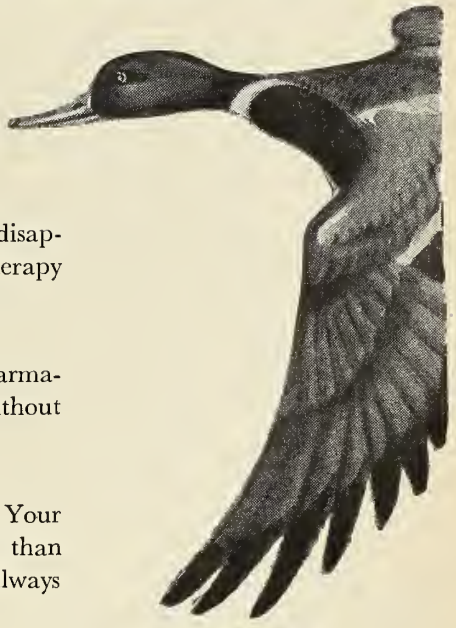
Date	Place	Speakers
Dec. 18, 1951	Kalamazoo Kalamazoo Academy of Medicine	R. J. Hubbell, M.D., Kalamazoo Otto O. Beck, M.D., Birmingham L. Fernald Foster, M.D., Bay City D. Hale Brake, Lansing State Treasurer Hugh W. Brenneman, Lansing
Jan. 15, 1952	Grand Rapids Kent County Medical Society	L. Fernald Foster, M.D., Bay City Senator Carlton H. Morris, Kalamazoo Hugh W. Brenneman, Lansing
Jan. 22, 1952	Saginaw Saginaw County Medical Society	L. Fernald Foster, M.D., Bay City J. E. Livesay, M.D., Flint H. B. Zemmer, M.D., Lapeer L. C. Harvie, M.D., Saginaw Hugh W. Brenneman, Lansing
Feb. 5, 1952	Big Rapids Mecosta-Osceola-Lake County Medical Society	L. Fernald Foster, M.D., Bay City Senator Milo A. Johnson, Greenville Hugh W. Brenneman, Lansing
Feb. 12, 1952	Owosso Shiawassee & Clinton County Medical Societies	L. Fernald Foster, M.D., Bay City Senator James M. Teahen, Jr., Owosso Hugh W. Brenneman, Lansing
Feb. 14, 1952	Ann Arbor Washtenaw County Medical Society	L. Fernald Foster, M.D., Bay City Bradley M. Harris, M.D., Ypsilanti D. Hale Brake, Lansing State Treasurer Hugh W. Brenneman, Lansing
Feb. 15, 1952	Muskegon Muskegon County Medical Society	L. Fernald Foster, M.D., Bay City William C. Vandenberg, Lansing Lt. Gov., State of Michigan Hugh W. Brenneman, Lansing
Feb. 19, 1952	Mt. Pleasant Gratiot-Isabella-Clare County Medical Society	L. Fernald Foster, M.D., Bay City Hugh W. Brenneman, Lansing
March 4, 1952	Battle Creek Calhoun County Medical Society	L. Fernald Foster, M.D., Bay City Senator Creighton R. Coleman, Marshall Hugh W. Brenneman, Lansing
March 7, 1952	Holland Ottawa County Medical Society	
March 18, 1952	Port Huron St. Clair & Sanilac County Medical Societies	L. Fernald Foster, M.D., Bay City John A. Martin, Jr., Lansing Auditor-General, State of Michigan Hugh W. Brenneman, Lansing
March 19, 1952	Bay City Bay-Arenac-Iosco County Medical Society	D. Hale Brake, Lansing State Treasurer J. E. Livesay, M.D., Flint Hugh W. Brenneman, Lansing
April 1, 1952	Monroe Monroe County Medical Society	To be announced in April Journal
April 15, 1952	Flint Genesee County Medical Society	To be announced in April Journal
May 7, 1952	Kingsley Inn Oakland County Medical Society	To be announced in April Journal





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Most sincerely,

Karl O. Mallard

Karl O. Mallard
President, Mallard, Inc.

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12:00 Noon to 1:00 P.M.

All speakers of the day on the stage at one time.

Here is your chance to ask questions of the day's lecturers and to hear discussed medical matters of value to you in your daily practice.

Section Meetings from 5:00 to 6:00 P.M.

at the

Michigan State Medical Society
Annual Session
Sheraton-Cadillac Hotel, Detroit
September 24-25-26, 1952

MSMS SURVEYS CENTRAL CALL-SYSTEMS

Most component County Societies have been exceedingly co-operative in helping the Michigan State Medical Society disseminate information on doctor availability (central call-systems), mediation committees and scholarship funds.

Information on these three topics was gathered by the MSMS Public Relations Department with three questionnaires sent to all secretaries of the county societies. The questionnaires reached the desks of the secretaries the day after the MSMS County Secretaries-Public Relations Conference held in Detroit, January 27. Within the first week, nine (9) County Societies returned the questionnaires to the Executive Offices in Lansing.

These questionnaires were sent out on instructions of The Council. The information contained in the answers on each of the three topics is being compiled and will be used to answer questions posed by reporters and writers for state and national newspapers and other publications.

MSMS RESOLUTION

Matters for Mediation Committee

WHEREAS, it has never been the policy of the medical profession to set specific fees for professional services, but rather to rely on the principle of a fair fee in each individual instance, taking into account the services rendered, the responsibility incurred, the professional skill required, the custom in that locality, but especially the economic status, and ability of the recipient to pay, and

WHEREAS, there has of late developed an increasing violation of these principles among a small but willful minority of the profession, and

WHEREAS, by persistently so doing this small minority is seriously undermining the good will and respect of the general public for the profession as a whole, which through the long past it has been the latter's constant endeavor to develop and maintain; therefore, be it

RESOLVED: That the House of Delegates of the Michigan State Medical Society strongly denounce such practices as are bringing the profession into disrepute; and be it further

RESOLVED: That all component county societies are hereby directed to bring all such willful and persistent impractices to the attention of their respective Committees of Mediation of such matters, for prompt and appropriate action, and to serve notice that if the perpetration of such impractices as reflect on the good name of medicine are persisted in, it may result in suspension of their membership.

This Resolution was adopted by the Michigan State Medical Society House of Delegates at its Annual Session of September 24-25, 1951, in Grand Rapids.

MSMS RESOLUTION

American Medical Education Foundation

WHEREAS, medical school officials estimate that there is an annual deficit of about $10,000,000 in medical school operation in this country, and needed construction at a cost in excess of $300,000,000, and

WHEREAS, many deans and other medical school officials have sought federal aid in this emergency, and

WHEREAS, the American Medical Association has been promoting free enterprise as the ideal system for this country, and

WHEREAS, most doctors of medicine now practicing paid only 20 per cent to 25 per cent of the actual cost of their education, there being a total deficit of some $8,000 to $10,000 per student paid either by private endowment or public aid; therefore, be it

RESOLVED: That this House of Delegates support the program of the American Medical Education Foundation by urging every physician in Michigan to contribute at least $100 per annum to this Foundation for a period of ten years, thus repaying some 10 per cent of the cost of his education; and be it further

RESOLVED: That business organizations, philanthropic trusts and other individuals interested in private enterprise be invited to contribute to the work of the foundation; and be it further

RESOLVED: That attention be called to the fact that this contribution can be earmarked for use by either the University of Michigan Medical School or Wayne University College of Medicine if you so specify.

This Resolution was adopted by the Michigan State Medical Society House of Delegates at its Annual Session of September 24-25, 1951, in Grand Rapids.

Meat and its Important Contribution of Essential Minerals

With the exception of calcium and iodine,[1] meat, as customarily consumed, makes an important contribution to the mineral needs of the American people. Its minerals include those needed in substantial amounts as well as those needed in trace amounts only.

The array of data listed below gives the approximate amounts of essential minerals provided by muscle meat when seven ounces per day are consumed.[1] The minerals include those now known to be essential components of the human organism—the skeletal framework and teeth, soft tissue structures including blood, and substances concerned in regulatory functions.

APPROXIMATE MINERAL CONTENT OF MEATS

200 Gm. (approx. 7 oz.),[1] Edible Portion (Uncooked)

	Beef Round	Lamb Leg	Pork Loin	Veal Shoulder
Minerals, total[2]	2.0 Gm.	1.8 Gm.	1.8 Gm.	2.0 Gm.
Calcium[2]	22 mg.	20 mg.	20 mg.	22 mg.
Chlorine[3]	147 mg.	136 mg.	125 mg.	147 mg.
Copper[3]	0.2 mg.	0.2 mg.	0.2 mg.	0.2 mg.
*Iodine[4] (Ohio animals)	0.02 mg.	0.03 mg.	Data not available	0.01 mg.
Iron[2]	5.8 mg.	5.4 mg.	5.0 mg.	5.8 mg.
Magnesium[3]	46 mg.	42 mg.	39 mg.	46 mg.
Phosphorus[2]	360 mg.	426 mg.	372 mg.	398 mg.
Potassium[3]	661 mg.	610 mg.	559 mg.	661 mg.
Sodium[3]	164 mg.	152 mg.	139 mg.	164 mg.
†Cobalt[5]	0.0002 mg.	———	Data not yet available	———
†Manganese[3]	0.03 mg.	0.03 mg.	0.02 mg.	0.03 mg.
†Zinc[5]	9.4 mg.	———	Data not yet available	———

*Iodine content of meat varies with the iodine content of feed of the animals.
†Needed in trace amounts only.

The average values for iron, phosphorus, and copper of the four kinds of meat shown constitute about 46, 25, and 100 per cent, respectively, of the National Research Council's recommended daily allowances for adults, and the average values for chlorine, potassium, and sodium constitute about 14, 63, and 16 per cent, respectively, of the estimated daily adult needs, as based on mineral balance studies.[6] Although no specific information is available on the quantitative needs for cobalt, magnesium, manganese, and zinc, nutrition information would suggest that the amounts reported above have nutritional importance or significance.

In addition to its notable content of essential minerals, meat also furnishes large amounts of biologically complete protein and important amounts of vitamin B complex, which includes biotin, choline, folic acid, inositol, niacin, pantothenic acid, pyridoxine, riboflavin, thiamine, and vitamin B_{12}. On the basis of its rich contribution of nutritional essentials, meat well deserves its prominent place in the daily diet of the American people, the world's best-nourished people.

1. Recent estimates of the U. S. Department of Agriculture indicate that the per capita consumption of meat in the United States approaches seven ounces per day.
2. Watt, B. K., and Merrill, A. L.: Composition of Foods —Raw, Processed, Prepared, In Agriculture Handbook No. 8, United States Department of Agriculture, 1950.
3. Estimated on basis of protein content of meats. Sherman, H. C.: Food Products, ed. 4, New York, The Macmillan Company, 1948, p. 155.
4. Ohio animals; varies with iodine content of feed. Johnson, H. J.: Bridges' Dietetics for the Clinician, ed. 5, Philadelphia, Lea & Febiger, 1949, p. 800.
5. Mitteldorf, A. J., and Landon, D. O.: Analytical Chemistry; Spectrochemical Analysis of Beef for Mineral-Element Content, Armour Research Foundation of Illinois Institute of Technology. In Press.
6. Dauphinee, J. A.: Sodium, Potassium, and Chloride Malnutrition, Including Water Balance and Shock, in Jolliffe, N.; Tisdall, F. F., and Cannon, P. R.: Clinical Nutrition, New York, Paul B. Hoeber, Inc., 1950, p. 341.

The Seal of Acceptance denotes that the nutritional statements made in this advertisement are acceptable to the Council on Foods and Nutrition of the American Medical Association.

ACCEPTED COUNCIL ON FOODS AND NUTRITION AMERICAN MEDICAL ASSOCIATION

American Meat Institute

Main Office, Chicago...Members Throughout the United States

Say you saw it in the Journal of the Michigan State Medical Society

MSMS RESOLUTION

Fluoridation of Water

WHEREAS, controlled experiments in several cities in the United States present acceptable evidence that the ingestion of small and carefully controlled amounts of fluorides during the period of tooth enamel formation substantially reduces the incidence of dental caries, without apparent deleterious effect, and

WHEREAS, the fluoridation of water is an effective approach to improving health through the prevention of dental decay, and is economically advantageous to the public as well as the individual, and

WHEREAS, the fluoridation of public water supplies is endorsed by the American Public Health Association, United States Public Health Service, American Dental Association, Michigan State Dental Society, in the interest of better health, and

WHEREAS, many Michigan communities still have not applied this health safeguard to their water supplies for the benefit of their citizens; now, therefore, be it

RESOLVED: That the House of Delegates of the Michigan State Medical Society endorse a carefully controlled and supervised process of fluoridation of communal water supplies for the prevention of dental caries; and be it further

RESOLVED: That a copy of this resolution be sent to every county medical society, the State Health Officer, and every local health officer in Michigan.

———

This Resolution was adopted by the Michigan State Medical Society House of Delegates at its Annual Session of September 24-25, 1951, in Grand Rapids.

CONTINUATION COURSE

On April 3, 4, and 5, 1952, the Frank E. Bunts Institute and the Cleveland Clinic Foundation will present a continuation course for physicians on *"The Diagnosis and Treatment of Malignant Disease."* Dr. Freddy Homburger, Research Professor of Medicine, Tufts College Medical School, Boston, will give the evening lecture on April 4. The other guest speakers will be Dr. Allan C. Barnes, Professor of Obstetrics and Gynecology and Chairman of the Department, Ohio State University College of Medicine; Dr. Brown M. Dobyns, Associate Professor of Surgery, Western Reserve University School of Medicine, Cleveland; and Dr. Thomas D. Kinney, Director of Laboratories, Cleveland City Hospital, and Professor of Pathology, Western Reserve University School of Medicine, Cleveland.

Inquiries regarding the complete program and registration may be addressed to the Frank E. Bunts Educational Institute, 2020 East Ninety-third Street, Cleveland 6, Ohio.

THE COST OF SICKNESS

Medical societies all over the nation report that the majority of complaints reaching grievance committees involve medical costs. To reduce such complaints, encourage physicians to: (a) discuss fees in advance with patients, (b) explain "those other medical bills" submitted by specialists and medical assistants, (c) itemize bills, (d) help patients budget for long-term medical care, (e) practice good PR in medical bill-collecting, (f) publicize the idea that medical care is available to all regardless of ability to pay, and (g) promote voluntary health insurance.

State and local medical societies need to police their own ranks and take disciplinary action against members guilty of unprofessional and unethical conduct. It's that one bad apple in the barrel that causes complaint. The medical profession prides itself on its high ethical standards and its dedication to serving humanity. It cannot afford to shelter the not-so-ethical man. Also, physicians who constantly over-charge should be firmly dealt with by their medical societies. Disciplinary action, when justified, strengthens the position of the profession in the eyes of the people.

Many a gripe is aimed at the doctor, and it's only justice that he occasionally have an opportunity to spout his own kicks about thoughtless or ornery patients who cause needless trouble and waste his time and energy. The *Saturday Evening Post* gave Dr. Robert K. Webster, Brazil, Indiana, just such an opportunity in a November 17, 1951, article called "I'm a Doctor—and I'm Human!" The Indiana physician points out that such patients are in the minority and offers some suggestions on how to be a good patient. The *Post* article and a piece entitled, "If Your Child is a Problem Eater," which appeared in the November issue of *Today's Woman,* are recommended reading.

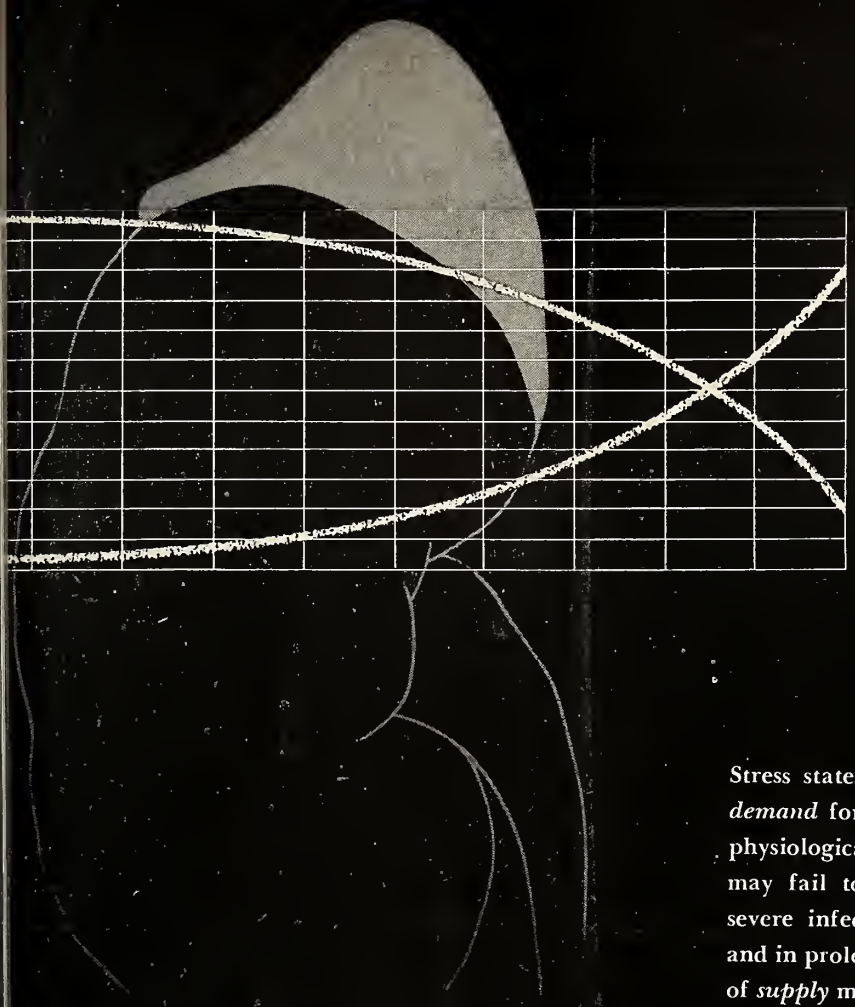
THE AMERICAN MEDICAL EDUCATION FOUNDATION

The 1952 campaign for funds on behalf of the American Medical Education Foundation will be held from April 15 to June 30.

The foundation's first year ended December 31 with more than 1,800 individual physicians contributing a total of $745,917.84. In addition, thirty-three organizations and thirty-three lay persons made contributions. These results, officers explained, may be considered quite satisfactory for a new undertaking of the magnitude of the foundation.

The AMA Board of Trustees has contributed

(Continued on Page 284)



demand and supply

Stress states may bring about an increased *demand* for corticoid hormones that even a physiologically hyperactive adrenal cortex may fail to meet. In the shock following severe infections, burns, or major surgery, and in prolonged convalescence, the problem of *supply* may be answered by subcutaneous, intramuscular or intravenous injection of Upjohn Adrenal Cortex Extract.

By Upjohn Adrenal Cortex Extract

Upjohn research in adrenal structure and function has aided the practice of medicine by the development of extracts which provide all of the natural adrenal cortical hormones.

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AMERICAN MEDICAL EDUCATION FOUNDATION

(Continued from Page 282)

another half million dollars to serve as a nucleus for the 1952 campaign. This brings to one million dollars the AMA contributions since the foundation was started a year ago. The AMA also is underwriting all the expenses of the foundation so that every dollar contributed can be passed on to the medical schools for their unrestricted use.

Under a new policy, adopted for 1952, alumni or friends of a medical school can make a contribution to a specific medical school through the foundation and the school will receive the full amount of the contribution, plus its full share of unearmarked funds.

The first distribution of funds to the medical schools was made in July, 1951. The balance of the funds raised during 1951 are now being sent to the medical schools through the National Fund for Medical Education.

THE AMA AND SENATE BILL 1149

This bill, which is intended primarily to effect the medical recommendations of the Hoover Commission on Organization of the Executive Branch of the Government, would provide for the transfer of various federal medical services to a new Department of Health.

The Hoover Commission's report in this regard was presented in March, 1949, based on reports received from its Medical Task Force in January and February of 1949. Although the report did recommend, in part, the program proposed by S. 1140, the basic or primary recommendations of the Commission were (a) that the Congress clearly define the beneficiaries entitled to medical care from the federal government and the relative priorities and such beneficiaries, and (b) that the present inconsistencies in the federal hospital construction program be resolved.

The Task Force, in conducting the studies prior to the issuance of its report, found that the existing federal medical program was "devoid of any central plan" and concluded that there must be overall planning, which would require "first a clear definition of the extent of the responsibilities, and second an organization appropriate to carry out the commitment."

Despite the fact that the American Medical Association is in favor of the establishment of a Department of Health and is in whole-hearted accord with the desire to effect economy in the operation of federal medical services, it is the belief of the Association that S. 1140 will not accomplish the desired results.—WALTER B. MARTIN, M.D., Trustee AMA.

MEDICAL MEETINGS AND CLINIC DAYS

A list of known medical meetings and clinic days, sponsored by county medical societies and other physicians' groups in Michigan, follows:

1952

Spring	MSMS Postgraduate Extramural Courses State-wide
April 3	Jackson County Medical Society's Clinic Day Jackson
April 9	Genesee County Medical Society's Cancer Day Flint
May 1	Ingham County Medical Society's Clinic Day Lansing
May 7	Third Michigan Industrial Health Day Flint
May 14	Wayne University Medical Alumni Clinic Day and Reunion.....Detroit
June 9-13	AMA Annual Session.....Chicago
June 27-28	Upper Peninsula Medical Society Annual Meeting.....Iron Mountain
June	St. Clair County Medical Society Clinic Day.....St. Clair
July 24-25	Annual Coller-Penberthy Medical Surgical Conference.....Traverse City
July 24-26	Conference on Housing and Living Arrangements for Older People....Ann Arbor
August	Third Annual Clinic, Central Michigan Committee, ACS Michigan Committee on Trauma, plus Michigan National Guard Medical Personnel, and Michigan Society of North Central Counties Grayling
Sept. 24-26	MICHIGAN STATE MEDICAL SOCIETY ANNUAL SESSION.....Detroit
Oct. 8	Clara Elizabeth Fund—Genesee County Medical Society—Lectures of 1952...Flint
Oct. 9	Fourth Michigan Cancer Conference Kellogg Center, East Lansing
October or November	American Academy of General Practice of Wayne County.....Detroit
Autumn	MSMS Postgraduate Extramural Courses State-wide

Additions to this list of meetings are invited by the Editor of JMSMS, in order to make this monthly announcement complete and accurate.

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MSMS County Secretaries-Public Relations Conference Breaks Attendance Record

Arch Walls, M.D., Detroit, Chairman of the MSMS Public Relations Committee, welcomed 191 registrants at the 1952 County Secretaries-Public Relations Conference, held at the Sheraton-Cadillac Hotel, Detroit, on January 27.

The morning session was devoted to FORMULA FOR FREEDOM, a PR project: "Why Formula is Valuable to Medicine," William Bromme, M.D., Detroit, Chairman MSMS Council; "How Formula is Applied"—a panel.

Members of the panel were: Press—C. L. Weston, M.D., Owosso; Radio—C. A. Payne, M.D., Grand Rapids; Cinema—A. E. Schiller, M.D., Detroit; Publications—K. H. Johnson, M.D., Lansing; Speakers—G. E. Millard, M.D., Detroit; Education—H. J. Meier, M.D., Coldwater. J. E. Livesay, M.D., Flint, conducted the question and answer period after the panel presentations.

Joseph Hainline, newscaster for Radio Station WJR, Detroit, opened the presentation at one end of the Ballroom with a simulated news broadcast on "The Formula Works." Following his speech, the audience was instructed by Chairman Arch Walls, M.D., Detroit, to turn its chairs one-quarter turn to the right. This move faced the seats to the side of the Ballroom where William Bromme, M.D., Detroit, Chairman of the MSMS Council, was located to deliver a short talk, "Why the Formula is Valuable to Medicine."

The next quarter turn of seats brought the audience around to the rear of the Ballroom. The latecomers now occupied front-row seats to listen to a panel discussion by media chairmen of the Public Relations Committee on "How the Formula Is Applied."

Otto O. Beck, M.D., Birmingham, MSMS President, spoke at the noon-day meeting on "The Beaumont Memorial Restoration—Our Responsibility."

In the afternoon, E. H. Fenton, M.D., Detroit, Chairman of County Society Secretaries during the past year, introduced J. Joseph Herbert, LL.B., Manistique, MSMS Legal Counsel. Mr. Herbert's subject was "What You Should Know About the Medical Practice Act and the Basic Science Act." L. Fernald Foster, M.D., Bay City, MSMS Secretary, presented "MSMS Techniques—and Why."



Formula for Freedom being discussed on January 27 in Detroit by MSMS President Otto O. Beck, M.D., Birmingham; Arch Walls, M.D., Detroit, Chairman MSMS Public Relations Committee, and L. Fernald Foster, M.D., Bay City, MSMS Secretary.

John A. White, M.D., Big Rapids, was elected Chairman of the Secretaries for the year 1951-52.

The 191 attendants were representative of the following groups:

County Secretaries—J. E. Mahan, M.D., Allegan (Allegan); W. R. Birk, M.D., Hastings, (Barry); P. J. Slosser, M.D., Tekonsha (Branch); T. B. Mackie, M.D., Sault Ste. Marie (Chippewa-Mackinac); N. L. Lindquist, M.D., Escanaba (Delta-Schoolcraft); E. P. Griffin, Jr., M.D., Flint (Genesee); C. H. Wallman, M.D., Alma (Gratiot-Isabella-Clare); A. J. Stein, M.D., Hillsdale (Hillsdale); J. L. Isbister, M.D., Lansing (Ingham); R. E. Rice, M.D., Greenville (Ionia-Montcalm); H. W. Porter, M.D., Jackson (Jackson); H. G. Benjamin, M.D., Grand Rapids (Kent); R. A. Biggs, M.D., North Branch (Lapeer); R. M. Duffy, M.D., Pinckney (Livingston); J. H. Jewell, M.D., Roseville (Macomb); B. E. Henig, M.D., Grayling (North Central); W. M. LeFevre, M.D., Muskegon (Muskegon); G. A. Drake, M.D., Petoskey (Northern Michigan); A. R. Young, M.D., Pontiac (Oakland); W. F. Strong, M.D., Ontonagon (Ontonagon); F. W. DeYoung, M.D., Spring Lake (Ottawa); Robert Bucklin, M.D., Saginaw (Saginaw); E. W. Blanchard, M.D., Deckerville (Sanilac); R. C. Brown, M.D., Owosso (Shiawassee); T. H. Bottomley, M.D.,

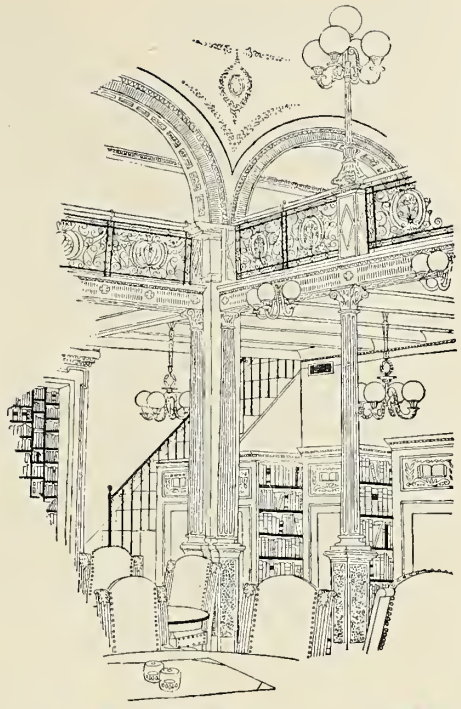
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(Continued from Page 286)

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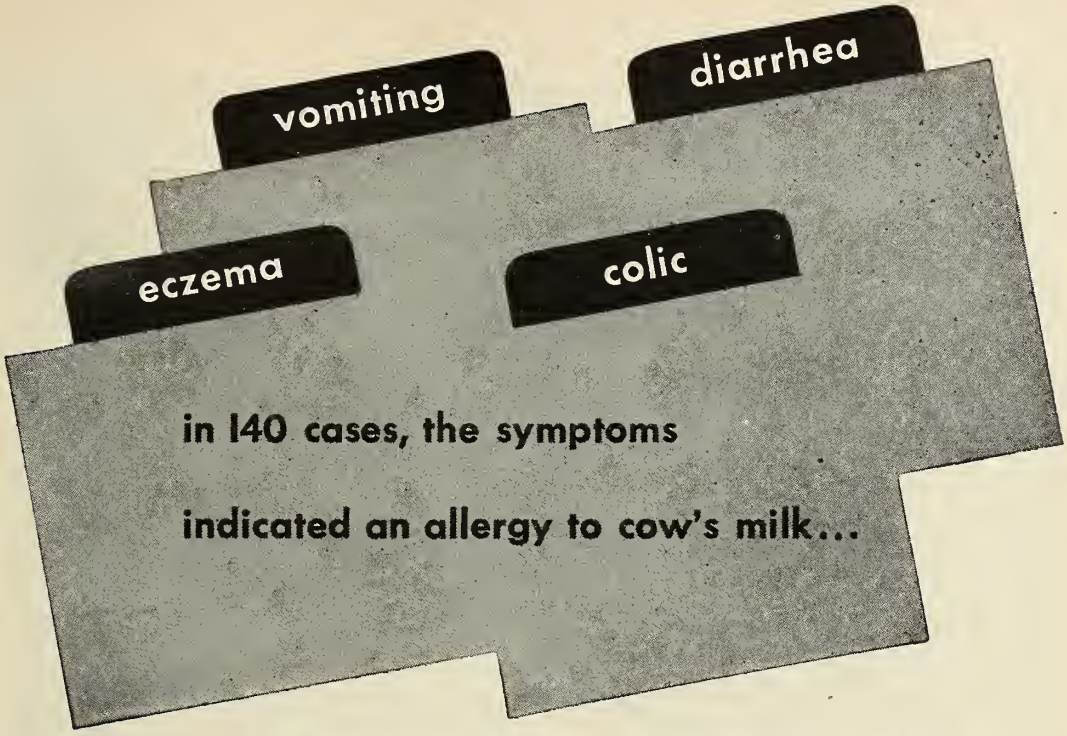
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Others Present—Capt. L. A. Potter, Michigan Department of Health; J. Joseph Herbert, MSMS General Counsel; E. H. Wiard, Michigan Health Council; J. C. Ketchum, J. W. Castellucci, Verne Collett, L. H. Freye, L. G. Goodrich, H. S. Hosmer, P. E. Klein and Neal L. McCue of Michigan Medical Service; W. H. Byrne; Miss Charlotte Ash, Mrs. T. E. Bachman, Miss Cary Guthaus, Miss Helen V. Hawkins, Miss Freda Heidelberger, Miss Doris E. Jarrad, Miss Patricia Kaczmarck, Miss Margaret Schultz, Miss Margaret E. Thompson and Miss Harriet A. Wahl of Michigan State Medical Assistants Society, and Mary Rose Wolfe.



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*Clein, Norman W.: Cow's Milk Allergy in Infants, Ann. Allergy 9:195 (March-April) 1951.

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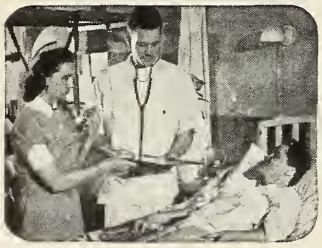
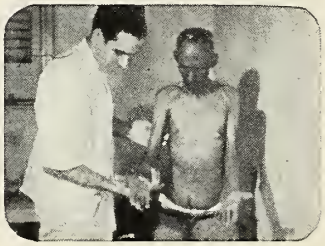
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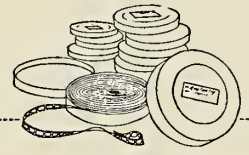




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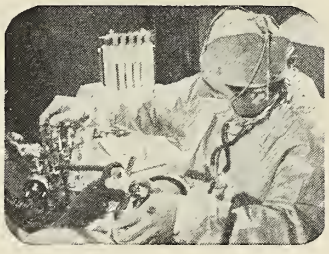
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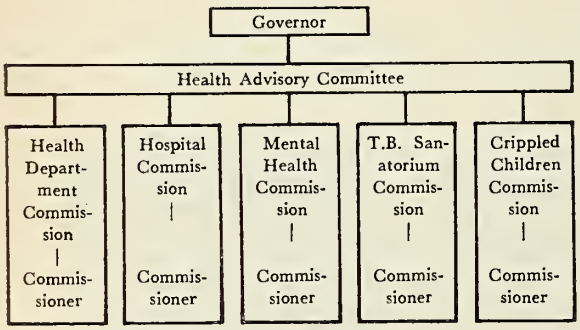


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Summary of Plan of Reorganization of the Health Functions of the State of Michigan

I. Administrative Plan

1. The need for co-ordination in the health functions of state government is recognized. We recommend that the five major branches of government health functions be retained as separate entities—The Health Department, The Mental Health Department, The Tuberculosis Sanatorium Division, The Crippled Children Commission and the Office of Hospital Survey and Construction. We recommend that all five branches be served by its commission with policy making powers. Further, we recommend that an over-all advisory committee be established to be composed of one member from each of the five commissions and the chairman to be designated from their group by the Governor. This over-all commission shall be advisory to the Governor on all health matters and meet regularly to co-ordinate all health functions. However, budget plans should remain the prerogative of each health division and should be handled as at present. In graphic form our recommendation is this:



(2) We recommend that the present advisory body to the health department be abolished and that a seven member commission be appointed by the Governor to serve seven-year overlapping terms. This commission should be given statutory powers of supervision and control. It should contain at least four doctors of medicine. Its functions should include the appointment of the health commissioner who would serve at the pleasure of the Commission.

(3) In similar fashion, we recommend that the other four commissions—namely, Mental Health, the TB Sanatorium Commission, the Crippled Children Commission and the Commission on Hospital survey and construction be given statutory powers of administration and control if lacking and that present powers be augmented, if needed, to give uniformity of control to all five commissions serving the major divisions of health functions. In short, we urge that the present Commissions be retained and their powers augmented if needed.

II. Some Specific Recommendations

1. That state law provide that the Health Commissioner must be a person with an M.D. degree and an M.P.H. degree with at least five years of demonstrated successful experience in public health administration.

2. That staff members of local or state health agencies not be permitted to serve on the various commissions.

3. That the State Health Department should include its present functions and in addition add to its duties the licensing of maternity homes, the sanitation services of the Department of Agriculture relating to human health, and the sanitation services of the Liquor Commission relating to human health.

4. That primary consideration be given the problem of raising the quality of personnel in State Hospitals and in filling present vacancies with qualified personnel. Realistic consideration should be given to salaries necessary to attract competent professional staff to State Hospitals and other health posts in State Government.

5. That present statutes be reviewed and changed where necessary to accomplish co-ordination of functions and lines of authority and supervision consistent with the administrative plan as outlined above.

III. Amalgamation Not Approved

We do not approve a proposed amalgamation of all the licensing boards in the health field.

Jackson E. Livesay, M.D., *Chairman*
Special Committee (MSMS) to Study
Report of "Little Hoover Commission"

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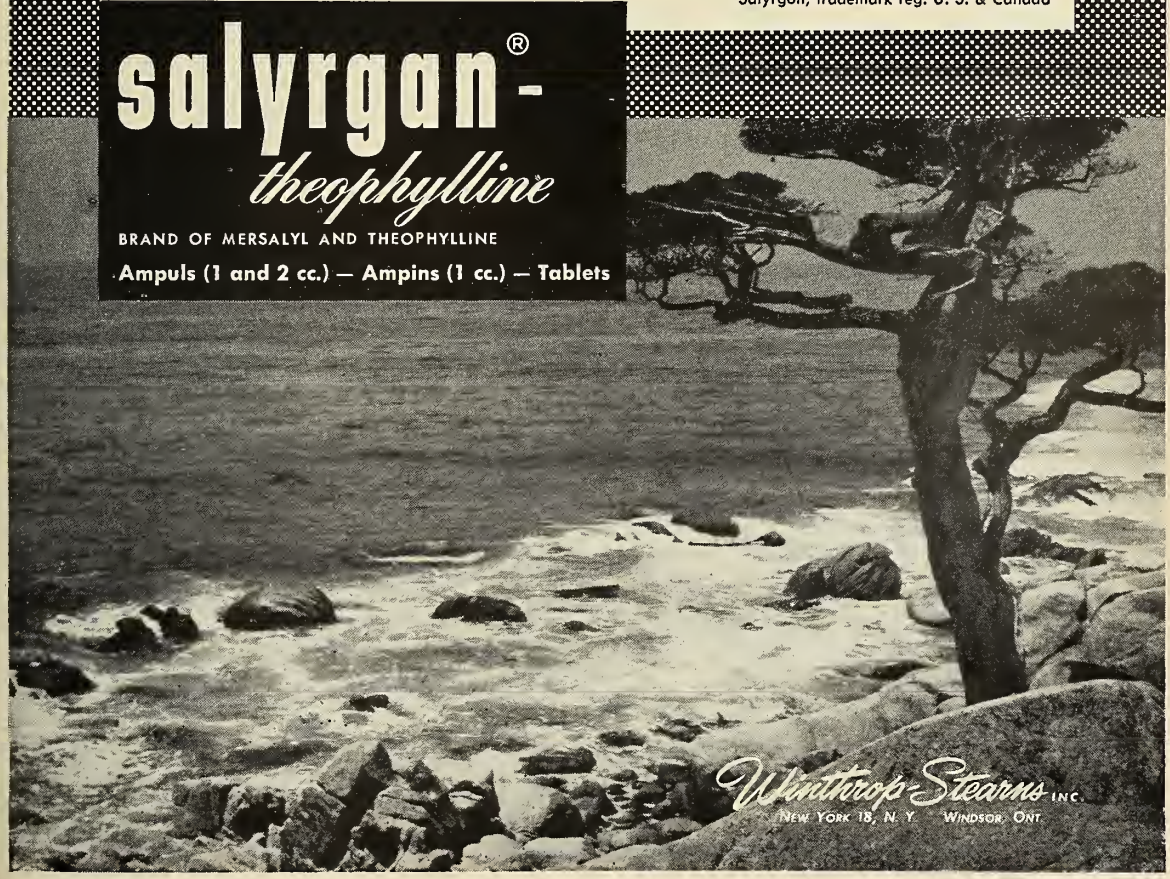
1. Hutcheson, J. M.: Manogement of Cordiac Failure. *Virginio Med. Monthly*, 74:458, Oct., 1947.
2. Noth, P. H.: Pick's Diseose: A Record of Eight Years' Treatment with Salyrgon, Ammonium Nitrate, ond Abdominol Porocentesis. *Proc. Staff Meet. Mayo Clin.*, 12:513, Aug. 18, 1937.

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Cancer Comment

MISCONCEPTIONS ABOUT UTERINE CANCER

Roger B. Scott, M.D., and James W. Reagan, M.D., of Western Reserve University School of Medicine, Cleveland, Ohio, in *GP* (December, 1951 issue) have called attention to some of the more common misconceptions about uterine cancer that have resulted in improper or delayed diagnostic or treatment procedures. Some of the more important of these, together with an abstract of the authors' discussion, are listed herewith:

1. *"Profuse, prolonged, or intermenstrual bleeding at the menopause has no special significance and will correct itself."*—Such symptoms demand a careful pelvic examination with uterine curettage, if necessary, to establish the cause of the condition. Hormones should never be given without careful pelvic examination. Abnormal uterine bleeding of any type is not a characteristic of the menopause and should be considered organic until otherwise proved.

2. *"Patients below the age of thirty with abnormal uterine bleeding may safely be kept under observation for a period of time before proceeding with diagnostic studies."*—The authors point out that the average age of patients with carcinoma *in situ* of the cervix is thirty-five to thirty-eight years, while the average age for invasive carcinoma of this organ is ten years older. They conclude that while youth is a relative blessing, it is no guarantee against the ravages of cancer.

3. *"Visualization and palpation of the cervix is sufficient to rule out cancer of this organ."*—Continued experience with the Papanicolaou smear method has shown its value in early diagnosis of cervical cancer. Confirmed by biopsy, the disease can be diagnosed in an early stage when absolute cures should approach 100 per cent. Neither visualization nor palpation can detect cancer as early as can cell smears and biopsy. A cervix may be symptomless and still contain a cancer.

4. *"A cervix which is cauterized and does not heal should be suspected of containing a carcinoma and appropriate measures then instituted to rule out the condition."*—If a cervix is so unhealthy as to demand cauterization, the presence or absence of cancer as the cause of the diseased tissue should be established by proper procedures of Papanicolaou smears and biopsy *before* rather than *after* cauterization.

5. *"A cervical biopsy during pregnancy is dangerous."*—Clinical experiences have shown this idea to be misleading. The danger of excessive hemorrhage has been overstressed. The authors issue a word of warning when examining slides of cervical tissue during pregnancy not to be misled by changes that may mimic carcinoma *in situ* and which will disappear postpartum. When there is definite evidence of invasion, treatment should be postponed until the pregnancy is concluded.

6. *"A diagnostic curettage of the uterus is dangerous, for it might disseminate malignant tissue."*—The danger of forcing tumor cells into vascular and lymphatic channels seems scarcely likely as the flow of such channels is into rather than away from the curetted uterine surface. Clinical or experimental evidence is lacking that excision of a malignant tumor by a wide margin or that uterine curettage can force tumor cells into nearby veins or lymphatics. When local or distant metastases occur after excision, it is more reasonable to assume that they had taken place prior to such procedures.

7. *"Radiation treatment of cancer of the cervix is passé and surgery is the treatment of choice."*—The authors supply the following table of five-year results of irradiation treatment of cervical cancer:

League of Nations—Stage 0	—100 per cent
League of Nations—Stage I	—55 to 80 per cent
League of Nations—Stage II	—30 to 45 per cent
League of Nations—Stage III	—15 to 25 per cent
League of Nations—Stage IV	— 0 to 5 per cent

The authors state that it is doubtful that results in radiation therapy will ever be much better than those given. They also feel that at least some of the widely publicized results of surgical treatment of cervical cancer are due to improved anesthesia, frequent transfusions, antibiotics, et cetera. More time is necessary to properly evaluate these surgical measures.

8. *"It is unsound to irradiate an organ and then remove it."*—It is argued that the cancer cells of the cervix can be killed by radiation, but doses

(Continued on Page 356)

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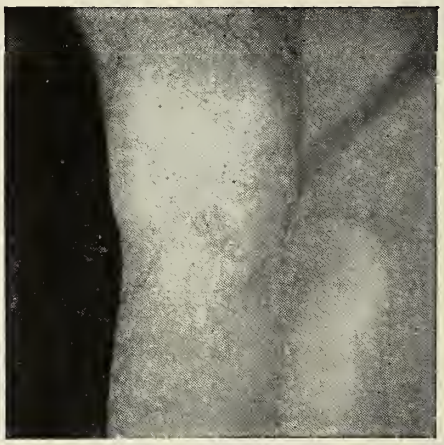


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Ward, L. E., Slocumb, C. H., Polley, H. F., Lowman, E. W., and Hench, P. S.: *Proc. Staff Mtgs., Mayo Clinic* 26: 361, September 26, 1951.

Literature on Request

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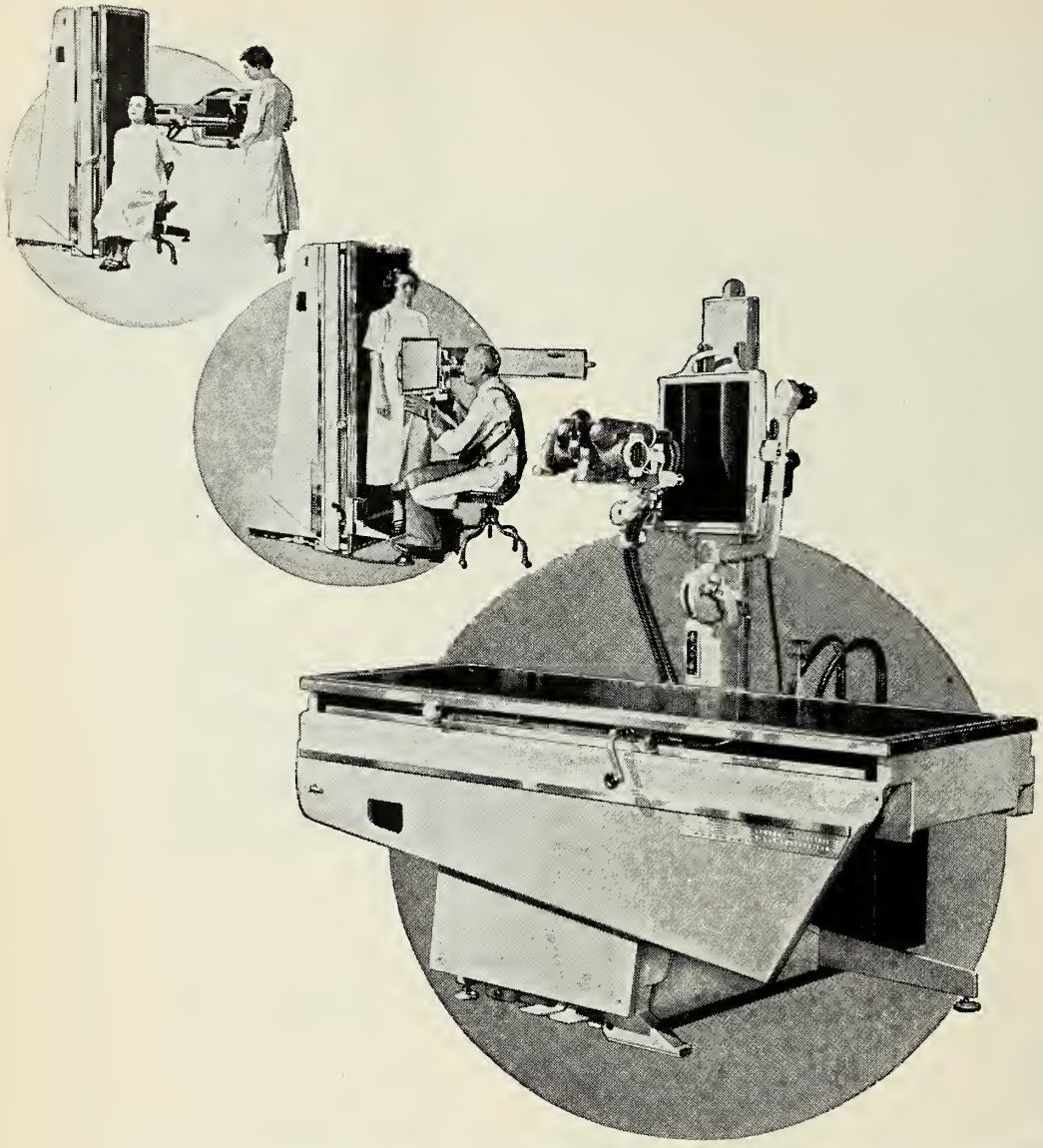


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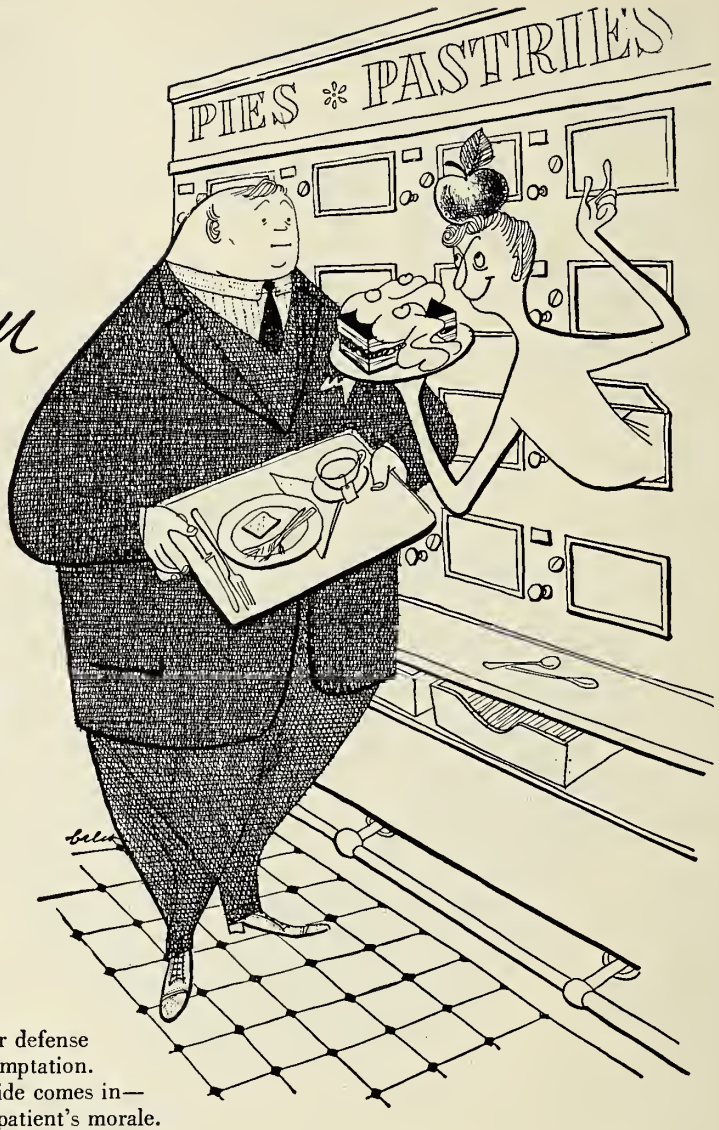
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Civil Defense is Self Help

By Max L. Lichter, M.D.
Detroit, Michigan

ONE HUNDRED THOUSAND injured—*now!* Take care of them.

This, in a nutshell, summarizes the basic problem confronting the medical profession in the atomic bombing of a potential target area in the State of Michigan.

In any large-scale disaster a prime consideration is professional care, the help that injured people need and expect. When one contemplates a problem of such huge statistical proportions, it becomes immediately obvious that a great deal of prior organizing and planning must be done if the situation is to be handled with any adequacy. It is essential that the application of medical care be not haphazard but, rather, carefully thought out. However, before medical care can be given with some measure of efficiency, it must be engrafted upon a sound and functional organization.

The responsibility of the medical profession in large-scale disaster is tremendous. If the individual physician would take time to think about the problem and study it, he would very shortly become aware of the complexity of the situation which faces Medicine. He will be forced to the conclusion that the only way his profession can approach the challenge of its responsibility is, first, by all physicians recognizing their important role; second, by united action on the part of all physicians; and third, by their active and interested cooperation.

He will realize that physicians individually cannot begin to meet the manifold duties involved in any worthwhile solution of the problem. He will appreciate that aside from his own participation in any organization, successful solution depends upon the development, with the assistance of allied professional groups, of teams and units and upon the training of thousands upon thousands of nonprofessional volunteers.

The keynote in Civil Defense is self-help.

It would then follow that the physician must be the leading figure in the development of this philosophy. If the citizens in our communities can be taught self-help, the physician will be better able to meet his responsibility to them. Those who have thoroughly studied the problem for a long period of time have had to reason in just this fashion.

In the Wayne County Medical Society, the Committee on Civil Defense and Disaster recognized early that a definite plan was needed in order that the physician's part in Civil Defense could be defined. The details of this plan were reported in this Journal in March, 1951. Basically there has been very little alteration. In close co-operation with the Detroit Office of Civil Defense and the Detroit Department of Health, the Society is attempting to make the plan an actuality rather than a paper exercise. Many of our members have assumed positions of great responsibility in the development of the various units and have given generously of their time and effort as evidence of their seriousness of purpose.

It soon became apparent that uniformity in professional care was absolutely necessary if any degree of completeness and efficiency in treatment were to be achieved. This necessity has been recognized by many of the major county medical societies throughout our country. It is, perhaps, unfortunate that these groups have had to work independently in developing their uniform treatment

Dr. Lichter is chairman, Committee on Civil Defense and Disaster, Wayne County Medical Society.

programs. But this was essential because of the relative absence of any functional policy, of which we were aware, being laid down at a national or state level. It was felt the lack of a single plan in no way mitigated our responsibility for the development of this important program. The Committee on Civil Defense and Disaster of the Wayne County Medical Society appointed two subcommittees, working closely together, to study the problam of developing 'standard operating procedures.' The results of their efiorts are detailed in the papers to follow.

The subcommittee on uniform medical treatment is under the chairmanship of Dr. Richard M. McKean. Dr. Rudolf J. Noer is chairman of the subcommittee on uniform surgical treatment. It is felt that their efforts and those of their colleagues are worthy of the highest commendation.

In preparing their reports, the members of the subcommittees kept two things in mind. One was the emergency aspects of the particular subject, and the other was the applicability of the material to everyday medical practice. While we do not all work in the same fields, it is incumbent upon each of us to brush up on those procedures with which we were once familiar.

In recognition of the need for uniform treatment procedures and of their professional value, the editor of The Journal requested the Committee of Civil Defense and Disaster of the Wayne County Medical Society to submit its report for publication in a special issue. It is a pleasure to comply with this request because it is desired to share the results of our efforts with all physicians throughout the state. Further, it is hoped that these articles will stimulate interest in the necessity for Civil Defense. It is planned to reprint the reports in the form of a brochure for wide distribution among professional groups.

It is our fervent hope that through reading these articles the physicians in the State of Michigan will more fully realize the scope of the responsibility which has been thrust upon them. We feel that philosophical discussions concerning the pros and cons of the possibility of atomic attack on our country should not deter us in preparing to do our part in Civil Defense. We know that our potential enemy is in possession of the weapon. We like to think that our country is the most peace-loving and enlightened nation in the world. We know that our leaders were faced with the awful question regarding the use of this terrible weapon against defenseless people, and they made a hard decision. Hiroshima and Nagasaki testify to that. If we found it so difficult to decide to use this weapon to achieve peace, is it to be supposed that our potential enemy will find it more difficult to use it to achieve conquest? If we recall our impressions of the character of our potential enemy, then the answer must be no. He will obviously have no compunction in using the atom bomb against our cities when it suits his purpose. Let us look at the problem in that simple manner and go forward with our planning. Let us, as physicians, recognize our grave responsibility in this potentiality and prepare to meet it. Let us make our people aware of our activity so that they may derive some comfort from the fact that we are not going to let them down. Finally, let us pray that it never happens.

Remember, one hundred thousand injured—*now!*

MSMS

LEHMAN SENATE BILL 2337—NEW EMIC

The Lehman bill consists of three titles. Title I provides for a Federal-State program of emergency maternity and infant care for the wives and infants of enlisted members of the Armed Forces. Hospital, medical, nursing, and related services in connection with pregnancy and childbirth would be provided for the wife of any enlisted member of the Armed Forces, Lehman stated in opening the hearings. Similar services would be available for all children of enlisted members of the Armed Forces who were under five years of age.

Title II goes a great deal further than Title I, for it would institute a system of Government-financed hospitalization for all dependents of enlisted men. The bill authorizes provision to these dependents of such hospital services as: "bed and board and such nursing services, laboratory services, ambulances, use of operating room, staff services, and other services, drugs and appliances as are customarily furnished by a hospital to its bed patients either through its own employes or through persons with whom it has made arrangements for such services, drugs or appliances."

This cryptic language authorizes use of Federal funds to purchase service-benefit insurance. — Marjorie Shearon, Challenge to Socialism, March 13, 1952.

The Development of a Program for Uniform Medical and Surgical Care in Disaster

By Richard M. McKean, M.D., and Rudolf J. Noer, M.D.

Detroit, Michigan

JOINT SUBCOMMITTEES on uniform medical and surgical care were formed, something under a year ago, to function under the Committee on Civil Defense and Disaster. Since then the members have been engaged in surveying the various facets of the situation with a view to concise presentation of practical solutions for problems which may arise in various fields. The papers which follow represent the current thinking of the committees in the areas considered. While some of them deal directly with factors peculiar to an attack with atomic weapons, it is important to remember that most injuries to be faced in any disaster are, in fact, problems confronting the doctor in his everyday contact with individual patients and their own personal "emergencies." This holds true even in that portion of the symposium which deals by title with "radiation injury" *per se*. In this light the material presented herewith seems peculiarly timely in our era when disaster seems persistently "just around the corner." We refer not alone to that seemingly nebulous and ephemeral "atomic attack" but to such emergencies as the Texas City explosion, the Kansas City area floods and other similar disasters.

Much of this material has been presented in various places and publications heretofore. There is a certain amount of unavoidable overlap between the various articles; it is felt that this is perhaps as much of an advantage as a disadvantage. Certain matters that are still the subject of active investigation have been deliberately omitted or sketchedly considered. We refer especially to certain phases of injuries to the endocrine system, particularly the anterior pituitary, the adrenal cortex and the gonads. The use of ACTH and cortisone and the results of their further study may well alter some of the concepts outlined in the present papers. For instance, there are some indications that the use of newer methods of therapy may alter the amount of irradiation which constitutes lethal dosage. The committee members are aware of their responsibility for keeping abreast of progress in their fields, and subsequent revisions of this material will be presented. We hold no brief for these methods as being necessarily better than others; they represent simply an attempt to present practical approaches to the problems involved. Longer study and protracted editorial effort might have produced a more cohesive effort, but the urgency of the situation made it appear of first importance that the material be presented at the earliest possible date. The committees welcome all suggestions as to how the presentation might be improved upon.

It must be remembered that a major catastrophe would require the ultimate in versatility and individual initiative. In an urban area such as ours, a considerable number of physicians who have practiced one specialty or another for many years might suddenly be forced to care for large numbers of patients whose injuries or illnesses lie in fields with which they have had little contact for many years. In such a time the general practitioner may well be the most effective of all physicians. We shall all have to be general practitioners in every sense of the word, treating all types of illness and injury as we meet them, with little or nothing to work with except our minds, hands and hearts. With this in mind only the barest essentials of emergency and early definitive treatment are considered. No attempt has been made to provide any sort of complete coverage of any given situation. Our aim has been to provide only a brief working outline. It is hoped that a few days will see a return to some semblance of order in the distribution of patients and physicians. Fortunately the more strictly surgical emergencies are matters of particular concern in the first ten days, whereas the important effects of radiation injury will not put in their appearance until the second week.

All our attention must be focused upon the dictum of "first things first." Proper priorities in treatment will be of paramount importance if the efforts of the comparatively few medical men are not to be needlessly dissipated at great cost of life and limb. It has been said that there are only two real emergencies: asphyxia and hemorrhage. Failure adequately to correct either of these in a mat-

Dr. McKean is chairman, Subcommittee on Uniform Medical Management.

Dr. Noer is chairman, Subcommittee on Uniform Surgical Management.

ter of minutes may well mean death of the patient. Other emergencies allow more time for care, varying in degree according to their nature. A heavy responsibility will rest upon each and every one of us who survives the catastrophe to decide carefully but promptly which patients require treatment first, and which of each patient's several injuries demand first attention. Some attempt has been made to indicate priorities in need for more definitive care at expert hands, but the extremely varying situations which will be found on first approach to mass casualties precludes any attempt at priority indication for the initial emergencies. This responsibility will inevitably fall upon the shoulders of the physician who first sees the patients; he will be forced to make his decisions in the light of common sense and past medical background and experience. One additional word of caution must be added, macabre though it is: time must not be wasted upon those already clearly beyond hope of survival. None of us who remain will be able to care for all he would wish to treat, because the very number of casualties will be overwhelming. Therefore we must proceed on the basis of "the greatest good to the greatest number"—wasting our precious minutes neither on those too slightly wounded to need skilled help, nor yet on those for whom such help can be of no avail. Contrary though this is to our entire tradition of succor for all who need or ask it, we must nevertheless steel ourselves to follow the course which will provide aid to the greatest possible number of those for whom proper care may mean the difference between life and death.

This collection of papers is presented with the fervent hope that they may never be needed for the purpose for which they have been prepared. Should the fatal event occur, however, it is our hope that it may provide a ready and quickly available source of first reference for all who need such help.

MSMS

VA INCREASES COLLECTIONS ON NON-SERVICE-CONNECTED CASES

Although still having trouble making collections, Veterans Administration reports it obtained $1,213,251 from outside sources for treatment of hospitalized non-service-connected cases in the last six months of 1951. This is almost as much as was collected on these accounts in the previous twelve months.

A Psychiatric Viewpoint on Civil Defense

By Peter A. Martin, M.D.
Detroit, Michigan

PSYCHIATRIC PREPARATION of the individual physician for participation in Civil Defense involves a twofold responsibility. The physician must not only be adequately trained to be able to care for psychiatric casualties during the emergency period, but, like all other individuals residing in the possible bombing area, he must be emotionally prepared himself to be able to withstand the shattering effects of actual atomic bombing.

The writer has no illusion that such a Herculean task could even be approximated by any written communication. But it will be the dual aim of this paper to present a psychiatric viewpoint of the basic principles involved in the emotional preparation of the individual for atomic bombing as well as the basic principles underlying the care of the emotionally disturbed patient resulting from atomic bombing of Civil Defense areas.

Every physician, no matter which branch of medicine he practices, may be called upon to treat psychiatric casualties because of the dangers of panic following atomic bombing. The most serious emotional problem for which the individual must be prepared is that of panic. It is a serious problem because many avoidable injuries and deaths, as well as disruptive mass reactions, may be caused by panic following the bombing. Panic may produce more casualties than nuclear radiation. Panic would add greatly to the burden of caring for casualties resulting solely from the physical destruction.

It is important now to define our terms. The word "panic" is commonly used to describe different phenomena. A differentiation will be made here between individual panic and group panic.

Group panic can best be defined by an illustration. At the Iroquois Theatre fire in Chicago in 1903, the victims followed the crowd to a few exits with the result that many were crushed to death despite the fact that actual fire damage was small. This is an example of mass panic—a disruptive group reaction. Imitative, uncritical behavior with

a strong response to suggestion and rumor play important etiological roles in such reactions.

Mass panic is a serious danger following atomic bombing or other large scale disaster. But it will not be within the scope of this paper to deal with the problem of disruptive group reactions. The handling of mass panic will not be the responsibility of physicians. Our concern here is with the preparation of the individual for, and with the treatment of the individual after, atomic bombing. The emphasis will be upon the problem of individual panic.

Individual panic will be used here to denote that extreme degree of anxiety in which the individual is so overwhelmed by his feelings in the traumatic situation that he experiences a shattering flood of excitation passively and automatically.

It is akin to fright—which is the name of the condition to which one is reduced if he encounters a danger without being prepared for it. Fright lays stress on the element of surprise.

This condition can be observed in daily living. Take an example of a five-year-old boy, who no longer took afternoon naps. On this particular afternoon, he surprisingly fell asleep on his bed. After an hour, his sister came running up the steps, burst into his room and shouted, "Wake up!" He sat up abruptly, looked around and with a dazed, bewildered, lost look upon his face, he began to sob, "I don't know what to do. I don't know what to do." He was obviously unprepared for the sudden awakening, and though he was in his own room, sitting on his own bed, with his own sister present, he acted as if bewildered and lost in a totally new situation. After a few minutes of reassurance he regained his orientation and his fright was allayed. It was interesting that as his mother and sister tried to reassure him, they both began to feel his fright and looked frightened until he regained his composure. This example illustrates both the "sudden" and the "unprepared" aspects of fright. It also illustrates the contagious aspect of fright, which may be akin to the contagious aspect of group panic.

Another example can be presented. Many an individual has had the experience of peacefully walking along when suddenly some friend jumped out from behind a tree intending to frighten him. He may have been frozen with fear, or he may have attacked, or he may have run. Again this illustrates a severe reaction of fright brought about by a sudden trauma which finds the individual unprepared. But now let us suppose that this same individual knew that a friend was waiting to jump out at him, though he didn't know just when it would happen. As he walked along, he would be on guard. He would be preparing to meet the sudden, but no longer unexpected nor unprepared for, attack; this time as he walked along he might not be at ease. He might experience apprehension —which denotes a certain condition of danger and preparation for it even though it can be an unknown one. Because of his apprehension, which involves preparation, when the other person would jump at him he would not be overwhelmed by fright, as previously described. He would not stand frozen. He would not attack or run. He might even laugh and pretend to be unmoved.

The factor of preparation is all important to prevent individual panic. Such individual panic was observed among green, inexperienced combat troops, under fire for the first time. The method which the Army devised to prevent such reactions was to train the troops under conditions simulating combat. The famous infiltration courses of World War II, in which the soldier was required to crawl through difficult terrain with live machine gun fire going on overhead, was an attempt to remove the unprepared factor which leads to individual panic. The prolonged intensive rigid training periods in the United States attempted to make the bizarre and distressing conditions of combat an experienced daily routine in the lives of the soldiers.

Some years ago a magazine article described how a mother helped her daughter function adequately in frightening situations. It started when the mother was ill and had no one to send shopping for groceries. Her little girl was too young to perform such a task, but necessity forced her to take drastic measures. Using the cans of food which she had in the home, she set up a grocery store. Pretending to be the grocery man to her little daughter as the customer, they acted out over and over the exact details of shopping to be done that day. Then the child would go to the store and would shop perfectly . . . free of overwhelming anxiety because the situation was no longer a new one but now was one in which the child felt "at home." This emergency measure later became an accepted part of the child's training. Once she was to take a long train trip alone. She accomplished this difficult task with ease and com-

posure, because before she left home, a train set was constructed and each possible problem was worked through and acted out in detail. What to expect from, and how to answer, the porter, the waiter, fellow passengers, and other details were rehearsed. Overwhelming anxiety was prevented in this little girl by building up defenses within her to meet every possible situation. Thus she avoided any sudden, unexpected, unprepared-for situation which might throw her into such a terrifying state.

An example of a very anxious patient could further clarify the element of preparedness as a prevention against overwhelming anxiety. This girl would develop acute anxiety states in which she experienced uncontrollable shaking, confusion and muscular weakness whenever she was called upon to give talks to her colleagues. To prevent these acute anxiety states, she would memorize the talk word for word. The night before she would repeat the talk over countless times until it was letter perfect. Then she would go into the deserted lecture hall and practice her speech so as to be familiar with the location. When the time for delivering her talk came, she was able to perform adequately without being overwhelmed by the excitations from within.

At this point a possible objection should be eliminated. Of course, an emotionally mature individual does not have to make such elaborate preparations. A person with self-confidence is able to handle such situations with relative ease. The more emotionally stable the individual is, the less susceptible he is to disorganization of his personality. However, it is conceivable that every person has his breaking point, and when we consider such catastrophic stresses as arise from an atomic bombing, anyone could stand additional preparation against such an external pressure.

The theme of the prevention of overwhelming anxiety, here designated as individual panic, has up to now stressed two approaches. The *first approach* endeavors to eliminate the element of surprise. The *second approach* endeavors to prevent overwhelming anxiety by a state of readiness within the individual achieved by prior planning and preparation. In performing the preparatory measures (example: the anxious girl who rehearsed countless times) the individual experiences antecedent strain. But it is minimal compared to overwhelming anxiety. And it is in the service of the individual as compared to the overwhelming anxiety where the individual helplessly experiences the flood of excitation. Prior preparation establishes stronger inner ego defenses. I am sure this will be understood by the physician in terms of immunization shots for certain diseases. Overwhelming anxiety occurs in situations of stress when these defenses do not function adequately. The defenses are not prepared to meet the onslaught of the disintegrative threat. This results in temporary disruption of the personality or individual panic. From my experience with an infantry division in active combat, I would estimate that with adequate preparation and with a few minutes advance warning, psychiatric casualties would be reduced 10 to 20 per cent in the event of atomic bombing of metropolitan areas.

In the event of atomic bombing the responsibility for preventing the danger of surprise is in the hands of the government. This involves adequate intelligence and civil defense systems. Despite such measures the bombing may come as a surprise. Therefore, prior preparation is the bulwark of the individual's defense against the disintegrative threat.

There is a *third approach* to the prevention of overanxiety. This is a method of mastering anxiety not prior to, but at the time of the danger situation. It is easier to master anxiety while some task is being accomplished or some physical activity can be exerted. It is more difficult to master anxiety if one is forced to wait quietly. Increased activity during the emergency situation is an important physiological and psychological defense against overwhelming anxiety. On the basis of his personal experience in combat, one United States Army commander, prior to entering into a combat situation, would impress upon his infantry men that when they were in the midst of active combat they should "Do something! Follow some plan! Don't just stand there!" He knew that some course of action, even if it were not the best course, would be better than immobilization. He also knew that because of the intensive repetitious training program, prior to combat, the soldiers would be likely to choose some appropriate course of action during combat.

It was frequently observed that a soldier in combat where he could fire upon the enemy or attack the enemy showed good emotional balance. The same soldier lying wounded in a rear area hospital would become panic-stricken upon hearing the sound of enemy planes overhead. This was

because he could not protect himself, he could not run, he could not fire against or attack the enemy. He could not release appropriate physical activity which would have been a defense against becoming overwhelmed by internal excitation.

The people of England had one psychologically vital slogan. After each bombing they attempted to work constantly to return to "business as usual." This is a preventive of further emotional disorders.

The following example illustrates the three principles presented. Recently an interesting series of events took place in one of Detroit's suburbs. Coincident with the roar of airplane engines overhead, a gas explosion took place in a business building. Since talk of atomic bombing had been prevalent, many mistook this explosion for the real thing. In the schools the children reacted as they had been told. They dropped to the floor under the desks as they had been taught. Then they followed the previously rehearsed plan of defense against atomic bombing. Some described it as a field day for the children—an exciting interruption of the daily routine. However, it was quite different for the adults. Many became frightened. They did not know what to do. Many ran out of their houses into the street. Mothers called the police, asking them to bring the children home from school. They asked what they were to do. They were totally unprepared for the problem and reacted in a manner that would have been detrimental to themselves and to others had it been an atomic bombing. It is paradoxical that children, who need the least preparation, have had the most preparation. Adults, who need the most preparation, have had the least preparation.

What is to be understood from this example: first, that the element of surprise was present and therefore set the stage for fright reactions. Second, that where prior preparation had been carried out (in the school system) overwhelming anxiety was prevented, and where there had been inadequate or no preparation (among the adults) severe fright reactions were displayed. Third, that prior preparation had dictated a course of action to be followed at the time of the disintegrative threat and that the physical activity involved contributed to the defense against emotional disintegration.

The physician should know how to prepare himself emotionally for atomic bombing, not only for his own safety and that of his family but also in order to be able to instruct the many who look to him for guidance. The following suggested approach could be life-saving.

1. Don't shrug it off. Don't say "What's the difference. If it happens we won't be here anyhow!" Recent observations have indicated that the danger from atomic bombing is not as great as it was previously believed. It is estimated that with adequate preparation and with only a few moments advance warning, fatalities may be reduced by 20 per cent and casualties by 50 per cent.

2. People need never be helpless. There is always something to do to improve the situation. If this can be recognized, purposive, rather than aimless, activity will take place. Individual initiative could be of great benefit during the emergency.

3. Get serious about it and prepare yourself. Read the booklet put out by the U. S. Government, entitled "Survival Under Atomic Attack."* It should be memorized. Your house should be prepared as directed in "Five Keys to Household Safety."

Unfortunately, the majority of people have done little or nothing towards utilizing this information which could prevent possible death, injury or panic. This is understandable because of the natural tendency to avoid the unpleasant. Facing the unpleasant possibility of atomic bombing causes the development of anxiety. Such anxiety cannot be entirely avoided if adequate preparations are to be made. Nor is such anxiety entirely detrimental to the individual. *Anticipatory anxiety can be considered as minimal, controllable anxiety which can help to prevent later maximal, uncontrollable anxiety. The problem is one of voluntarily enduring a limited amount of anxiety in order not to be overwhelmed later by an excessive amount of anxiety.*

The city of New York is well advanced in its preparations for atomic bombing. A visitor who first notices houses with a sign in front saying "Bomb Shelter No. 30, Capacity 80" has a reaction of strangeness, but after a few days it becomes an accepted part of the environment. This indicates the importance of a master plan to help each individual know exactly what he is to do and to whom he can and should turn. This is being worked out at higher levels and is being brought down to

*"Survival Under Atomic Attack" is the official U. S. Government booklet obtainable from the Superintendent of Documents, Washington 25, D. C. Individual copies are for sale at ten cents each.

the level of individual participation. The national approach is not within the scope of this paper, but it is mentioned to help the physician recognize that he probably will be called upon to rehearse his designated role a number of times before the expected emergency. It is a difficult matter of timing when this should be done. It is up to the government to decide on the basis of their intelligence information. If it is done too early, it creates the problem of undue anxiety. If it is done too late, it leads to the danger of individual and group panic. If the physician is given specific duties and trained adequately, the danger of being overwhelmed by anxiety is greatly diminished. The physician should recommend to others that they take Red Cross courses in first aid. They are particularly good preparation for atomic bombing or other disaster. The more peaple who could participate, the better. Or he should recommend that they become active members of the Civil Defense Corps. This in itself contributes to individual defense against overwhelming anxiety.

Now, attempt to visualize an individual, adequately prepared as described above, in an atomic bomb explosion, where no alert has been given. He will see the flash before he hears the explosion. He drops to the floor immediately and pillows his head in his arms. He gets behind some available protective barrier. He knows that most casualties are due to flash burns and flying debris. He knows panic may cause him to become a casualty, even if he escapes from the danger of nuclear radiation. He remains there a long minute after the explosion . . . frightened beyond description, but not overwhelmed by his anxiety. After this long minute he must realize this! *It is all over* and *he is safe. Another bomb in the same place is unlikely.* With this recognition can come a feeling of comparative security.

Then there is work to be done. That is the key in continuing to ward off individual panic. He does the work for which he has been prepared. He may show initiative and give duties to other individuals. He keeps his wits about him in the service of self-preservation and also in the service of preserving others. Having trained civil defense members appear on the scene as quickly as possible prevents panic. Having physicians at work treating casualties is another panic preventor. In England, the mere presence of a person in authority was often sufficient to create a constructive attitude.

The importance of the *attitude* of the civil defense worker must be recognized. The attitude in itself contributes greatly to the successful care of other persons and to the prevention of disturbances in others. If the physician is adequately prepared, he will show by his authority and confidence that he is capable of coping with the situation. The emotionally disturbed person who has been reduced to feeling like a lost child will respond quickly. Experience with combat psychiatric casualties showed that the *attitude* of the individuals who *first* attend these casualties is *the most important factor* in their treatment. No matter how much the physician may learn about methods of treating combat casualties, it would not be of great value if he himself were emotionally disturbed during the emergency. The attitude of the physician could either soothe and protect the casualty or it could contribute to the further disruption of his ego. With this recognition of the importance of attitude in treatment of psychiatric casualties, the physician can turn to the following basic principles of treatment. Difference in treatment will be determined by the type of reaction within the individual. There will be many variations of individual reactions.

Tyhurst describes three characteristic but overlapping phases in individual reactions to sudden disaster or stress. The first period is *the period of impact,* which corresponds to the duration of the direct initial stress or emergency. During this period some individuals remain "cool and collected," and capable of organized activity. Some, and perhaps the majority, are stumped and bewildered. They may manifest automatic behavior and psychological disturbances associated with fear and anxiety. A third group show manifestly inappropriate responses with confusion or paralyzing anxiety and uncontrolled emotional outbursts.

During the *period of recoil,* which follows immediately after the period of impact and lasts several hours or days, there is a gradual return of self-consciousness and awareness for the majority. There may be emotional outbursts, anxiousness, fear and anger with a great need to talk over experiences. It is with this group during this time that the greatest good can be done with treatment. These individuals should be treated in a quiet atmosphere by medical aides who are calm, reliable and trained in their job and with a physician available as needed. These individuals need verbal reassurance and a chance to express their fears. Re-

assure them that the danger has passed and is unlikely to return. Hot food and hot sweet drinks are simple, effective aids at this time. Those individuals who are the least disturbed should be given constructive tasks to perform. Those who are more disturbed should be given an opportunity to sleep with or without the aid of barbiturate sedation as the physician deems it necessary. The individuals showing the most severe emotional disturbances may need heavy quick-acting sedation and even physical restraint.

The third period is called the *post-traumatic period*. During this time the full awareness of the disaster develops. The reactions of this period present persistent anxiety states, fatigue states, recurrent traumatic dreams, depressive reactions and post-traumatic neuroses. These will be evacuated and treated under the direction of trained psychiatrists who are familiar with such problems.

Now for a few important facts pertaining to age groups. The middle-aged panic most. The older age groups panic less, possibly because the elderly people feel that they don't have so much to lose. Children don't panic if parents don't panic. People who have hysterical neuroses in peacetime do well under such conditions of stress. The school and the teacher play an important role in the reaction of the children. To children under five the bombing has little reality importance. It is the reaction of the teacher or parent which has reality value. For example, in England a mother and her child were pinned under the debris of her shattered home for hours before being freed. They rushed the pair to the hospital. Upon arrival the main concern of the mother was that the child had been exposed to cold during the trip to the hospital. This typical British unruffled attitude was so important to the child. He wasn't the least bit upset by his experience. This example illustrates clearly the concept motivating the writing of this paper. The psychiatric casualty is reduced to the status of a frightened child. If the physician himself will be adequately prepared . . . *emotionally as well as technically* . . . his attitude will exert a calming and quieting effect upon the psychiatric casualties. It can prevent a further disruption of their egos. Then he can use his technical knowledge and skill to restore them to normal living.

Of all groups in the civilian population, the medical profession should become the best trained and best prepared for the emergency situation. I believe it is fruitless to make such a statement without contributing any thought as to how this difficult but vital task might be accomplished.

As indicated previously, repeated trials in a simulated situation would be of value. Extensive and intensive dissemination of information can be of value—which is one reason for publishing pamphlets and papers like this one. But the physician may not be able to integrate the information he receives with the anxieties it may cause him to experience. It might be accomplished by small groups of doctors meeting regularly with a qualified psychiatrist to discuss the problems to be faced. It might be considered an experience in "group therapy." The groups would be formed from those physicians who would be working together, following the bombing, at some assigned station. Any anxieties could be utilized as material for such discussions. Three problems which might arise will be mentioned here as examples:

1. How will you feel when you are forced to remain in the danger zone while others are being evacuated?
2. How will you feel about separation from your family?
3. How will you feel treating casualties without sufficient medical supplies, such as blood and plasma?

Summary

This paper attempts to formulate some basic psychiatric principles as guideposts for the physician participating in Civil Defense efforts. Through an understanding of these principles, the physician can (1) actively participate in emotional preparation, of himself and other individuals, for atomic bombing, and (2) contribute to the prevention and treatment of psychiatric casualties during the emergency situation.

MSMS

BLUE CROSS NOTICE

Congratulations to the Blue Cross-Blue Shield Plans. We have just received notice of the reciprocity agreement by which your Blue Cross-Blue Shield policy will pay full Michigan benefits in participating hospitals throughout the country instead of the emergency provisions. Remember this provision for your own good and don't forget to tell your patients who are Blue Cross holders about this new liberalization.

Casualty Evacuation Plan

By Joseph A. Witter, M.D., and
Raphael Altman, M.D.

Detroit, Michigan

IT IS OUR purpose to outline the plan for evacuation of casualties in the event of a major disaster. Existing hospitals could not possibly handle the estimated 100,000 casualty load in the event of an atomic bombing. Therefore, facilities are being devised and planned to cope with any major situation, bombing or otherwise.

The Casualty Care Section of the Wayne County Medical Defense Plan has been designed to act as a buffer to the existing hospitals. Casualty Care Stations have been set up in schools peripherally placed about the city to receive patients as they are brought from the disaster area by ambulance. It is easy to see that present hospitals would soon be taxed beyond their capacities.

The basic unit in medical emergency care is designated as a Casualty Care Station. Sixty-seven of these have been set up in school buildings, in addition to forty-six such stations located in large industrial plants, manned by industrial medical personnel. This makes a total of 113 stations that can be activated. They are being so organized that they can participate immediately in event of disaster.

The function of these stations will be to provide triage, radiation decontamination, treatment of shock, burns, fractures, and other injuries requiring emergency surgery. They will send home those patients who do not need further treatment. Patients requiring more definitive care will be evacuated to existing hospitals. It will be immediately apparent that a station charged with such greater responsibilities will need a large complement of trained personnel and ample supplies.

The Casualty Care Stations have been divided into ten zones, each one controlled by a doctor, acting as zone leader, under whom there are station leaders each in charge of a school. Approximately 500 individuals are assigned to each station (Table I); among these are sixteen doctors, thirty nurses, ten pharmacists, twelve dentists and the civilian personnel who will act as nurses-aides, medical aides, litter bearers. Other specialists will handle communication, transportation, welfare and records. The medical as well as the civilian personnel in each station are being organized and trained in teams for more efficient function in case of disaster. Operating under the command of the doctor acting as school leader will be an executive officer, usually the school principal.

TABLE I. PERSONNEL OF CASUALTY CARE STATION AND FIRST-AID POST

	M.D.	Pharm.	D.D.S.	Nurse	Medical Aids	Lay	
Admin.	Leader	2		1		5	
Triage	2	2		2	12		
Shock	2			6	12		
Surgical Teams	10			5 —)7 2	10 —)14 4		
Gen'l. Duty			1	15	30		
Anesth.			5				
Supply		2				10	
1st Aid Post	2	4	4		12		
Litter Teams					30	240	
Commun.						40	
Records						Welfare	
Ambulance						80	40 Ambulances
Totals	16	10	10	31	110	375	40

The floor plan of each Casualty Care Station has been analyzed and a traffic pattern (Fig. 1) laid out so there will be a smooth flow of patient traffic from the time they are admitted until disposition is made. The rooms have been marked for assembly, radiologic survey, triage, shock, burns, surgical wards, general wards, supply room and morgue. A mess area will also be set up in each school to feed the large complement of people involved in each station. Assigned to each school will be its own transportation unit, consisting of panel trucks or other vehicles which can function as ambulances. Separate doors with driveway access will be utilized for incoming and outgoing traffic. The school play yard will serve admirably as an ambulance dispatch point. The individual in charge of transportation will designate those vehicles which are to go forward to bring in litter patients from the disaster area and those which are to evacuate patients from the Casualty Care Station to existing or improvised hospitals.

There will of necessity be an unavoidable period of delay between the moment of an atomic explosion and the time when evacuation of casualties can begin. During this period the police, firemen and radiation monitors will survey the situation and issue clearance as soon as possible. This time will also be utilized by the headquarters medical group to ascertain which of the previously designated Casualty Care Stations will be safe and

Dr. Witter is chief, and Dr. Altman is alternate chief, Casualty Care Section.

available. In cases where a school designated as an Emergency Station is rendered unsafe for use, the personnel will immediately be assigned to reenforce other stations which can function. The respective complements of these stations will be notified according to a pre-arranged plan. In the event of a major disaster all personnel attached to a Casualty Station are expected to re-

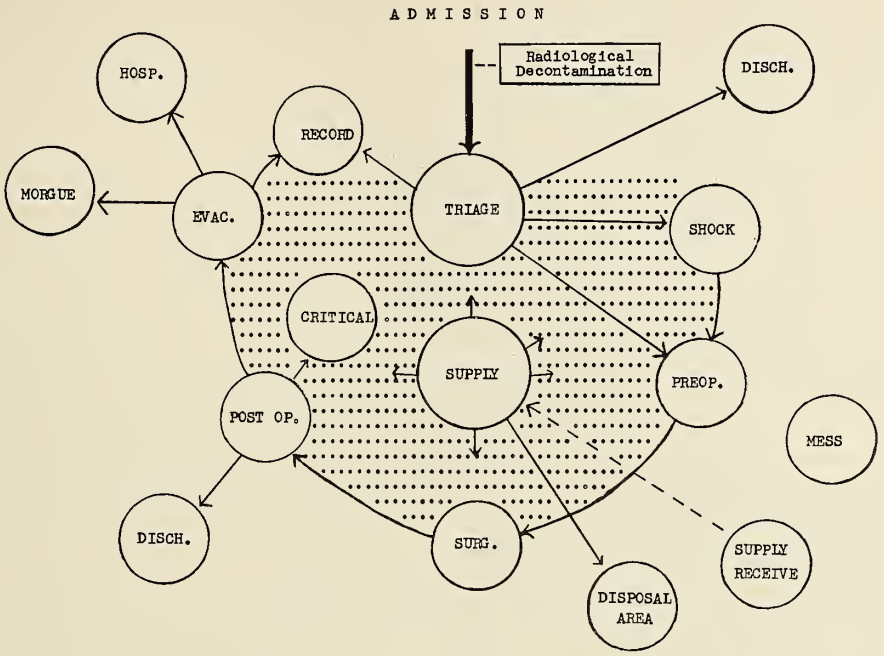


Fig. 1. Flow of traffic in Casualty Care Station.

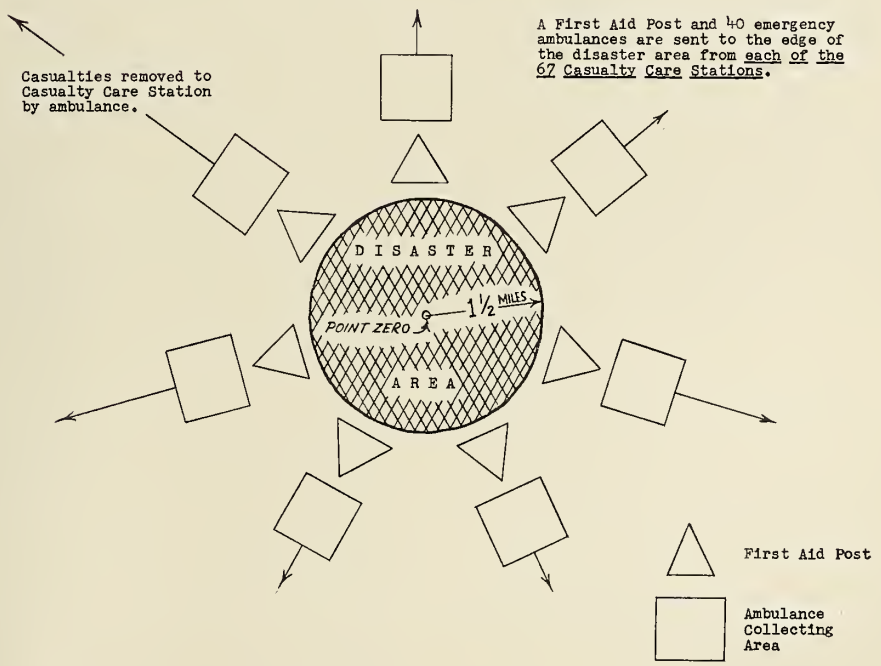


Fig. 2. Relationship of first aid posts and Casualty Care Stations to disaster area. While only seven first aid posts and ambulance collecting areas are shown on this diagram, there would actually be sixty-seven—one sent out from each of the sixty-seven Casualty Care Stations.

port to the school as soon as possible. Assembling in the gym or auditorium, they will be briefed as to the zero point of the disaster, and the safe distance to which the forward echelons may go. The various teams shall begin to function at once.

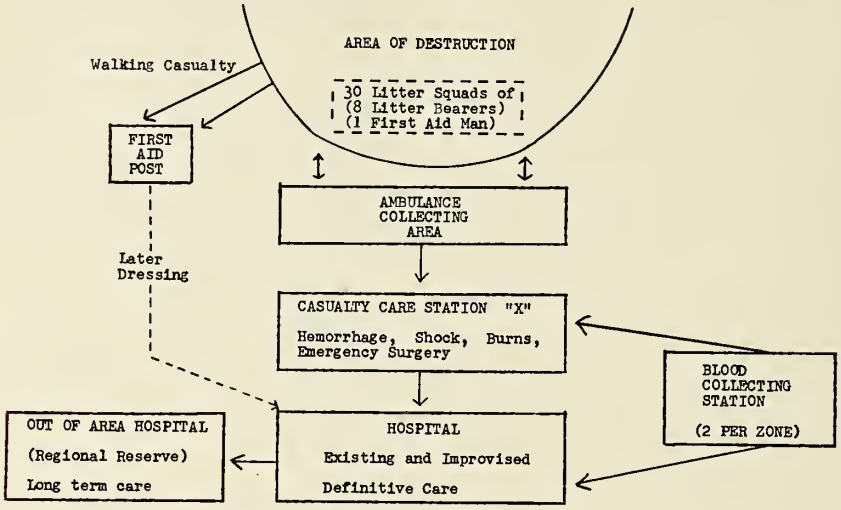


Fig. 3. General scheme of evacuation.

An integral part of each Casualty Care Station is the advanced echelon which will be composed of an ambulance collecting unit and a first aid post. As soon as those forming the complement of this group are assembled, they will be dispatched to a point as near to the scene of disaster as possible, usually within a mile and a half of zero point. They will there select suitable buildings and set up an ambulance collecting station for litter patients, and a first-aid post for care of the walking wounded. The first-aid post will consist of two doctors, four dentists, four pharmacists and four medical aides. The building they select will be designated by an appropriate banner prominently displayed. Casualties who are able to walk, and whose injuries are not sufficiently serious to require hospital care, will be directed to these posts. Lacerations will be sutured, minor fractures will be splinted, sedatives given, et cetera. It is felt that this plan will do much to relieve the congestion of the Casualty Care Stations and hospitals.

The ambulance collecting station will be set up very close to the first-aid post (Fig. 2). Attached to this echelon will be ambulance, litter bearers and first-aid men. Litter squads each consisting of eight litter bearers and one first aid man will be sent into the area of destruction to administer first aid, including morphine to seriously wounded persons. These casualties will be carried back to the collecting point. Here they will be placed in improvised ambulances and transported to a Casualty Care Station. The ambulances will then return to the collecting point. It is planned to have thirty litter squads, and forty vehicles to serve as ambulances, attached to each station. The litter bearers attached to each ambulance point, and who work in a disaster area, will be under the direction of mobile control units who will estimate the casualty load in their area of operation, direct the first-aid and litter squads and decide, where necessary, on priority of evacuation.

The safety of litter squads from the standpoint of radiation hazard will be the responsibility of radiologic monitoring crews.

The shuttle system of ambulances will also be available to bring forward additional personnel, and may also function as a means of communication and supply between the forward posts and Casualty Stations to which they are attached. Additional communication will be organized through radio cabs, short wave and motorcycle messengers.

This outlines the pattern of traffic flow, from the disaster area to the ambulance collecting post, from there to the Casualty Care Station, and, if necessary, from these stations to the existing hospitals (Fig. 3). It is easy to conceive that our existing hospitals would soon be taxed beyond their capacities to expand. The evacuation scheme

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Shock and Hemorrhage

By Joseph L. Posch, M.D., and
Rudolf J. Noer, M.D.
Detroit, Michigan

SHOCK MAY be described as a disturbance resulting from trauma, characterized by profound depression of the circulation, rapid, shallow breathing, more or less sensory and motor paralysis to the nervous system, and often accompanied by lowered body temperature. The basic physiologic disturbance in surgical shock, whatever the cause, is a decrease in the circulating blood volume. This fundamental disturbance must be borne in mind in all of our considerations, for it is correction of this decreased circulating blood volume which is the essential element of all of our treatment.

Shock has been discussed under many headings and there are many phases and terms related to it. In our consideration of the casualties to be met in major catastrophes, however, we are particularly interested in that phase of shock known as *traumatic shock*. This has also been referred to as "secondary shock" or "surgical shock." This type of shock may develop at almost any time up to several hours following the injury, and under certain circumstances where trauma is treated, or other harmful conditions intervene, the situation known as delayed shock may occur at a later date. In all of these situations, however, the basic situation is essentially the same. The degree of shock usually bears a more or less direct relationship to the severity of the trauma which is responsible for the condition.

Hemorrhagic shock is a condition very similar to that of traumatic shock which is produced by excessive loss of blood. While the conditions are not physiologically identical, for all practical purposes we may consider them as closely related, for the shock-like state following hemorrhage demands exactly the same treatment as traumatic shock except that the blood replacement program must be more extensive.

The symptoms of shock are varying degrees of loss of consciousness (though the individual is commonly entirely conscious and somewhat anxious in appearance), weakness, nausea and vomiting, perhaps incontinence, perhaps mental disturbances, and eventually total unconsciousness.

Clinical manifestations are evidence of severe trauma (usually), severe perspiration, pallor, cold and clammy skin, and shallow respiration. The patient may be restless, thirsty and nauseated. The pulse is rapid and rather feeble in many cases, though rapidity is not essential to a diagnosis of shock. There is a reduction in blood pressure including systolic, diastolic, and also pulse pressure reduction. Heart sounds are usually faint.

In severe shock the blood volume is reduced by 40 to 50 per cent of normal. Anemia may be present, and leukocytosis is the rule. Urinary output is low and the carbon dioxide content and chloride of the blood fall.

Treatment of shock should be directed simultaneously toward restoration of the lost circulating blood volume and toward treatment of the condition responsible for the shock. Hemorrhage obviously demands immediate treatment. Care must be taken in searching for the cause of hemorrhage not to increase the trauma by undue motion of the patient; dirty clothes should be removed by cutting away to minimize trauma. Severe bleeding may be controlled by pressure directly applied at the site of bleeding or, if necessary, a blood pressure cuff may be applied proximal to the area if it be on the extremities, and inflated as a tourniquet. As a general principle, arterial bleeding is the only type in which a tourniquet is wisely applied; venous bleeding can usually be controlled by local pressure and if on the extremity, by elevation of the part as well.

Overheating of the patient should be avoided. It has been shown that the traditional treatment of applying external heat to the patient in surgical shock is not a wise one since it may have some deleterious effect in producing capillary dilatation. The patient's normal body temperature should be conserved by blankets or other covering, but external heat should not be applied. Pain should be relieved if it is a prominent factor. The best method for administering pain-relieving drugs is by way of the veins since collapse of peripheral circulation makes absorption of subcutaneous drugs inefficient. Fractures of bones should be splinted as early as possible to lessen pain stimuli. The patient's feet may be slightly elevated, an elevation of about 15 degrees apparently being of aid in early shock.

When severe dyspnea is present from chest or abdominal injuries, however, the patient will breathe more easily in a sitting or semi-sitting position. Rest is of fundamental importance to all patients in shock.

Replacement of the lost circulating blood volume should be begun as early as possible. Whole blood should be given immediately if available, either intravenously or, if necessary and if equipment is available, by intra-arterial infusion. A great deal of blood may be needed, for it has been estimated that in severe injuries patients may sometimes require as much as 1.5 to 4 liters of blood. If blood is not available, blood plasma is the next best material to use for replacing the lost blood volume. In the absence of blood plasma, physiological saline solution or dextrose solution may be given, but one must bear in mind that the rapid diffusion from the circulation of these electrolytes makes their use in the treatment of shock of only temporary value. Other materials for intravenous fluid therapy are discussed elsewhere in this series and will not be considered here.

Oxygen therapy is also very useful, and the rate of flow if by intranasal catheter should be at least 7 liters per minute. Careful placement of the intranasal catheter is necessary if efficient absorption is to take place. Ordinarily the length of catheter needed in the nasopharynx is about that distance from the tragus of the ear to the nostril. A very useful procedure, if the patient is conscious, is to measure off this distance on the tip of the nasal catheter, advance the catheter to about the indicated point, and then further advance it until the patient swallows a bolus of oxygen. The catheter should then be withdrawn to a point just proximal to that at which he does swallow a bolus of oxygen. This is the most efficient location for the tip of the nasal catheter.

Patients in surgical shock must not be moved until the shock has been controlled. The only emergencies which take precedence over treatment of shock are hemorrhage and asphyxia. Both of these must be controlled immediately. Most other conditions, however, can await replacement of some of the lost circulating blood volume and some recovery of the patient. Only if shock persists in spite of emergency therapy, and concealed bleeding is suspected, may surgery be performed immediately for control of bleeding sources.

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The Training of Blood Procurement and Distribution Teams

By D. H. Kaump, M.D., and E. R. Jennings, M.D.

Detroit, Michigan

THERE are many problems facing Civilian Defense authorities in time of disaster. One of the more important of these problems concerns the procurement and distribution of fresh whole blood. The quantity of this material needed has been variably estimated from 30,000 units per week for each 50,000 casualties to 200,000 units in forty-eight hours for 80,000 to 100,000 casualties. Recognizing this acute need, the Wayne County Civil Defense authorities set up, in the Services Branch of Civilian Defense, a blood procurement and distribution section. This section is charged with the development of ways and means to provide blood and blood substitutes to meet emergency needs. The section functions, as outlined, include (1) a plan for the procurement of donors at the time of emergency, (2) provision for personnel for drawing and typing of blood, (3) provision for the storage of blood at the donor station, (4) provision for the issuing of blood as required for transportation to casualty stations, first aid stations, improvised hospitals and existing hospitals, (5) provision for storage and issuance of blood and blood substitutes provided by other agencies, and (6) co-ordination of the above with the efforts and facilities of the American Red Cross.

The committee appointed to study and act on this program included Doctors Raphael Altman, O. A. Brines, W. B. Cooksey, E. J. Hammer, W. B. Harm, F. W. Hartman, F. W. Hyde, E. R. Jennings, J. A. Kasper, E. C. Long, Perry Martineau, Walter Stryker, and D. H. Kaump, chairman. The committee then divided its task into two major divisions: first, the estimate of the location and the number of blood procurement and distribution units which would be necessary, together with the methods of recruitment of donors; and second, the composition, recruitment, and duties of the various units together with the training curriculum which would be necessary.

From the Departments of Pathology, Wayne University College of Medicine, Providence Hospital, and Alexander Blain Hospital.

Location and Number of Units

Regarding the solution of the first phase of the general problem, it was decided to activate twenty-five blood procurement and distribution units, each to consist of forty or more persons as outlined below. Of the twenty-five units, two are to be assigned to each of the ten major medical zone divisions and five units are to be free and available for assignment in any location where they are needed.

The committee felt that "preparedness" blood typing would aid in the recruitment of donors, in that it would allow the collection of blood from specific and known types with the greatest possible facility. Whole blood transfusions cannot be given until the blood type and Rh factor of both the recipient and the donor are known, except when group O universal blood donors are used. Since only forty-five per cent of the general population have O type blood, it would be impractical to supply in the amounts needed. Therefore, it will be necessary to use all types of blood, matching donors and recipients type for type. In a disaster area many laboratory facilities may be wiped out, and those remaining will be greatly overtaxed. Under disaster conditions it would probably be impossible to type in time more than a small percentage of the number of injured who need immediate blood transfusion. In order that as many individuals may receive blood as quickly as possible, it will be necessary to know their blood types and Rh factors before disaster strikes. By ascertaining the blood types and Rh factors in a large percentage of the population before the bombs fall or other types of disaster occur, and by recording this information, it will be possible to give them needed blood almost immediately. The donors would be alerted by radio or telephone by the Office of Civil Defense and requested to report to specific bleeding stations in their respective areas. Only donors holding Office of Civil Defense, Michigan Department of Health, or American National Red Cross identification tags, or pocket cards, would be requested to report to blood collection stations. This would include those individuals between the ages of eighteen and fifty-nine who have had "preparedness" blood typing performed.

Each bleeding and processing center would have supplies and equipment. The essentials are: donor sets and recipient sets, donor bottles, carts, ice, tables, chairs, tourniquets, donor cards, alcohol, surgical dressings, syringes, Wassermann tubes, saline, typing sera, test tubes, racks and opsonic pipettes. The following items would be nice to have if they were available, but the work could be done without them: thermometers, stop watches, sphygmomanometers, copper sulfate solution and containers, procaine, water baths and centrifuges.

Composition and Training of Units

A blood procurement and distribution unit is to consist of four blood collection teams and one blood typing team. Each unit is to be under the direction and supervision of a physician specifically trained for this purpose. A single blood collecting team is to consist of a receptionist, a team chief and assistant team chief, two medical history nurses, one bleeding room aide, one custodian of blood, and one recovery room attendant. The blood typing team is to consist of one technician, two assistant technicians and two technician's aides. Thus the total composition of the unit includes approximately forty persons.

The duties of the blood procurement team are as follows: The *team chief* is responsible for the operation of the bleeding team, and the responsibilities of this duty include that he must be an expert venisectionist, must be fully trained in the setting up of the blood collection station, and be aware of the location of supplies and equipment to be used in this station. In addition, he must know and understand completely the over-all plan for collecting whole blood and the method of preparation of whole blood for transportation as well as the management of donors with reactions. The *assistant team chief* will also be an expert venisectionist and should be able to assume the duties of the team chief if necessary. The *receptionist* will act as a "traffic director" and will be responsible for the training and administration of two or more clerks, who can be trained to record the initial history which includes the name, address, and telephone number of the donor, who can examine identifications or pocket cards and screen out unsatisfactory donors, and prepare bottle labels. He will accept only those donors of specified types. The *medical registration nurses* will consider the medical history, such as past diseases (particularly hepatitis), will record the temperature, hemoglobin, blood pressure, and will reject those donors who are found to be unsuitable for any medical cause. The *bleeding room attendant* will escort the donors to the bleeding room, assist the veni-

sectionist and prepare the bleeding bottles and blood procurement sets for use. The *blood custodian* will accept the bottles of blood after they have been procured, and prepare them for storage or for shipment together with the recipient sets. Immediately after procurement, he will cool each bottle of blood for approximately fifteen minutes in cracked ice and place the filled blood bottles marked type O in insulated paper cartons. He will place a recipient set in each carton for each bottle of blood, will then seal the carton and apply the label bearing "type O blood" and the date of collection. Those bottles of blood which are not of O type he will label appropriately and finally deliver the cartons of blood to the "transportation office," which will pick up the cartons of blood from the various blood collecting stations and deliver them as directed. The *recovery room attendant* may train an assistant to work with him on an emergency basis if necessary. He will take donors to the recovery room when necessary, will attend them there and release them subject to the approval of the team chief.

The *blood typing team* will be in charge of the *senior technician,* who will accept the blood for typing and turn it over to one of the assistant technicians. The *assistant technicians* will prepare the cell suspensions and serum solution, set up the blood tying tubes and act as recorders for the final interpretation. The interpretation as to blood type will be made by the technician in charge. The *aides* will clean the glassware, assist with the labeling of glassware, and will see that the material is appropriately cleaned and returned to the place of its source.

It is estimated that one such unit could procure approximately 600 units of blood in an eight-hour period. Thus, it would be possible for the twenty-five units to collect approximately 15,000 units of blood in each of the eight-hour periods during the activation of the unit. Initially, at least, this would prove to be an inadequate amount, and consequently it would be necessary that similar units be set up in other portions of the state in order that they might procure blood in a similar manner and send it in to the local office of Civil Defense.

It is realized that in the event of a disaster many procedures which are usually performed in a well-organized civilian blood bank would probably not be carried out. Since, however, the personnel of the bleeding teams and typing teams will be laymen and without much previous laboratory experience, it is felt that during the training period more information should be given them than they really need. Much of this will be useful merely as background and orientation for them, and it is felt that, should an emergency arise, they would be much better able to decrease the amount of processing if they understood the ideal arrangement of a civilian blood bank. With this in mind, the following curriculum was designed, and used for instruction of students at Marygrove College. We hope to learn from this study whether it is possible to train lay people in this work in the short time allotted for it.

CURRICULUM—BLEEDING TEAM

Period 1:
- (1) Introduction
 - (a) Purpose of course
 - (b) History of blood transfusion

Period 2:
- (2) Examination and records
 - (a) Donor cards
 - (b) History
 - (c) Temperature
 - (d) Pulse
 - (e) Blood pressure
 - (f) Hemoglobin determination
 - (g) Assignment of accession number
 - (h) Labeling of specimens
 - (i) Reasons for donor rejections

Period 3:
- (3) Positioning of patient
- (4) Draping
- (5) Application of tourniquet
- (6) Preparation of skin
- (7) Anatomy of veins of antecubital space

Period 4:
- (8) Selection of vein
- (9) The donor set
- (10) The anticoagulant
- (11) The venipuncture—anesthesia

Period 5:
- (12) Collection: side tubes
- (13) Surgical dressing
- (14) Recovery room
- (15) Donor reactions
- (16) Hemoglobin regeneration
- (17) Storage of blood

CURRICULUM—TYPING TEAM

Period 1:
- (1) Purpose of course
- (2) Duties of members of team

Period 2:
- (3) Preparation of glassware
- (4) Constituents of blood—clot, serum, plasma, et cetera
- (5) History of blood groups
- (6) Technique—OCD method—collection, reverse typing, direct typing, et cetera
- (7) Errors in typing

Period 3:
- (8) The compatibility test—cross match
 - (a) Definition
 - (b) Technique
 - (c) Compatibility of groups
 - (d) Sources of error

Period 4: (9) The Rh factor
- (a) Discovery
- (b) Dual nomenclature
- (c) Antibodies
- (d) Orders of antibodies
- (e) Technique

Period 5: (10) Transfusion reaction
- (a) Classification
- (b) Laboratory procedures which aid in diagnosis of reaction

The teaching program, as outlined above, has been carried out and will be followed by "on-the-job" training. It is hoped that the students of the bleeding teams will be permitted to observe the operations of the American Red Cross at their main building and in their mobile units. During the first phase of this on-the-job training, they will watch the workers at the Red Cross Center perform their daily tasks. They will be assigned in four-hour periods to each of the three major stations, (1) history taking, preparation of materials and equipment, (2) venipuncture and bloodletting, (3) recovery room and blood storage. Following this training, they will be given an opportunity to practice venipuncture in some Detroit hospitals and clinics. Perhaps additional experience can be obtained as assistants for the OCD Preparedness Typing Program in this area. At this point in their training, specialization of the members of the bleeding teams will begin. Those students who are most adept at venipuncture and learn this technique with the greatest facility will be designated as team chiefs and assistant team chiefs. The others will be assigned as receptionists, medical history nurses, bleeding room aides, blood custodians, and recovery room attendants. Once a student has been definitely classified in one of the above categories, he will henceforth receive instruction and gain experience in only the duties of his special part of the team. The final phase of the training of the personnel of the bleeding teams will be in the American Red Cross Mobile Units. Following an additional period of observation, the students will be permitted to assist and participate in the activation of these groups. The American Red Cross Mobile Unit is ideal as a training center. The job these workers perform and the problems they face each day as they travel about the city are almost identical to those we envision for the bleeding teams in time of disaster.

It is proposed that the "on-the-job" training of the typing teams can be accomplished in the hospital laboratories of Detroit. It is anticipated that these students will be trained in small groups and under close supervision.

Following the completion of the course, the members of the teams will be examined in practical laboratory and blood bank procedures. We do not know at the present time whether the curriculum, together with the "on-the-job" training as designed, will satisfy the need that exists. It is only by examination of lay people who have followed this course of study that we will learn whether it is possible to train previously uninitiated people in these procedures.

The faculty for this pilot study has been composed of pathologists in the Detroit area. Should the experiment prove successful, it is thought that enlargement of such training programs to include the large numbers of people necessary can be developed from technical personnel now working in the Detroit hospital laboratories.

MSMS

Many a veteran of the last war will remember that he was generously exposed to left-wing socialistic propaganda, including pamphlets which painted a misleading but rosy-hued picture of socialized medicine. . . . The young, eager-seeking and uncertain, but impressionable, minds of the eighteen-year-olds would be fertile ground for indoctrination in socialized farming, socialized housing, socialized power, and for Oscar Ewing's socialized medicine.—AAPS, February News Letter.

CASUALTY EVACUATION PLAN

(Continued from Page 312)

then calls for transportation of patients from existing hospitals to outlying communities such as Birmingham, Pontiac, Flint, Mt. Clemens, Ann Arbor, Eloise, et cetera. It is thought that these communities will be able to provide evacuation facilities for this final step in the chain.

Organization on such a vast scale is difficult and requires the time and co-operation of many individuals. Some details are still to be perfected. We feel a plan that can quickly be activated is insurance for the community. It is costly in time, effort, and money, but it is insurance we *must carry*.

Management of Burned Patients

By Joseph L. Posch, M.D.
Detroit, Michigan

THE TREATMENT of severe burns must achieve three objectives:

1. The prevention and combating of shock.

2. The restoration and maintenance of the patient's normal physiological status.

3. The prevention of infection and the promotion of early epithelial covering of the denuded surfaces.

First Aid

Administering first aid in burn cases, Civil Defense first-aid workers should carry out only a gross cleaning process, i.e., removal of large and easily separated particles of clothing, dirt, debris, or skin. They could then apply the appropriate size of cellulose pad and secure it with a bandage.

Later, after arrival in a hospital, the attending physician may wish to remove the dressing and inspect and clean the area. He would then apply a new cellulose dressing or change to another method of treatment for which he had the necessary supplies available.

Casualty Care Station—Suggested Treatment

1. History (if possible). Determine the etiological agent.

2. Examination of patient. Estimate burned areas and search for other injuries.

A useful estimate of body burns may be obtained from the following figures:

	Per cent of Surface Area
Entire Head	7
Entire Neck	2
Anterior Trunk	13
Posterior Trunk	13
Both Buttocks	5
Genitalia	1
Both Upper Arms	8
Both Forearms	6
Both Hands	5
Both Thighs	19
Both Legs	14
Both Feet	7
	100%

TABLE I. CONDENSED OUTLINE FOR THE TREATMENT OF BURNS

I. Determine Depth	
A. 1st degree—reddening of skin	
B. 2nd degree—blisters	
C. 3rd degree—complete burn of skin with a resultant yellowish greenish color	
II. Estimate of Body Surface	
Both lower extremities including the buttocks	—38%
Trunk including the neck	—38%
Both upper extremities	—18%
Head	— 6%
III. Replacement of Body Fluids	
Blood or Plasma—1 liter per 10% of body burns	
2 liters per 20% of body burns	
3 liters per 30% of body burns	
IV. The Employment of Oral Electrolytic Solution	
3 to 5 quarts a day—consisting of the following solution: 1½ level teaspoonfuls of salt and ⅔ level teaspoonfuls of sodium citrate or sodium bicarbonate to each quart of water.	
V. The Application of A Large Cellulose Burn Pad	

3. Estimate the depth of the burn:

Classification of Burns:

1st degree: Destruction of surface epithelium only.

2nd degree: Surface destruction plus blistering due to splitting of epithelial layers.

3rd degree (superficial): Destruction of the entire epidermis, though some epithelial elements (sweat glands and hair follicles) may remain.

3rd degree (deep): Loss of all epithelial elements, with charring of the deeper tissue.

4. Search for other injuries—severe shock may result from compound fractures or severe bleeding, as well as from burns.

5. Put the severely injured patient at rest. Make him lie down. A walking burn patient is much more susceptible to shock than one who has remained at rest. Give morphine sulfate grains 1/6 intravenously, slowly. The absorption by any other route is unpredictable in burn shock.

6. If there is a personnel shortage, concentrate efforts at first on those patients with burns of over 10 per cent, and with severe (3rd degree) burns of less than 30 per cent of body surface.

7. Control room temperature to help combat shock, if possible.

8. Give parenteral fluids ("cut down" or femoral puncture if necessary).

Whole blood—2.5 to 5 per cent of body weight is preferable to compensate for imme-

diate decrease in red blood cells mass. A simple formula to follow is:

1 liter for a 10 per cent burn
2 liters for a 20 per cent burn
3 liters for a 30 per cent burn

This should be given in the first twenty-four hours, and the larger part of it in the first six hours.

Half again as much should be given in the next twenty-four hours.

If whole blood is not available, irradiated plasma may be substituted, but blood is preferable.

Electrolyte solutions are also necessary. Orally, the patient can be given a solution containing 1⅓ level teaspoonful of salt and, when possible, ⅔ level teaspoonful of sodium citrate or sodium bicarbonate per quart. Three to five liters may be taken in the first twenty-four hours. During the next day, the patient should take one-half of that amount for the second twenty-four hours.

A plasma substitute such as gelatin, dextran, or periston may be used.

9. Eye burns should be treated to prevent corneal opacities (see section on eye injuries).

10. If available, oxygen by nasal catheter—8 liters per minute—should be given to combat anoxia.

11. As nearly as possible, infection should be prevented and the patient handled as cleanly as possible. However, in large disasters, it will be impossible to adequately clean the burned areas, so, the immediate local treatment should consist of the application of a dressing consisting of a large cellulose pad.

It is hoped that the available supplies will include the following:

Large cellulose pads—1 inch or more thick—faced and backed with gauze—constructed like a sanitary napkin. The gauze facing is extremely fine (44 by 36 type I gauze) to minimize adherence to the burned area. The backing is a much coarser gauze to give greater protection.

Two sizes may be available—one size approximately 12 by 24 inches for application to extremities and smaller burned areas; and the other, 24 by 36 inches.

For large burned areas of the trunk, 3-inch and 6-inch widths may be included.

These pads can be cut down into various shapes to fit smaller burned areas.

The pad is then held in place by woven elastic roller bandages applied firmly and evenly but with only gentle pressure. Rubberized bandages should not be used.

Place the pad or dressing over the burn so that it covers the area completely. If more than one pad is needed, place the pads so that the edges do not overlap. Avoid having gaps of uncovered tissue.

Be sure that the pressure is even and firm, and not too tight in one area, to cut off circulation. It is better to have a loose dressing than one that is too tight.

12. The patient is made comfortable in bed, with burned extremities elevated.

13. Analgesics and sedatives are used, if necessary, for the control of pain.

14. Oxygen therapy is continued as long as possible.

15. Encourage and provide means for all intake of fluids of the high caloric and high protein diet. If necessary, tube feedings are administered. Vitamins and iron are main aids in the general nutritional therapy. Penicillin is given to control infection.

Observe closely for acute massive edema, laryngeal edema (a tracheotomy may be required), and also observe for tracheal bronchitis.

Burns of the chest or head are also associated with burns of the respiratory passages, and are often more dangerous than they appear to be. Either laryngeal edema or pulmonary edema may develop. If laryngeal obstruction develops, emergency tracheotomy may be life saving.

16. An indwelling urethral catheter may help prevent soiling of dressings where indicated.

In mass disasters, the main objectives are prevention and control of shock, coverage of the wounds, reduction of pain, and immobilization to rest the injured parts.

MSMS

It is hard to understand how members of an organization dedicated solely for their benefit and survival can neglect taking an active part in the work of that organization.—Kark L. Swift, M.D., President Wayne County Academy of General Practice.

Treatment of Soft Tissue Injuries

By Duncan A. Cameron, M.D.,
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Detroit, Michigan

IN ANY MAJOR catastrophe, injuries to soft tissues create problems which may be divided as follows:

1. Hemorrhage requires prompt control.

2. Asphyxia, if present, demands immediate relief.

3. Simple wounds must be differentiated from complicated wounds.

Involvement of underlying large vessels or nerves, or serous cavities such as joints, pleural or peritoneal sacs, may project a degree of seriousness into what may first appear to be a simple injury.

4. The prevention of infection in general, tetanus or gas gangrene in particular, is a major objective.

5. The very number of casualties may cause confusion and overwhelming of existing facilities to the point where determination of priorities in treatment assumes paramount importance.

This discussion will confine itself to the treatment of abrasions, contusions, sprains, puncture wounds, avulsions, lacerations, and traumatic amputations at or near the site of injury (1) at the first aid post, (2) at the casualty care station, and to their disposition. It will also indicate those cases which will definitely require further care, with some estimation of priority needs in their evacuation.

Serious bleeding as a consequence of these injuries may greatly complicate them. The loss of one or two pints of blood will almost surely induce a state of shock, and the loss of half of the body blood is always fatal. In all serious bleeding, the first thought should be to apply direct pressure to the bleeding point. If bleeding cannot be controlled by direct pressure (a piece of cloth, a portion of the patient's own clothing, a bath towel, or a gauze compress) one should think of the use of a tourniquet at a site proximal to the injury if the wound be on an extremity. Deep bleeding from the head, neck, or trunk of the body makes such control impossible, and pressure alone must be relied upon as the casualty is first encountered. It cannot be too strongly emphasized that a tourniquet is a dangerous instrument and that the person who applies it must assume the direct responsibility for the welfare of the extremity distal to its point of application. He must see to it that the patient is brought to the attention of someone competent to apply other measures for the control of hemorrhage within a time interval of twenty to thirty minutes and must directly call to the attention of the personnel to whom he transfers that patient that a tourniquet has been applied to the extremity.

In the event of great catastrophe, minor wounds will necessarily be ignored and the patients referred from the site of catastrophe through the casualty care station to some distant point, even ten to twenty miles away for care. However, if at all possible, abrasions, puncture wounds, avulsions and lacerations should at least be washed with a neutral soap followed by a rinse of sterile water, washed with saline alone, or at least by tap water alone; a dry sterile dressing applied to convert the open wound to a closed wound; penicillin of the three-day variety administered; and a brief descriptive diagnosis, the treatment, and the disposition of the case noted on a tag so that duplication of this early simple treatment will not be necessary as the patient travels away from the area.

The problem of tetanus could be solved by universal toxoid administrative with annual booster shots. Tetanus antitoxin should probably, in the event of great catastrophe, be administered only for the relatively deep puncture wound and the laceration which is to be closed by either suture or adhesive tape coaptation. The danger of anaphylactic shock and serum sensitization, and the need for repeated fractional doses in many cases, probably indicate that tetanus antitoxin should not be administered at the time of catastrophe, but be postponed for two or three days.

Scalp.—

I. Abrasion:
 1. First Aid Post (FAP)
 (a) No treatment.
 2. Casualty Care Station (CCS)
 (a) Wash with tap water.
 (b) Dry sterile dressing.
 (c) Penicillin.
 (d) Tag. (This term here and hereafter refers to brief descriptive diagnosis, treatment given, and disposition of case.)

II. Contusion:
1. FAP
(a) No treatment.
(b) If question of degree of injury, refer to CCS.
2. CCS
(a) Inquire concerning loss of consciousness, headache, dizziness, diplopia, et cetera. (See section on Cranial Injury).
(b) Tag. (Warn *patient* concerning later development of symptoms.)

III. Puncture Wound:
1. FAP
(a) Compress with firm pressure to control bleeding if necessary.
(b) Refer to CCS.
2. CCS
(a) Shave sufficient hair for good examination.
(b) Wash with tap water.
(c) One or more deep sutures may be required to control bleeding.
(d) Dry sterile dressing.
(e) Penicillin.
(f) Tag. (If question of injury to skull or penetration, refer to section on Cranial Injury.)
(g) Tetanus antitoxin (?).

IV. Avulsion of Scalp:
1. FAP
(a) Firm pressure with gauze compresses to control bleeding.
(b) Send to CCS.
2. CCS
(a) Wash with tap water.
(b) Control hemorrhage by ligation or suture ligature if necessary.
(c) Replace scalp and suture.
(d) Dry sterile dressing.
(e) Penicillin.
(f) Tag.
(g) If avulsion cannot be replaced to cover pericranium, send to hospital.
(h) If avulsed skin is absent, send to hospital.

V. Laceration of Scalp:
1. FAP
(a) Firm pressure with gauze compresses to control hemorrhage.
(b) Send to CCS.
2. CCS
(a) Shave hair for exact examination.
(b) Wash with tap water.
(c) Look for foreign bodies and injury to calvarium.
(d) Suture wound.
(e) Dry sterile dressing.
(f) Penicillin.
(g) Tag.

Face.—
I. Abrasion:
1. FAP
(a) No treatment.
2. CCS
(a) Wash gently with tap water.
(b) Dry or vaseline gauze sterile dressing.
(c) Penicillin.
(d) Tag.
If of severe degree with tissue loss, refer to Maxillo-Facial Group. (See proper section.)

II. Contusion:
1. FAP
(a) No treatment.
2. CCS
(a) Check for fracture.
(b) If suspected, refer to hospital for x-ray.
(c) Tag.

III. Puncture Wound (See section for Maxillo-Facial Injury):
1. FAP
(a) No treatment except for control of bleeding by gauze compress pressure.
2. CCS
(a) Wash with tap water.
(b) Probe wound for underlying injury, penetration of sinus, et cetera.
(c) Make decision on necessity for suture closure.
(d) Penicillin.
(e) Tag.

IV. Lacerations:
1. FAP
(a) Pressure over gauze compresses for control of bleeding if necessary.
2. CCS
(a) Divert to Maxillo-Facial group cases involving appreciable structural disorganization, loss of tissue or member, et cetera.
(b) Wash with tap water.
(c) Control bleeding by ligation if necessary.
(d) Suture or adhesive tape coaptation.
(e) Dry sterile dressing.
(f) Penicillin.
(g) Tag.

Neck.—
I. Abrasion:
1. FAP
(a) No treatment.
2. CCS
(a) Wash with tap water.
(b) Dry sterile dressing or vaseline gauze.
(c) Penicillin.
(d) Tag.

II. Contusion:
1. FAP
(a) No treatment.
2. CCS
(a) Examination for emphysema, hematoma, et

cetera. If present, divert to hospital for further care.
(b) Tag.
(c) Further care fifth day.

III. Puncture Wound:
1. FAP
(a) Pressure compress to control bleeding.
(b) Always send to CCS.
2. CCS
(a) Assess for damage to great vessels, nerves, injury to pleura, perforation of trachea or esophagus. If present, divert to hospital immediately for further care. Determine need for tracheotomy. (See EENT section for indications.)
(b) If assessment for serious deep injury is negative, wash with tap water.
(c) Dry sterile dressing with bulk.
(d) Penicillin.
(e) Tag.
(f) Further care on third day.

IV. Laceration:
1. FAP
(a) If major, dry sterile dressing with pressure to control bleeding.
(b) Evacuate to CCS.
2. CCS
(a) Wash with tap water.
(b) Assess for deep injury as in puncture wounds. (If complicated, divert to hospital for definitive care.)
(c) If no deep injury, wash with tap water.
(d) Suture or coapt with adhesive tape.
(e) Penicillin.
(f) Tag.

Chest Wall.—(See section on Injuries to Chest)

I. Abrasion:
1. FAP
(a) If major, dry sterile dressing.
(b) Evacuate to CCS.
2. CCS
(a) If involving large area or of some depth, wash with tap water.
(b) Apply layer of vaseline gauze.
(c) Dry dressing with adhesive tape.
(d) Penicillin.
(e) Tag.

II. Contusion:
1. FAP
(a) Direct to CCS.
2. CCS
(a) Assess for rib fracture, intrathoracic complication, injury to liver or spleen.
(b) If negative, tag.
(c) If fracture, of three or more ribs, send to hospital.
(d) If possible internal injury to liver or spleen, refer to shock team for observation or evacuate to hospital.

III. Puncture Wounds:
1. FAP
(a) Assess for pleural injury (emphysema or sucking).
(b) If minor, dry sterile dressing and walk to CCS.
(c) If complicated, vaseline gauze dressing with pressure to tamponade wound.
(d) Evacuate to CCS (by litter if there is dyspnea or shock).
2. CCS
(a) If minor, wash with tap water. Dry sterile dressing. Penicillin. Tag.
(b) If complicated by emphysema, but not sucking, wash with tap water. Vaseline gauze. Dry sterile dressing with some bulk for tamponade. Tag.
(b) If complicated by emphysema, but not sucking, wash with tap water. Vaseline gauze. Dry sterile dressing with some bulk for tamponade. Tag.
(c) If sucking, wash with tap water. Suture sucking wound. Dry sterile dressing. Observe for increasing dyspnea, which may indicate pressure pneumothorax. Evacuate to hospital.
(d) If pressure pneumothorax develops, place thoracotomy tube (see section on Chest injuries) or remove some sutures from wound, and place vaseline gauze tamponade. Dry sterile dressing. Evacuate to hospital.

IV. Laceration:
1. FAP
(a) Dry sterile dressing if necessary to control bleeding.
(b) Evacuate to CCS.
2. CCS
(a) If minor, wash with tap water. Dry sterile dressing. Penicillin. Tag.
(b) If major, wash with tap water. Suture. Dry sterile dressing. Penicillin. Tag.
(c) If complicated by pleural involvement, treat as in (b). Observe for developing pressure pneumothorax. Evacuate to hospital.

Abdomen.—

I. Abrasion:
1. FAP
(a) If major, dry sterile dressing. Evacuate to CCS.
2. CCS
(a) If minor, wash with tap water. Dry sterile dressing. Penicillin. Tag.
(b) If major, wash with tap water. Vaseline gauze dressing. Dry sterile dressing. Penicillin. Tag.
(c) If appreciable skin loss, should be treated as burn. (See section on Care of Burns.)

II. Contusion:
1. FAP
(a) If major, evacuate to CCS by litter.
2. CCS
(a) If minor, examine and advise. Tag.
(b) If major, assess for shock and peritoneal irritation.
(c) If signs of peritoneal irritation, but no shock, evacuate to hospital by litter immediately.
(d) If shock alone or accompanied by signs of peritoneal irritation, refer to shock group for evacuation to hospital by litter when feasible.
(e) Penicillin if complication present or suspected.

III. Puncture Wounds:
1. FAP
(a) If minor, dry sterile dressing. Evacuate to CCS.
(b) If major, evacuate to CCS by litter.
2. CCS
(a) Wash with tap water.
(b) Assess for signs of shock and peritoneal irritation.
(c) If no evidence of penetration, dry sterile dressing. Penicillin. Tag.
(d) If signs of penetration but no shock, evacuate to hospital by litter for exploration.
(e) If shock alone or plus signs of penetration, refer to shock group. Then evacuate to hospital as soon as feasible for exploration.
(f) Give penicillin if complication present or suspected.
(g) If minor puncture wound by all criteria, wash with tap water. Dry sterile dressing. Penicillin. Tag.

IV. Laceration:
1. FAP
(a) If minor, dry sterile dressing. Evacuate to CCS.
(b) If large or deep, control bleeding by firm pressure exerted through large compresses. Evacuate to CCS by litter.
(c) If small evisceration, dry sterile dressing. Evacuate to CCS by litter.
(d) If large evisceration, return bowel to mid abdomen. Dry sterile dressing. Snug binder. Evacuate to CCS by litter.
(e) If any possibility of penetration, treat as small evisceration (c).
2. CCS
(a) If no deep involvement, wash with tap water. Suture. Penicillin. Dry sterile dressing. Tag.
(b) If any possibility of penetration, wash with tap water. Dry sterile dressing. Penicillin. Tag. Evacuate to hospital.
(c) For laceration with small evisceration and no evidence of shock, same treatment as for penetration (b). If in shock, refer to shock team before evacuation.
(d) Laceration with gross evisceration. Return viscera to mid abdomen. Apply moist compresses and snug binder. Penicillin. Tag. If shock is present, refer for treatment. If not, evacuate to hospital at once.

Low Back and Buttocks.—

I. Abrasion:
1. FAP
(a) No treatment. To CCS by litter if major injury.
2. CCS
(a) Same as Abrasions to Abdomen.
(b) If major and involving perineum, evacuate to hospital.

II. Contusion:
1. FAP
(a) No treatment. Evacuate to CCS by litter if major.
2. CCS
(a) Examine for fracture of spine, transverse process, possible renal injury, or possible intra-abdominal complication.
(b) If minor, no treatment. Tag.
(c) If major (possibility of deep damage), evacuate to hospital by litter. (See Fracture of Vertebral Column and Genito-Urinary section.)

III. Puncture Wounds:
1. FAP
(a) If minor, no treatment.
(b) If major, dry sterile dressing. Evacuate by litter to CCS.
2. CCS
(a) Minor: Wash with tap water. Dry sterile dressing. Penicillin. Tag.
(b) Major: Check for renal injury, intra-abdominal injury, injury to pelvic rectum, or sciatic nerve.
(c) Treat as for minor injury (a) and evacuate to hospital. (If shock is present, however, refer to shock group.)

IV. Lacerations:
1. FAP
(a) Minor: No treatment. To CCS.
(b) Major: Dry sterile dressing. Evacuate by litter to CCS.
2. CCS
(a) Minor: Wash with tap water. Suture if indicated. Dry sterile dressing. Penicillin. Tag.
(b) Major: Check for renal injury, peritoneal penetration, rectal injury or injury to sciatic nerve.
(c) If uncomplicated, same as for minor injury
(a) with attention to deep bleeding.
(d) If complicated, wash with tap water.

Control deep bleeding. Dry sterile dressing. Penicillin. Evacuate to hospital if no shock. (If shock is present, refer to shock group.)

Perineum.—

I. Great potential danger if injury to male and female genitalia, rectum, and urethra.

II. Treatment at FAP and CCS levels essentially as for Abdomen and Low Back and Buttocks. (See section on Urology.)

Upper Extremity.—

I. Abrasions:
 1. FAP
 (a) Minor: No treatment.
 (b) Major: Dry sterile dressing, sling. Refer to CCS.
 2. CCS
 (a) Minor: Wash with tap water. Dry sterile dressing. (If some depth, use vaseline gauze.) Penicillin. Sling if at or near elbow. Tag.
 (b) Major: If contused, check for fracture or dislocation. If of some depth and size, treat as burn. (See section on Burns.)
 (c) If any possibility of fracture, apply sling and refer to Fracture Group.

II. Contusions:
 1. FAP
 (a) Minor: No treatment.
 (b) Major: Sling. To CCS.
 2. CCS
 (a) Minor: Sling. Tag.
 (b) Major: Check for fracture and dislocation. If clinical suspicion of either, refer to Fracture Group. If not present or suspected, apply sling.

III. Avulsions of Arm:
 1. FAP
 (a) Control of hemorrhage imperative. Tourniquet or continuous, firm manual pressure over heavy compress or even patient's clothing may be necessary.
 (b) Evacuate by litter to CCS.
 2. CCS
 (a) If shock is present and no bleeding, wash gently with tap water. Dry sterile dressing. Penicillin. Refer for shock therapy. Then evacuate by litter to hospital.
 (b) If shock is present and bleeding (with or without prior dressing), remove dressings. Control gross bleeding with hemostats and ligation. Wash gently with detergent soap. Dry sterile dressing. Penicillin. Refer for shock therapy.
 (c) If no shock and previous dressing, penicillin. Evacuate to hospital.
 (d) If no shock and no previous dressing, wash with tap water. Firm, dry sterile dressing. Penicillin. Evacuate to hospital.

IV. Sprain (Wrist):
 1. FAP
 (a) If no question of fracture, firm dressing.
 (b) If question of fracture, evacuate to CCS.
 2. CCS
 (a) If no fracture or dislocation, apply firm dressing. Tag.
 (b) If question of fracture or dislocation, sling. Refer to Fracture Group.

V. Puncture Wounds:
 Dangerous in arm because of superficial location of vessels and nerves in axilla, arm, elbow, and wrist.
 1. FAP
 (a) Minor: Dry sterile dressing. Evacuate to CCS.
 (b) Major (vessel or nerve involvement) with bleeding, apply firm compress to control. Dressing. Evacuate to CCS.
 (c) If hemostats not satisfactory, apply tourniquet proximal to wound. Dry sterile dressing. Evacuate to CCS.
 (d) If nerve involvement, dressing as above. Sling. Evacuate to CCS.
 2. CCS
 (a) Whether major or minor, check for large vessel and nerve involvement.
 (b) Minor without complication: Wash area with tap water. Dry sterile dressing. Penicillin. Tag.
 (c) Minor with hemorrhage, from non-vital vessel:
 (1) Wash with tap water.
 (2) Open wound if necessary, isolate vessel or vessels and ligate.
 (3) Suture wound.
 (4) Dry sterile dressing.
 (5) Penicillin.
 (6) Tag.
 (d) Minor or major with hemorrhage from axillary or high brachial vessels:
 (1) Wash with tap water.
 (2) Firm, sterile compress pressure bandage for hemostasis.
 (3) Penicillin.
 (4) Evacuate to hospital for vascular surgery.
 (5) If evacuation to hospital (4) is impossible, anesthetize, open wound for exposure, re-anastomose arteries, ligate veins.
 (6) If necessary to control bleeding, hemostats may be applied with or without ligation and then patient evacuated to hospital for further care.
 (e) If minor or major with severance of nerve alone,
 (1) Wash with tap water.
 (2) Dry sterile dressing.

(3) Penicillin.
(4) Sling to forearm and/or hand.
(5) Advise concerning secondary care.
(6) Tag.

(f) If minor or major with hemorrhage and nerve section,
(1) As above plus primary neurorrhaphy. (See section on Peripheral Nerves.)

VI. Hand:
1. FAP
(a) No treatment.
2. CCS
(a) Wash with tap water.
(b) Minimal debridement, if any.
(c) Cover exposed bone or tendon with skin (if at all possible) by suture.
(d) Dry sterile dressing in position of function.
(e) Penicillin.
(f) Advise concerning later definitive care.
(g) Tag.

Lower Extremity.—

I. Abrasions:
1. FAP
(a) Minor: No treatment.
(b) Major: Dry sterile dressing. Evacuate to CCS. (By litter if necessary).
2. CCS
(a) As for Upper Extremity.
(b) Crutches instead of sling.

II. Contusions:
1. FAP
(a) As for Upper Extremity.
(b) Substitute crutches for sling.
2. CCS
(a) Minor: No treatment.
(b) Major: As for Upper Extremity.
(c) Crutches for ambulation.

III. Traumatic Amputation of All or Part:
1. FAP
(a) As for avulsion of arm.
(b) Tourniquet application if necessary.
(c) Evacuation to CCS.
2. CCS
(a) Toes: Wash with tap water. Dry sterile dressing. Penicillin. Crutches if necessary. Advise concerning definitive care. Tag.
(b) Portion of foot: As for toes, except apply pressure bandage.
(c) Involving tibia: As above. Ligate vessels if necessary. Evacuate to hospital if no shock. If in shock, refer for therapy.
(d) Involving femur: Same as tibia.

IV. Puncture Wounds:
Dangerous in high anterior thigh where femoral vessels and nerves are quite superficial; also popliteal area. Common femoral artery and popliteal artery are vital.
1. FAP
(a) As for Upper Extremity.
(b) Tourniquet useless above mid-thigh. Use firm pressure for hemostats over bleeding point. (Continuous manual pressure if necessary.)
(c) To CCS by litter.
2. CCS
(a) Same as for Upper Extremity. Deep bleeding may be difficult to detect in thigh.
(b) Joint perforation through small puncture wound may be ignored. Patient should be warned of possible complication of hemorrhage, effusion, and infection. Tag for treatment on third to fourth day.
(c) If large puncture wound, close skin with suture to prevent further contamination.

V. Laceration:
1. FAP
(a) Minor: Dry sterile dressing.
(b) If of considerable length and/or depth, but not into muscle bellies, tendons of foot, knee or ankle joint, and uncomplicated by hemorrhage: Firm sterile dressing. Evacuate to CCS, walking.
(c) If complicated by hemorrhage, apply large compress with pressure. If to no avail, apply proximal tourniquet and redress with large firm sterile dressing.
(d) For hemorrhage above mid-thigh, continuous manual pressure over laceration may be necessary. Maintain during evacuation.
2. CCS
(a) Minor laceration: Wash with tap water. Dry sterile dressing. Penicillin. Tag.
(b) For laceration of some depth and/or length, as above. Suture or adhesive tape coaptation.
(c) For laceration near knee, check for joint penetration. If present, wash with tap water. Dry sterile dressing. Penicillin. Evacuate to hospital for further care.
(d) For laceration of foot with severance of tendons, wash with tap water. Dry sterile dressing. Penicillin. Advise concerning later definitive care. Tag.
(e) For laceration with deep bleeding from non-critical area, wash with tap water. Ligate bleeding vessels, muscle, and skin. Close wound by suture. Dry sterile dressing. Penicillin. Crutches. Tag.
(f) For laceration involving common or superficial femoral and popliteal arteries, obtain hemostasis by tourniquet, pressure bandage, or by maintained manual pressure over compresses. (Hemostats may be placed on vessel ends if necessary.) Penicillin. Evacuate to hospital as soon as possible. If impossible to evacuate to hospital, these vessels should be re-anastomosed in CCS as soon as possible as they are vital to life of the limb.
(g) For laceration with section of nerves, see section on Peripheral Nerves.

First Aid for Simple Fractures

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IT IS ASSUMED in presenting this simplified outline of first aid as related to bone and joint injuries that the first aid attendant has had at least a superficial course in first aid and has some knowledge of the treatment of wounds and the application of splints.

Skull.—

I. Keep patient lying down with head and shoulders slightly raised if face is of normal color or flushed. If pale, keep level or head slightly lower.

II. Move only in a horizontal position and avoid unnecessary handling.

III. Do not give stimulants or anything by mouth. Keep warm.

IV. If blood or mucus collects in throat, lower head and turn slightly to the side.

V. Control bleeding from the scalp by applying a sterile pad and direct pressure over the bleeding point. Apply head bandage.

VI. If breathing ceases and pulse is still felt, institute artificial respiration.

Spine.—

I. Neck:

1. Do not move or lift patient's head to the back, side, or forward.
2. If moved, maintain slight traction on the head in a longitudinal axis. Place sand bags or pillows on either side of the head after the patient has been placed on a rigid flat surfaced splint that extends well out beyond his head, e.g., a door. Place arms at side and then "mummify" the patient to the splint so that no motion of the spine is possible.

II. Lower Spine:

1. Transport lying on the back with a pillow under the small of the back. Use a flat surface rigid splint.
2. Never lift into or allow patient to assume a sitting position.

Pelvis.—

I. Transport in the lying position on a rigid splint. Tie ankles together before moving onto splint.

Lower Extremity.—

I. Hip and Femur:

1. Steady the limb by grasping the foot and ankle. Apply gentle traction and move the limb into a normal position so it is at the side of the body. Hold it there.
2. Apply the Thomas splint, or a long board splint from the armpit to the ankle, or tie the limbs together and use the opposite limb as a splint.

II. Knee Cap:

1. Straighten the extremity. Apply the Thomas splint or a straight board from the buttock to the heel, padding well under the knee.

III. Leg:

1. Grasp the foot or ankle and apply gentle traction. Apply the Thomas splint or a straight board from the thigh to the foot.

IV. Ankle and Foot:

1. Place a large padded dressing around the ankle or foot and apply an ascending bandage.
2. Keep patient off the extremity.

Upper Extremity.—

I. Clavicle:

1. Place arm and forearm in a sling with the elbow flexed to 90 degrees. Then with another sling bind the arm to the side.

II. Arm:

1. Place the arm in a normal position in relation with the body with the elbow straight. Then apply a Murray-Jones splint with mild traction.

III. Elbow:

1. If the elbow is flexed, carefully apply an arm sling and then bind the arm to the body. A sling may be used around the neck and wrist to help support the elbow.
2. If the elbow is straight, place the arm in a normal position and apply the Murray-Jones splint without traction.

IV. Forearm and Wrist:

3. With the patient's hand out straight, splint the forearm out straight using two long basswood splints, padding being applied over the fracture site before the splints are secured in place with roller bandage or triangular bandages.

Generally speaking, improvised splints may be used, and will have to be used whenever "formal splints or splinting material" is not available. It is an accepted rule that the first regulation in the first aid of fractures is to "splint them where they lie." It is the purpose of the first aid attendant to prevent any further damage to the injured extremity at the time he first sees him or until he can be safely transported to a hospital for definitive care.

The Emergency Treatment of Fractures (Casualty Care Station)

In the treatment of various types of fractures, it is difficult to plan any standardized method that might be adequate for all types of cases. There are many fractures that present very special problems, and the proper method of treatment for such cases can only be determined after careful evaluation of these factors.

However, in dealing with a large number of casualties, one must plan some uniform care. We shall first consider simple fractures:

1. All simple fractures with no displacement should be immobilized immediately in circular plaster cast.

2. All fractures of long bones with displacement, should be treated by skeletal traction.

3. Oblique fractures of long bones with displacement, may be treated with open reduction and internal fixation, if trained personnel and facilties are available.

4. Fracture-dislocations, unless trained personnel is present, are best treated by skeletal traction.

5. After a period of time in skeletal traction and when healing begins to take place as shown by x-ray, then these cases should be immobilized in circular plaster casts. The pins may be incorporated in cast to maintain traction if necessary. Many of these cases can be immobilized as soon as bone position is satisfactory.

Condylar fractures of lower humerus, fractures of condyles of tibia and tri-malleolar fractures of lower tibia are best treated by open reduction and internal fixation with screws if facilities and trained personnel are present.

Compound Fractures.—In treatment of compound fractures, proper debridement is of the greatest importance. Skeletal traction is the safest and simplest method of mass treatment of compound fractures of long bones.

The completeness of wound excision unquestionably is one of the determining factors of the end result in treatment of such cases. The surgical clean-up and preparation of the wound begins when the patient enters the operating room. After the patient is anesthetized, the logical order of procedure is as follows:

1. Traction is maintained while the clothing is cut away or removed.

2. The wound is protected by a sterile dressing.

3. An air inflated tourniquet is applied if possible to control hemorrhage if severe.

4. With the wound and fragments protected by sterile dressings, the surrounding skin of the extremity is shaved and cleansed with soap and water and a brush for ten minutes, using sterile brushes and irrigating with warm saline or water. No antiseptic or soap is allowed to enter the wound.

5. Traction is maintained while sterile drapes are applied to the extremity.

6. The skin edges are excised approximately 0.5 cm. around the entire wound. The wound is extended longitudinally so that thorough inspection of soft tissue damage can be accomplished. All viable skin is saved.

7. The wound edges are then protected with sterile towels.

8. Warm, sterile saline irrigation of the wound is continued during the debridement in which all contused, traumatized, dead, and contaminated soft tissue is excised. Black dark areas of muscle should be excised down to fresh bleeding surfaces. All hematomats are removed, and loose, small fragments of bone which are devoid of periosteal or soft tissue attachments are excised. Large cylinders of bone should never be excised or removed. Soiled and stained bone ends are carefully rongeured. No force should be used to irrigate, rather allowing the fluid to gravitate out of the wound.

9. Nerves and tendons, which retract and are later difficult to locate, should be preserved and reunited in a simple manner after the debridement.

Primary closure may be considered after a good surgical debridement if:

(a) The soft tissue injury is not severe and antibiotic or chemotherapy has been instituted early.

(b) The time interval between the injury and surgical clean-up has not been unduly prolonged.

(c) Contamination of the wound has not been severe, and has been properly alleviated.

(d) The circulation of the extremity is not severely injured.

(e) The skin can be closed without tension.

Primary closure should never be attempted if:

(a) The wound is very extensive, dirty, and difficult to debride.

(b) Extensive soft tissue and bone damage is present.

(c) Debridement has been delayed more than eight to twelve hours.

(d) Circulation is embarrassed.

(e) Skin cannot be closed without tension.

10. When the wound cannot be closed, it should be covered by loosely packed non-adherent sterile vaseline gauze and a mild pressure dressing held in place by a plaster-of-Paris cast, split from end to end. This should not be disturbed for seven to ten days unless evidence of infection intervenes.

11. If the wound is clean in seven to ten days, a split skin graft may be applied to close the wound.

12. Length and position need not be sacrificed, if the principles of traction, counter traction, and immobilization of the joint above and below the fracture, are kept in mind. Skeletal traction appropriately applied, distant to the wound, supported by a plaster cast, and swung up under an orthopedic bed with ropes and pulleys for suspension are, generally speaking, preferable to immediate internal fixation.

Antibiotics should be administered in full dosage.

The possibility of gas gangrene must be remembered at all times. Adequate debridement, with removal of all dead and devitalized tissue, especially muscle, is the best prophylaxis. Rapid pulse, fever, appearance of toxicity developing in the early period after compound fractures should raise the question of gas gangrene. The wound should be inspected if this suspicion is present. Excision of affected tissues, large doses of antibiotics, use of antitoxin are valued in treatment. Get expert help for treatment of gas gangrene if possible.

Tetanus antitoxin should be given unless individual has had toxoid, in which case a "booster dose" of toxoid should be given.

Fractures of Spine.—Fractures of cervical spine should be treated by traction, using Crutchfield tongs or head halter for fixation. The tongs are preferable.

Fractures of dorsal and lumbar spine should be treated by hyperextension, and immobilized in hyperextension plaster jacket, unless contraindicated by spinal cord injuries or some unusual type of fracture.

Treatment of Penetrating Joint Injuries

If there is a penetrating or perforating wound of the joint, wide surgical exposure of the joint should be done as early as possible through one or more incisions with careful excision of damaged soft tissue and cartilage with the removal of all available foreign bodies. The joint cavity should be thoroughly irrigated with sterile saline. The synovial membrane and capsule should be closed by any possible means with instillation of the proper antibiotics into the closed cavity. The skin and superficial tissues should be left open widely, while the extremity is enclosed in a plaster-of-Paris splint, with a window cut out over the wound. The joint should be aspirated in twenty-four to forty-eight hours and antibiotics re-instilled. Closure of the superficial wound by suture or skin graft can often be accomplished in three to five days after the above treatment.

Emergency Amputation

Amputations among casualties are resorted to only when an extremity is irretrievably damaged or a nearly complete traumatic amputation has been performed by the wounding missile. Complete destruction of the blood supply to an extremity usually means amputation is inevitable. An open circular amputation performed at the most distal point possible is probably safest. A circular incision is planned so as to avoid needless sacrifice of skin and subcutaneous fat and these tissues allowed to retract. The deep fascia is then incised at the level to which the skin has retracted. The superficial muscles are divided on a level with the incised deep fascia and permitted to retract. The deep muscles are then cut through to the bone at the level to which the superficial muscles retracted. Periosteum is incised with a scalpel and the bone divided with the saw at the deep muscle retraction. Careful attention should be directed at avoiding stripping or injury to the periosteum. Arteries and veins are individually ligated, transfixation ligatures being placed distal to initial simple ligatures. Skin traction is immediately applied.

Management of Chest Injuries from Atomic Bombing

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THE RECORDED experiences from the Hiroshima and Nagasaki bombings indicate that the survivors of an atomic explosion manifest direct blast injuries in a far lower percentage of cases than individuals exposed to the detonation of high explosive powders. The incidence of ruptured ear drums among survivors at Hiroshima and Nagasaki, for example, was about 1 per cent in contrast to a much higher incidence in survivors of the Texas City disaster caused by explosion of ammonium nitrate. Serious direct blast effects on the lungs are believed to be of similarly low incidence in atomic bomb casualties in contrast to indirect chest injuries produced by the collapse of buildings and by flying glass. It is anticipated, therefore, that the majority of chest casualties following atomic bombing will consist of the more familiar types of traumatic cases encountered in civilian life involving direct contusion of the chest with associated rib fracture, pneumothorax, hemothorax and lung contusion in the severe traumatisms. Effects on the lung may also occur in connection with burns about the face or from inhalation of smoke from fire.

Although air blast injuries may not be common, emphasis should be placed on recognition since such casualties may present a deceptively good appearance in the early phase when serious damage actually has occurred. The main symptoms are pain or oppression beneath the sternum, dyspnea, harassing cough, and hemoptysis. Physical examination may reveal few signs on auscultation initially, and observation of respiration and other vital signs in conjunction with the history is important. The occurrence of deafness or demonstration of rupture of the tympanic membranes confirms exposure to air blast. *Rest with the head slightly elevated* and *morphine* constitute the early treatment. *Oxygen* is urgently required whenever dyspnea is increasing.

It should be stressed that pulmonary injury produced by smoke or fire may also appear to be of minor consequence during the first few hours only to be followed by serious pulmonary edema. Substernal oppression, dyspnea, harassing cough and expectoration of frothy sputum are ominous signs and warrant the same management accorded to air blast casualties. *Super-imposed infections may occur in all pulmonary injuries, usually after forty-eight hours,* and it is *a good working rule to administer penicillin to all patients who exhibit râles or areas of percussion dullness.*

ACTH, Cortisone and Adrenal Cortex Therapy

The usefulness of adrenocorticotropic hormone, cortisone, and adrenal cortex extracts in the management of atomic casualties is not known. The limited evidence available suggests that all of these agents have the capacity to support life in the extremis, whether it is threatened by almost overwhelming trauma, burns or infection. Attention is further directed to the regularity with which atrophy of the adrenal cortex was encountered in Japanese casualties succumbing two weeks or more after exposure. Extracts of adrenal cortex may be administered with scant regard to possible adverse effects, but the production of potent preparations will be limited by expense for some time to come. Therefore, the major question concerns the advisability of employing cortisone or ACTH which are currently available in quantity. The adverse side effects of ACTH and cortisone make it certain that wholesale administration of either substance would result in more harm than benefit. For example, these compounds break down the barriers to spread of infection. They are probably contraindicated in hypertension, which is known to be a common temporary phenomenon in persons exposed to catastrophic disasters, and the potentially harmful effects of ACTH or cortisone on the diabetic, nephritic or ulcer patient are also well known. It is therefore recommended that ACTH and cortisone be not advised as a measure of routine therapy for atomic casualties but that these agents be reserved as a possible adjunct in the management of selected cases under the close supervision of qualified senior physicians.

Management of Infection

Infection in a variety of forms plays an important role in atomic casualties. Burn cases, traumatic casualties and radiation injury cases alike may succumb to secondary infections. Defenses against infection are lowered by the granulocytopenia produced by irradiation and additional por-

tals of entry may be provided by ulcerations in mouth and pharynx, by radiation induced denudation of gastrointestinal surfaces, and by hemorrhagic foci in the lungs. Partenterally administered procaine penicillin is the cheapest, most available and most easily administered antibiotic agent. Its utility, however, may be definitely less than that of aureomycin, terramycin or chloramphenicol, particularly where the gastrointestinal tract is concerned. It is recommended that procaine penicillin be administered by daily intramuscular injection to all casualty cases in which infection may be anticipated, the dosage preferably being at least 500,000 to 600,000 units daily. Aureomycin, terramycin and chloramphenicol when available may also be employed by the oral route in divided doses of approximately 500 mg. every eight hours. These antibiotic agents affect a wider bacterial spectrum than penicillin and are definitely preferred when gastrointestinal ulceration is present. In the presence of active infection it may, of course, be necessary to employ larger doses of antibiotics, and it is self evident that the particular agent employed be selected whenever the bacterial agent concerned can be identified. Simultaneous administration of two or more antibiotic agents lacks firm scientific support, and in this connection it may be remarked that aureomycin, chloromycetin and terramycin all possess the capacity to interfere with the antibacterial action of penicillin. When sheer desperation prompts resort to the application of multiple anti-infective agents, we recommend that streptomycin be one of the two antibiotics because of its demonstrated capacity to reinforce rather than interfere with the other antibiotics.

Surgical Injury of the Thorax

Traumatic injuries of the thorax will fall mainly into two classes, namely, penetrating and non-penetrating wounds. It is highly probable that in the case of bombing the type of injury seen will be mainly of the non-penetrating type. Contusion of the chest wall with or without fracture of ribs or other boney structures can give rise to serious intrapleural damage. It must be remembered that it is possible to have a pneumothorax which may be of the tension type even in the absence of disruption of the chest wall. Such patients should be treated promptly with the aspiration of air and of blood if it is present.

Individuals with severe chest wall contusion and also with penetrating wounds of the chest are liable to develop severe pulmonary edema, setting up a symptom complex which is known as "the wet lung of trauma." In order to break up the reflex nerve chain which is thought to cause this disorder, it is necessary that intercostal nerve block be employed.

Fractures of the ribs have long been treated by circular strapping of the chest. It is now thought that this is probably an unnecessary, and in many instances a useless, type of procedure. The main point to remember in treating such injuries is that pain is relieved by intercostal block in order that the patient may cough with ease and freedom, because the serious consequences which follow this type of injury are in the main directly related to the patient's inability to keep the airways clear. If there is intrapleural injury, producing either tension pneumothorax or hemothorax, these must be promptly cared for by aspiration, and if the rent in the lung is large, the employment of an intercostal catheter drainage attached to a closed drainage bottle may be needed.

As was stated earlier, penetrating wounds of the chest may not be commonly seen, but they will undoubtedly occur in some instances being caused by flying particles of steel and of sharp-edged pieces of masonry. If the injury to the chest wall is severe and a sucking wound is present, an airtight dressing should be attached securely over the wound and the patient transported as quickly as possible. The mere presence of a foreign body within the lung does not call for its immediate removal. In fact, it has been shown that such removal is carried out with better results after a variable period of waiting in order that the lung hematoma may clear.

Hemothorax should be treated by its immediate evacuation without the replacement of air. It should be remembered that while the initial hemorrhage from a lung wound may be great, the bleeding stops rather rapidly and secondary hemorrhage is rare. It is therefore rarely necessary to do an open thoracotomy in order to control a lung wound. Bleeding which is coming from a severed intercostal or some other large vessel will of course require definitive treatment. If the blood becomes clotted within the pleural space, it is better to leave it so for a period of time when either a chemical or surgical decortication can be done. Wounds of the mediastinum and those of the lower

(Continued on Page 334)

Trauma of the Nervous System

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Acute Craniocerebral Injury

General Principles of Treatment.—

Observation of Patient.—Careful evaluation in order to anticipate complications (subdural, epidural hematoma and hydroma).

This requires:

1. Primary and secondary neurologic examinations, particularly observing the state of consciousness.
2. Recording pulse, respiration, blood pressure every half hour and temperature every two hours. In seriously ill patients recording of the fluid intake and output, the diet's caloric and protein values, and the patient's weight.
3. Diagnostic lumbar puncture.
4. Attention to all associated injuries.

Oxygen Content of Blood.—Maintenance of an adequate oxygen saturation of the blood. This may be brought about by:

1. Positioning of the air passages so that obstruction is avoided: (a) elevate lower jaw, (b) turn head to one side, (c) slight semi-Fowler's position. (Place in position where respirations are least labored).
2. Aspiration of all mucus from the upper air passages and by positioning body so that mucus will be expelled by gravity (head lower than body).
3. The use of oxygen by means of a nasal catheter rather than oxygen tent (in order that nursing care, aspiration of mucus, et cetera, may be constantly done).

Temperature.—Elevation in temperature may be controlled by:

1. Exposing the body surface in order to radiate heat. Don't cover the patient with blankets, a pneumonia jacket and shoulder blanket to place him in a chilled oxygen tent. This elevates the temperature.
2. The use of tepid sponges and ice water enemas in order to maintain a temperature below 103° F.

Nourishment.—The requirements in fluid and food may be maintained by:

1. A fluid intake of 2,400 to 3,000 cc. daily when a significant elevation of temperature is not occurring. If temperature above 100° F., add 1,000 cc. for every 2 degrees of increase. In the seriously ill patient, maintain 1,500 cc. urinary output every twenty-four hours.
2. Administration of fluids and food (twenty-four hours from time of injury) preferably by means of a nasal feeding tube (in the unconscious patient).
3. The food must contain adequate caloric, protein and vitamin values for the child or adult (2,000 calories in 2,500 cc. of a combination of water, milk, sugar, eggs and vitamins).

Comfort of Patient.—Rest and comfort may be provided by:

1. The employment of special nurses or attendants when possible in the acutely sick patient.
2. Analgesics and sedatives, preferably pentobarbital sodium (nembutal) 90 mg. (1½ grains) alternating with codeine 60 mg. (1 grain) used freely when necessary.
3. Freedom from restraints as far as possible.
4. The avoidance of a distended bladder and incontinence by an indwelling catheter or condom attached to a drainage tube and bottle.
5. The use of an enema every third day.
6. Insistence upon cleanliness of the skin and the body orifices.
7. Elevation of the head.
8. Avoidance of stimuli (noise, light and relatives).
9. Ice bag to the head, if desired.

Other Measures.—Specific measures other than supportive and nursing care may require:

1. The use of penicillin and/or sulfadiazine as a prophylactic measure either routinely or when the frontal or temporal base is fractured. Penicillin may be used routinely in postoperative patient.
2. Physiotherapy to paretic and paraplegic extremities in the early period of injury.
3. Occupational therapy as soon as practical.
4. Discussion with and instruction of the patient in order to provide him with a reasonable viewpoint concerning sequelae.

The principles presented in this article apply to care in the Casualty Care Station or in institutions equipped for more definitive care.

Special Measures in Treatment of Complications.—

Scalp Lacerations.—May be treated by:

1. A wide and adequate preparation of the surrounding scalp by shaving, soap, water, ether and alcohol.
2. The insertion of a finger covered by a sterile glove into the wound in order to assess the underlying skull damage.
3. Suture by silk using 1 per cent procaine anesthesia.

Compound Fracture of the Skull.—This requires:

1. Detailed roentgen studies before operation to determine the degree and position of comminution.
2. Early operation (emergency) within twelve hours.
3. Penicillin, 30,000 units every three hours from the time of admission.
4. Neurosurgical technique of operation employing the complete facilities of modern surgery. This applies to all of the following procedures which may, at any time, demand the maximum in skill and armamentarium. They should be available.

Simple Depressed Fracture of the Skull.—May be treated by using the following principles:

1. Election of time for operation allowing patient to recover from the initial effect of injury.
2. Early operation if "dynamic" signs occur such as progressive lethargy and stupor or Jacksonian convulsions.
3. Management in latter event as in compound fracture.

Subdural Hematomas (Acute and Chronic) and Subdural Hydroma.—Acute cases may require:

1. Operation as soon as possible after diagnosis has been made.
2. The use of two trephine openings in the frontal area, left and right, as exploratory openings.
3. Counter drainage if and as required.
4. The injection of air into the ventricular system for a ventriculogram if a suspected collection is not found. This is in preference to further multiple openings.
5. Trephine then as directed by the ventriculogram. Chronic cases may require:
 (a) Management as an elective case usually preceded by an air study.
 (b) Exploratory trephination to identify lesion.
 (c) Drainage of a liquid collection by appropriate counter opening.
 (d) Removal of a solid collection by means of a suitable bone flap.

Epidural Hematoma.—Should be treated as follows:

1. Early operation as soon as diagnosis is made.
2. The use of a subtemporal opening for removal of the collection.
3. The effort is made to remove only as much bone as necessary to evacuate the clot.

Massive Intracerebral Hemorrhage.—This requires:

1. Early operation after the diagnosis and localization of the lesion.
2. A cortical incision is made for evacuation of the clot which is usually accidentally identified through an opening made for removing an epidural hemorrhage.
3. A craniotomy flap is suitable if a diagnosis is made by means of a brain cannula tap through a trephine opening.

Brain Abscess.—May be treated as follows:

1. Early operation in abscess complicating "open" cranial wounds with total "debridement" of the purulent collection rather than drainage. (Example — abscess following shell fragment wounds of war.)
2. Delayed treatment to encourage encapsulation in abscess following "closed" injuries, complicating sinus fractures.
 (a) Initial tap of the abscess with instillation of penicillin. Multiple taps may be curative.
 (b) Removal of the encapsulated abscess by craniotomy if necessary.

Spinal Cord Injury

The effective treatment of patients with involvement of the spinal cord or the cauda equina involves the acceptance of the principle that a productive life may be compatible with great neurologic deficiency, that hopelessness cannot be accepted as a reason for indifferent care. Two main classes of injury occur.

1. Closed injuries of the spinal cord or cauda equina produced by fracture.

2. Open or penetrating wounds of the spinal cord or cauda equina produced by high or low velocity missiles, e.g., metal fragments, knife stabs.

General principles of care apply to both groups and these must be meticulously followed. Some injuries in Group 1 may require surgical treatment. All in Group 2 should be surgically treated. The indications for such therapy are considered under separate headings.

General Principles of Care.—

Transportation of the patient to a point for definite treatment under suitable conditions.

1. Movement of the spine must be avoided.

2. A position of extension must be provided. This is most simply executed by placing the patient in a prone position on a stretcher.

3. If delay in transportation occurs, catheter bladder drainage should be established and the patient instructed regarding bladder emptying.

Diagnosis.—

1. Upon reaching a point where definite treatment may be initiated, a careful examination is first made and recorded. Notation is made concerning the deep tendon reflexes, abnormal reflexes, the sensory loss and sphincter disturbance.

2. Diagnostic roentgen studies may be made upon admission to avoid subsequent movement of the patient.

3. A careful Queckenstedt examination is made to determine the presence or absence of cerebrospinal fluid block either partial or complete. The use of contrast media studies (pantopaque) may be desirable.

4. An indwelling catheter is inserted if this has not already been carried out.

5. Decision is made concerning the indication for surgical or conservative treatment.

Surgical Treatment.—

1. Group 1 patients may be treated by laminectomy if a spinal block is present upon manometric study. The presence of comminuted loose fragments compressing dura and spinal cord may require laminectomy. Rapid hyperextension may be employed in place of early laminectomy. A persistent block may require decompression by laminectomy. Cervical dislocations are treated by means of traction with Crutchfield tongs.

2. Group 2 patients must have debridement of the soft tissue wounds as soon as practical. Definite debridement of the spine wound must be done only under ideal conditions employing modern facilities and skill. Indications for laminectomy include the presence of bone fragments or metallic fragments within the spinal canal. A spinal fluid block or spinal fluid leak requires laminectomy.

3. In Groups 1 and 2 a progressive or dynamic increase in neurologic signs requires surgical exploration at the level of injury as soon as practical.

Conservative Treatment.—

1. Care of the skin.

(a) The patient may be placed upon a Stryker frame and turned every two hours. If such or similar frame is not available, frequent changing of position in bed is essential. Air mattress may minimize bed sores.

(b) The skin is kept dry and clean.

(c) Hyperextension casts must be bivalved as soon as possible and the upper half removed at each turning.

(d) All pressure points must be avoided.

(e) Decubiti are treated by exposure to light and excision.

2. Care of the bladder.

(a) An indwelling catheter may be inserted. During catastrophic situations suprapubic drainage may be established to avoid accidents of urethral catheter removal during delayed transportation.

(b) A tidal drainage apparatus is employed in conjunction with the indwelling catheter. The patient may be trained to irrigate his bladder manually twice or three times daily with boric solution.

(c) Sulfadiazine, 1 gram (15 grains) three times daily, is used to prevent bladder infection.

(d) The catheter is removed, cleaned and sterilized and reinserted every ten to fourteen days.

(e) The head of the bed or Stryker frame is elevated.

3. Care of the morale. The patient is encouraged from the outset to help himself in personal care, moving and turning. He is instructed early in the fundamentals of rehabilitation. The

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physical and vocational therapists must begin their program as soon as the patient can be moved to an area where this is possible.

4. Rehabilitation.

Peripheral Nerve Injury

The treatment of peripheral nerve injuries is contingent upon an early recognition of interruption of function. Several fundamental surgical principles may then be applied. The optimim result of surgical treatment is closely dependent upon the mobility of the affected part which can be maintained only by exercise. There are two main classes of nerve interruption: 1. Anatomic. 2. Physiologic.

General Principles of Care.—

Anatomic Interruption. Nerve Division.—Lacerations of the extremities may result in division of peripheral nerves either completely or partially. Such nerve divisions are suitably treated by "primary" suture under satisfactory operating conditions. (If such conditions do not obtain, a "secondary" suture is performed three to six weeks after injury).

Nerve and Tissue Injuries.—High velocity missiles produce injuries to nerves surrounding tissue. This is best managed by "debridement" of the soft tissue and approximation of the nerve ends, if divided, by means of a single "sling" suture. The wound is allowed to remain open, covered with petrolatum gauze, the patient evacuated for further care. (A "secondary closure" of the wound is then performed within ten days after injury. Three to six weeks later a "secondary" nerve suture is then made. Within this period the devitalized portion of the nerve becomes demarcated and the epineurium is thickened, permitting more secure suturing). In both primary and secondary nerve suture the affected part is splinted until wound healing occurs.

Infection.—In infected cases it is preferable to treat infection and perform neurorrhaphy six weeks after the wound has completely healed.

Surgical Treatment.—Definitive surgical treatment of the interrupted nerve employs those measures which produce the ideal environment for axonal growth both internally (within the nerve sheath) and externally, including the following:

1. Silk or fine tantalum wire may be used for approximation.

2. The approximation is made without undue tension.

3. By means of long incisions adequate exposure of the nerve permits freeing of the trunk in order to overcome gaps due to loss of substance.

4. The details of surgical technique follow accepted neurosurgical principles. Operation is usually performed under local or general anesthesia with complete equipment which includes an electrical stimulator.

Physiologic Interruption.—The function of a peripheral nerve may be disturbed by "closed" injuries including a blunt force and the contusion or stretching associated with fracture and/or dislocation of a bone of an extremity. High velocity missiles may produce a molecular dissolution of the nerve fibers without actual contact. A neuroma in continuity or extrinsic nerve scarring and callus inclusion may slowly interrupt the transmission of impulses. Treatment requires careful observation of the patient's disability to determine the presence or absence of improvements in sudomotor, sensory or motor function by individuals expert in this field.

JMSMS

MANAGEMENT OF CHEST INJURIES FROM ATOMIC BOMBING

(Continued from Page 330)

chest in which the diaphragm may be involved likewise require immediate and definitive care. Superficial wounds of the chest wall should be debrided and, in contradistinction to other wounds, should be primarily closed.

In the main, therefore, the immediate treatment of the chest wound should involve such measures as are necessary to restore the patient's pulmonary physiology to as near a normal state as possible. If shock is present, blood or blood substitutes should be given. The large majority of chest injuries should be treated by these means in the forward area, and they should then be transported as soon as possible to a rear area where proper study and definitive care can be administered.

Resuscitation and Anesthesia

By Ferdinand E. Greifenstein, M.D.

Detroit, Michigan

IN THE SUCCESSFUL management of the wounded individual, the maintenance of adequate respiratory effort is of first importance. Not only should the efficiency of the mechanics of respiration be maintained but, in addition, preservation of a patent airway is absolutely essential for adequate ventilation.

Obstruction of the air passages in the unconscious patient may occur for a variety of reasons: (1) the dropping backward of the tongue into the hypopharynx; (2) collapse of the supporting soft tissues of the neck; (3) collection of blood or mucus in the pharynx or tracheobronchial tree; (4) the presence of foreign bodies at any level in the tracheobronchial tree.

These factors may result in inadequate amounts of air reaching the lungs despite the fact that the patient is making strong efforts to breathe.

Respiratory obstruction may be manifest in several ways. The individual may not be breathing at all and no movement of the chest detectable. Short, gasping types of respiration, often accompanied by a jerking movement of the head and neck, are frequently indicative of obstruction. Strenuous use of the accessory muscles of respiration, indicated by a short jerky type of breathing, uneven descent of the diaphragm and contraction of the muscles of the neck, may be seen.

Treatment of Respiratory Obstruction

Placing the subject in the prone position with his head turned to one side and resting on one arm will frequently alleviate the obstruction. This position will assist also in draining blood and mucus out of the subject's mouth and pharynx.

The tongue should be brought forward. This is easily accomplished by grasping the tongue with the thumb and forefinger and actually pulling it forward. Because the surface of the tongue is usually well lubricated, it helps to use a piece of gauze or cloth to prevent the tongue from slipping out of one's grasp.

If for any reason it is inadvisable to turn the patient in the prone position, the respiratory obstruction may often be relieved with the subject in the supine position by lifting the chin and extending the head. It may be necessary to lift the jaw forward by lifting at the angle of the jaw and tilting the subject's head backward and bringing the chin upward and forward. The tongue should be lifted forward out of the mouth as previously described.

The aspiration of blood or mucus from the mouth or pharynx may be accomplished with the use of an ordinary soft rubber ear syringe. Repeated aspiration may be necessary.

Foreign bodies, such as broken teeth, may be removed by opening the mouth and extracting the foreign body with the fingers. A small block of wood or a rolled gauze or cloth should be placed between the teeth far back in the patient's mouth to prevent closing of the jaws over the operator's fingers.

Artificial Respiration

After the patency of the airway has been established, if the subject is in need of artificial respiration, the *back pressure-arm lift method* should be used.

The subject is placed prone, elbows bent, arms overhead with one hand upon the other. The cheek is placed on the hand, the face turned slightly to one side. The operator kneels on one knee at the head of the subject and puts the foot of the opposite leg near the elbow. He places his hands on the subject's back, in such a way that the thumbs just touch, the heels of the hands being just below a line running between the armpits. He rocks slowly forward, elbows straight, until his arms are approximately vertical, exerting steady pressure upon the chest. Then he commences to rock backward slowly and slides his hands to the subject's arms just above the elbows. He raises the arms until resistance and tension are felt at the subject's shoulders. Then he drops the arms. This completes a full cycle. The cycles are repeated 12 times per minute, the expansion and compression phases being of equal length, the release periods being of minimum duration. A standard technique for administering the method is being prepared by a committee representing many organizations.

Alternate Methods

1. Hip lift-prone pressure method: The subject is placed in the prone position and the hips lifted and lowered. When the hips are lowered, pressure is exerted on the lower part of the thorax (at the

lower ribs) to aid in expulsion of air. Raising of the hips 3 to 4 inches causes active inspiration because of descent of the inert diaphragm and hyperextension of the spine. The hips are raised and lowered approximately fifteen times per minute. A piece of cloth, shirt, or belt may be passed beneath the hips to facilitate lifting.

2. The hip roll method may be used to reduce fatigue on the part of the operator. In this maneuver the subject is grasped at the distant hip and "rolled" onto the rescuer's knee. This also can be combined with the prone pressure method.

3. If the patient cannot be placed in the prone position, artificial respiration may be administered by grasping the arms at the elbows, extending them over the patient's head, then bringing the arms down over the chest and pressing them against the chest wall.

Specific Procedures

1. Conserve body heat of the wounded man who has been chilled, by the judicious use of blankets or other available covering. It is important that adequate blanketing be placed underneath, as well as above, the individual. Heat should not be added until blood transfusion is in actual progress.

2. Administration of fluid or any other material by mouth is to be avoided, at least until the final diagnosis and disposition are made.

3. Treat pain with morphine (1/6 grain or 10 mg.) if the pain is severe. Do not give morphine to patients with severe head wounds, who are not breathing, or whose respiration is shallow. Do *not* assume that all seriously wounded need morphine. The drug is best administered intravenously, given slowly and well diluted. When injection is impossible (no syringe), morphine gr. ¼ may be held under the tongue until it is dissolved. No patient should receive more than ¼ grain of morphine.

4. Plasma or a satisfactory plasma substitute should be administered if the blood pressure is at critically low levels, and pulse fast and weak. The plasma should be reserved for the critically injured patient. Plasma should be given only to the extent of maintaining the systolic blood pressure at a level of 85 mm. of mercury.

5. Extreme care should be observed in positioning the patient and in making him comfortable. Sudden shift in position may prove deleterious to the patient's circulation and respiration,

(Continued on Page 340)

Emergency Treatment of Genito-Urinary Tract Injury

By George E. Chittenden, M.D.

Detroit, Michigan

Blast

Compression—associated with other intra-abdominal or intrathoracic injuries.

I. Kidneys.
 1. Symptoms—related to associated injuries.
 (a) Anuria.
 (b) Oliguria.
 (c) Hemorrhage.
 2. Immediate Treatment:
 (a) Supportive.
 (b) Plasma—whole blood.
 (c) Antibiotics.

II. Bladder. Rupture of distended bladder.
 1. Symptoms.
 (a) Suprapubic pain and distension.
 (b) Abdominal rigidity.
 (c) Possible bloody urine.
 (d) Difficulty or inability to void.
 2. Associated injury—fracture of pelvis.
 3. Immediate Treatment:
 (a) Supportive.
 (b) Plasma—whole blood.
 (c) Antibiotics.
 (d) Indwelling catheter.
 (e) Trocar suprapubic if unable to catheterize.

Trauma

I. Kidney—(1) High velocity fragments (puncture). (2) Rupture.
 1. Symptoms.
 (a) Pain in flank and upper abdomen.
 2. Findings.
 (a) Shock.
 (b) Mass in flank and abdomen.
 (c) Muscle spasm and rigidity in flank and abdomen.
 (d) Hematuria.

 Findings may vary depending upon other visceral injuries.
 3. Immediate Treatment:
 (a) Supportive.
 (b) Plasma—whole blood.
 (c) Morphine.

II. Ureteral—Puncture or rupture from high velocity fragments.
 1. Diagnosis will probably not be made but should be suspected if puncture of abdomen takes place along course of ureter.
 2. Immediate Treatment:
 (a) Treatment of other visceral injuries are more important.

III. Bladder—(1) High velocity fragments (puncture). (2) Rupture.
1. Symptoms.
 (a) Pain in suprapubic region.
 (b) Evidence of skin wound if (1).
2. Findings.
 (a) Pain in suprapubic region and inguinal region.
 (b) Distension.
 (c) Lower abdominal muscle spasm or rigidity.
 (d) Hematuria.
3. Immediate Treatment:
 (a) Supportive.
 (b) Plasma—whole blood.
 (c) Morphine.
 (d) Antibiotics.
 (e) Indwelling catheter.

IV. Urethra—(1) High velocity fragments. (2) Rupture (partial or complete).

High velocity fragments may (a) puncture urethra and corpora cavernosum; (b) produce external trauma.
1. Symptoms.
 (a) Pain.
2. Findings.
 (a) Hemorrhage.
 (b) External wounds.
 (c) Shock.
3. Immediate Treatment:
 (a) Control of hemorrhage by pressure dressings.
 (b) Plasma—whole blood.
 (c) Antibiotics.
 (d) Morphine.

Rupture.

(Partial)
1. Symptoms.
 (a) Pain (urethra, perineum).
2. Findings.
 (a) Hematuria.
 (b) Subcutaneous hemorrhage.
3. Immediate Treatment:
 (a) Indwelling catheter.
 (b) Plasma—whole blood.
 (c) Antibiotics.
 (d) Morphine.

(Complete)
1. Symptoms.
 (a) Pain (urethra, perineum, supra-region).
 (b) Oozing of blood from penis.
 (c) Inability to void.
 (d) Shock.
2. Findings.
 (a) Subcutaneous hemorrhage, especially of the perineum, scrotum and inner surface of thighs.
 (b) Bladder distended.
 (c) Suprapubic pain.
 (d) Abdominal muscle spasm and rigidity.
3. Immediate Treatment:
 (a) Catheterization if possible. If not, suprapubic trocar or puncture with spinal needle under local anesthetic.
 (b) Plasma—whole blood.
 (c) Antibiotics.
 (d) Morphine.

V. External Genitalia (scrotum and contents)—All degrees of trauma: minor—major.
1. Symptoms.
 (a) Pain.
 (b) Hemorrhage.
 (c) Shock.
2. Findings.
 (a) According to severity of injury.
3. Immediate Treatment:
 (a) Control of hemorrhage.
 (b) Ligation of bleeding points.
 (c) Pressure dressings.
 (d) Plasma—whole blood.
 (e) Antibiotics.
 (f) Morphine.

VI. Spinal Injuries with Paralysis—Care of bladder important.
1. Symptoms.
 (a) Paralysis of lower extremities.
2. Findings.
 (a) Paralysis (according to spinal level).
 (b) Distended bladder.
3. Immediate Treatment:
 (a) Indwelling catheter.
 (b) Suprapubic trocar.
 (c) Plasma—whole blood.
 (d) Antibiotics.
 (e) Morphine.

Techniques of Immediate Treatment

I. Always record:
1. Name and address.
2. Date and time of injury.
3. Location of injury—extent of injury.
4. Treatment:
 (a) Amount of blood, plasma.
 (b) Antibiotics.
 (c) Morphine.

II. Priority of evacuation:
1. Immediate hospitalization.
 (a) Rupture or puncture of kidney.
 (b) Rupture or puncture of bladder.
 (c) Complete rupture of urethra.
 (d) Spinal injury.
2. Hospitalization as soon as possible.
 (a) Suspected rupture of viscus.
 (b) Blast injuries.
 (c) Partial rupture of urethra.
3. Hospitalization when convenient.
 (a) Injuries to genitalia.
4. Ambulatory.
 (a) Superficial injuries.

III. Cleansing of wounds.
1. Soap and water.
2. Sterile dressings.

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Emergency Care of Eye Injuries

By Windsor S. Davies, M.D.
Detroit, Michigan

Chemical Ocular Burns

THE IMMEDIATE first aid treatment of chemical ocular burns is of paramount importance. The most effective treatment is water, water and MORE WATER. This may be accomplished by placing the patient on his back and thoroughly irrigating his eyes with water, lifting the lids so that irrigation may reach as far thereunder as possible. Another method is to immerse the head far enough into a pail of water so that the eyes may be opened and closed under water and thus cleanse them of the irritant. One may also have the patient use the cup of the hands to flush water into the eye. The eyeball and conjunctival sac should then be carefully investigated, searching for chemical irritants which may be imbedded and which should be removed. Acid burns usually show an immediate and sharp demarcation as to their extent. Alkali burns, on the contrary, may cause continued destruction.

Neutralization of severe burns by the use of acids in the case of alkali burns and of alkalis in the case of acid burns has proven to be unwarranted and should not be considered in the treatment of chemical burns of the eyeball.

Following the emergency irrigation and inspection of the eye, the injured person should then be transported to a station where the eyeball can be anesthetized with 0.5 per cent pontocaine or similar ocular anesthesia, and then again be irrigated copiously with normal saline or water for five or ten minutes. At this time the eye should again be inspected for the presence of particles which may be retained from the chemical burn which may continue the irritation. The extent of the corneal burn may be determined by the installation of 2 per cent buffered fluorescein solution. The damage is then shown by the presence of a greenish stain of the corneal, scleral or/and conjunctival tissue.

The conjunctival sac may then be filled with ophthalmic hydrosulphasol, using an eye dropper and handling the eyeball very carefully. A pressure bandage is then lightly applied to both eyes, and the care of the burn should be continued under the direction of an ophthalmologist.

Arsenical burns such as may be caused by Lewisite can be decontaminated specifically by an installation of 5 per cent BAL "dimercaprol" which may be either in the form of an ointment or in an ethylene glycol solution.

Chemical burns of the eyelids should similarly be irrigated copiously with water or saline, flushing well to remove foreign material and particularly to remove particles of the offending material.

Foreign Bodies

Ocular foreign bodies may lie free on the surface of the eyeball, may be in the cul-de-sacs or may be imbedded in the cornea, sclera or conjunctiva.

Loose foreign bodies may oftentimes be removed by irrigation. If not, a cotton-tipped applicator moistened with sterile water or normal saline is useful in their removal. The foreign body is best located by having adequate illumination and by proper eversion of the eyelids when the search is made. Care must be taken in manipulating the eyelids and eyeball in search of such a foreign body to be sure the eyeball itself is not lacerated, because such manipulation may result in extrusion of the ocular contents by the pressure applied.

Imbedded corneal foreign bodies are best removed following the installation of 0.5 per cent pontocaine. These foreign bodies are oftentimes readily removed with the aid of a cotton-tipped applicator. If the foreign body is more deeply imbedded, this may necessitate the use of a foreign-body spud to carefully remove the particle. When the imbedded foreign body is located in the visual axis of the cornea, care must be exercised to avoid excessive trauma to the corneal tissue because of the subsequent scar tissue proliferation which may result in visual loss. Following the removal of a loose foreign body, no pad is required. When an imbedded corneal foreign body is removed, it is possibly better to apply a dressing to the eyeball to keep the lids closed until the corneal wound is healed. The use of local antibiotic ointments following the removal of the foreign body may be indicated.

Where there is difficulty in locating or removing a foreign body, whether loose or imbedded either due to lack of time, poor illumination, lack of instruments, et cetera, it is best to place a pad on the closed eyelids and permit the foreign body to be removed at a station where facilities are available for this purpose.

Lacerations

Lacerations of the eyelids should be washed with soap and water and debrided. Sterile dressings may then be applied with moderate pressure so that the patient may be transported to a location where closure of the lid lacerations may be done adequately. Proper closure of these lacerations is important, especially where the lid margin has been lacerated in order to avoid disfigurement and oftentimes subsequent reconstructive surgery.

Where the injury results in exposure of the cornea, it is most important to protect the cornea from drying by the copious application of a lubricant or a mild ophthalmic ointment. Protective dressings are not indicated in these cases due to the possibility of trauma to the cornea from the bandage that is applied. It is most important to keep the exposed cornea well lubricated until surgical repair of the lids may be made to protect the exposed eyeball. Where inspection reveals that the sclera or cornea has been lacerated, a sterile binocular dressing should be applied, no irrigation should be attempted and the patient transported by litter to the station or the hospital where facilities are available under experienced personnel to properly evaluate the severity of the wound and provide subsquent treatment. An important early treatment of penetrating ocular wounds is the administration of tetanus antitoxin.

A common ocular injury from flying debris is the presence of an intraocular foreign body. This possibility should always be suspected where eye trauma has occurred. Such patients should have both eyes bandaged and be transported to a station where facilities are available for further eye care.

Orbital Rim Fractures

In injuries about the head and face, especially where marked edema around the eye has occurred, one should keep in mind the possibility of facture of the orbital rim. Palpation about the orbital rim should be made early to ascertain, if possible, if there is displacement. If displacement is suspected, further studies by x-ray should be made early so that operative replacement may be accomplished. Many of these deformities are not discovered until all edema has subsided when reconstruction presents a much more difficult problem.

Atomic Explosions—Special Problems

The immediate damage to the eyes in atomic explosions is in great part the result of blast and concussion. Ocular burns are common. Temporary blindness may result. Temporary dazzling has been noted.

In actinic or flash conjunctivitis the symptoms of acute pain, photophobia, inflammation and swelling of the bulbar conjunctiva and lids and epiphora occur from four to twelve hours after exposure. The involvement is usually bilateral. The acute discomfort lasts usually for fifteen to twenty hours. Treatment for this is the installation in each eye of 0.5 pontocaine, not cocaine, several drops usually being required to give relief. This may be followed by a drop of 1:1000 adrenalin. Ice compresses give considerable relief from pain, and sedation may be prescribed.

Except in case of chemical burns where copious irrigation is of immediate necessity, and exposure of the cornea where constant lubrication is required to avoid drying, when in doubt about ocular injuries, bandage both eyes with a light pressure bandage and direct the patient to a station where care may be given by one experienced in the treatment of ocular injuries.

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SHOCK AND HEMORRHAGE

(Continued from Page 314)

Hemorrhage has already been discussed as a part of the shock picture, recognizing that though hemorrhagic shock and traumatic shock are not physiologically identical they are so closely related that for all practical purposes they may be considered together. The treatment of hemorrhagic shock is, first, control of hemorrhage, and second, the treatment of all shock as outlined above. Loss of blood demands blood replacement, and there is no substitute for blood. As a general rule, patients who have lost large amounts of blood can adequately handle large amounts of blood replacement. The danger of elevating the blood pressure and starting bleeding over again, which has been so much emphasized in some writings, is probably far less than the danger to the patient of continued acute anemia and the anoxia which is a part of that picture.

Ear, Nose and Throat Emergency Treatment

By James E. Croushore, M.D.

Detroit, Michigan

Respiratory Obstruction

RESPIRATORY obstruction may result from injuries to the larynx and upper trachea and from maxillo-facial wounds. Injury may be crushing in the type of lacerations from flying objects. In maxillo-facial wounds the tongue may fall back into the pharynx and must be pulled forward. If patient is unconscious, a large safety pin can be fastened in tip of tongue affording an easy anchor to grasp. An anesthetists air-way may be useful.

Fractures of the larynx resulting in acute edema or hematoma may cause obstruction in a few moments. If intubation tube is not available, tracheotomy is indicated. If a tracheotomy tube is not available, a fairly firm rubber tube, about 2.5 inches long, may temporarily be sutured in the tracheotomy incision.

Acute laryngeal obstruction may result from inhalation of hot air. (Look for singeing of hair in the nasal vestibule.) Hoarseness in burns is of great importance in determination of need for constant observation with a possibility of tracheotomy in mind. Such patients are safer and more comfortable in a semi-recumbent position, not lying flat.

Symptoms Indicating Need of Tracheotomy.—Cyanosis, retraction of suprasternal and supraclavicular areas, retraction of intercostal spaces, hoarseness or aphonia, restlessness, anxiety and possibly "struggling for air." Pulse rapid, at first somewhat full, later becoming weak. Remove all foreign bodies in mouth: false teeth, chewing gum, food, vomitus, blood and any other debris found. If obstruction is not relieved by these measures, do a tracheotomy.

Avoid heavy sedation in respiratory obstruction.

Nose

Fractures of nose may cause severe nasal hemorrhage. Nasal packing is best emergency measure in reducing or stopping blood flow. Vaseline packs are superior to dry packs. Oxycel and other local coagulants may be used. Immediate reduction of nasal and facial fractures is not necessary in emergency situations.

Fracture through cribriform plate may cause cerebrospinal fluid to escape from the nose. Under these circumstances there is great danger of meningitis if nose is packed.

Ears

Fractures through base of skull involving the temporal bone may result in hemorrhage and flow of cerebrospinal fluid from external auditory canal. Do not irrigate or make any attempt to clean out the canal for at least three days.

Lacerations of auricle usually do not require emergency repair. When debridement is done, be conservative to avoid disfigurement. Approximate by suturing skin only; do not pass suture through cartilage.

RESUSCITATION AND ANESTHESIA

(Continued from Page 336)

as well as aggravate already existing injuries (see fractures and tourniquets).

Anesthesia

Patients requiring anesthesia and operation should be evacuated to the hospital promptly.

Small lacerations, debridements prior to dressing and evacuation may be done under local or infiltration anesthesia with 1 per cent procaine.

Blocks, such as brachial, et cetera, are extremely unsatisfactory in advance stations because of the time factor frequently involved in obtaining satisfactory anesthesia by these methods and because of the technical difficulties involved.

GENITO-URINARY TRACT INJURY

(Continued from Page 337)

IV. Indwelling catheters.
 1. Preferably Foley No. 14 or 16, 5 cc. bulb.

V. Suprapubic puncture.
 1. Shave area immediately above symphysis.
 2. Soap and water.
 3. Skin antiseptic.
 4. 3 to 5 cc. 2 per cent procaine ¾ to 1 inch above symphysis.
 5. Insert trocar or spinal puncture needle with point of needle directed slightly towards umbilicus.
 6. Aspirate with syringe (50 cc.).

VI. Antibiotic of choice.
 1. Penicillin S-R, 400,000 units.
 2. Streptomycin, 1.0 gm.

VII. Morphine, gr ¼, or Demerol, 100 mg.

Acute Radiation Injury

By Lawrence Berman, M.D., A. Hazen Price, M.D., and Louis D. Stern, M.D.

Detroit, Michigan

WHEN AN ATOMIC bomb explodes, injury to civilians results in three ways: (1) The *intensive blast* produces serious trauma, including concussion, bruises, and fractures either directly or by falling debris. (2) *Burns* result from the direct action of radiant energy (flash burns) or from burning clothing (flame burns). (3) *Acute radiation injury* results from the exposure of the whole or major portion of the body to the initial nuclear radiation of an atomic explosion. This consists of gamma rays and neutrons, 98 per cent of which are emitted during the first minute after the explosion. This type of radiation injury should be clearly distinguished from irradiation sickness, the symptom complex resulting from therapeutic irradiation in the treatment of disease. In this condition, the number of roentgen units is carefully controlled and the adjacent tissue amply protected.

From data collected following the Japanese bombing, as well as from observations made in subsequent explosions, it can be concluded that the syndrome of radiation injury may result from any sort of atomic explosion, e.g., either an air burst, surface burst, or underwater burst. Those persons who are in the open, unshielded by natural objects, will constitute the most exposed group. Those protected by natural objects or buildings of concrete, brick, or metal, will be less exposed, and those in tunnel caves or air raid shelters, the least affected. Those persons in close proximity to the blast will be killed immediately. Those a mile or so from the source of radiation will receive very little, if any, radiation effects. It should be noted that large numbers of those persons with radiation injury will also have burns of varying degree as well as blast injuries. This will of course make evaluation of subjective symptoms difficult.

The severity of the clinical picture of persons affected by radiation injury is mainly dependent therefore upon the distance they happened to be from the site of explosion and the type of intervening protection.

The one symptom which is believed to be the best presumptive evidence of radiation effect is vomiting. It occurs within two hours of exposure and is so constant in occurrence that it should be a valuable aid in screening those exposed and those unaffected. Many persons will vomit for psychologic reasons, but when a large amount of data was collected in Japan, the relationship of this symptom to real injury was indisputable. If it lasted only a few hours, it could be concluded the injury would prove to be very mild or at least moderate. If it lasted twenty-four to forty-eight hours, the cases were considered severe, and if it continued for several days, very severe and usually fatal injury had occurred. The clinical symptoms and findings are characterized mainly by hemorrhage, infection, anemia, and malnutrition.

TABLE I

Mild to Moderate Injury 100r-300r units	*Severe Injury* 300r-400r units	*Very Severe Injury* 600r or more units
Vomiting for *1-2 hrs.*	Vomiting for *1-2 days.*	Vomiting for *several days.*
Then, after *two to four weeks:*	Then, after *one to three weeks:*	Then, after *two to three days:*
possible epilation	epilation	diarrhea
sore throat	malaise	sore mouth and throat
malaise	sore mouth and throat	fever—coma
diarrhea	diarrhea and vomiting	emaciation
purpura	pallor-purpura	
100% *recovery* unless complicated by poor previous health or superimposed injury or infection.	bleeding	
	emaciation	
	Death in 50% cases from hemorrhage and sepsis.	Death in 100% cases within 14 days

Clinical Picture of Radiation Injury

The data to follow is that derived from an analysis of the report on the bombings in Japan, as well as from the experimental work done on animals having received a comparable dose of x-ray.

Causes of Pathological Findings.—The clinical manifestations are related to injury of various tissues concerned with the formation of blood cells and antibodies, and the maintenance of an intact vascular system. The order of radiosensitivity of the more common tissues is:

1. Lymphoid tissue and bone marrow.
2. Epithelial cells.
3. Endothelial cells of blood vessels.
4. Connective tissue cells.
5. Nerve cells.

Hematologic Manifestations.—The principal signs of irradiation damage to cells of blood-forming and blood-vascular tissues are:

1. Degenerative morphologic changes in lymphocytes (pyknosis, karyorrhexis, vacuolization) in tissues and blood.

2. Decrease of lymphocytes in blood.
3. Swelling and ulceration of lymphoid tissues, followed by atrophy.
4. Decrease of granulocytes in blood.
5. Decrease of platelets in blood.
6. Anemia.
7. Atrophy of bone marrow.
8. Prolonged coagulation time.

Disturbances in Hemostatic Mechanism.—The hemostatic mechanism is more complicated than can be explained on the basis of current knowledge, and the damages produced by total body x-irradiation are so far reaching that most, if not all, of the clotting mechanism may be directly or indirectly involved. In addition, there is evidence of widespread vascular damage about which little is known. Since the normal hemostatic mechanism is not well understood and the effects of x-irradiation are only partly known, rational and complete treatment of irradiation hemorrhage cannot yet be firmly established. However, certain factors in the pathogenesis of the syndrome are established and limited therapeutic aid is available.

Irradiation hemorrhage was said to be the most frequent cause of death in those who died from irradiation injury in Japan. As our information has been extended, there is cause to question the validity of this conclusion. In dogs subjected to total body x-irradiation in the lethal range, hemorrhage is generally the most obvious gross finding, but it is doubtful that it is often a primary cause of death. Nevertheless, hemorrhage is an important factor in the morbidity if not in the mortality of animals so exposed.

In dogs exposed to 450r total body x-ray, the extent to which irradiation hemorrhage develops may vary considerably. The organs most frequently demonstrating hemorrhage are organs of motion, the heart, lungs, and gastrointestinal tract. There is also hemorrhage in the lymph nodes, and bleeding about the teeth is also a frequent finding. The following changes in the hemostatic mechanism have been described for these animals: (1) thrombocytopenia, (2) an increased concentration of fibrinogen, (3) a prolongation of the whole blood clotting time, (4) the occasional demonstration of a circulating anticoagulant, and (5) petechial hemorrhages and ecchymoses. To summarize, it is beyond doubt that the evidence pointing to increased clotting time after irradiation is not attributable to chance alone.

Factors Affecting Prognosis.—The severity and speed of development of the various pathological phenomena and clinical manifestations depend on:

1. Dosage of ionizing radiation.
2. Individual susceptibility (including pre-existing disease of the hematopoietic tissues).

Scope of the Problem of Medical Management.—On the basis of the experience of the atomic explosions in Japan, it is estimated that about 15 to 20 per cent of the surviving casualties of an atomic bombing will suffer chiefly from radiation sickness. The majority of these do not require medical attention. However, attempts to estimate the number of casualties to be expected in the Detroit area must take into account the differences in the types of buildings, amount of protection offered by shielding, density of population peculiar to this area, and the facts that the Japanese populations received no prior warning and were subjected to the activity of bombs which are already obsolete.

Diagnosis.—Very characteristic changes take place in the peripheral blood, as listed previously. It is to be expected that in the event of an atomic bomb attack, there will develop a severe acute shortage of technical personnel for making blood counts and associated studies. Therefore, the recognition of radiation injury would perforce be based, to a great extent, on the clinical findings, and probable dosage of ionizing radiation, estimated, in part, on an approximate knowledge of the distances of victims from the center of the explosion.

Where technical facilities are available, blood studies should be as complete as possible, both for determining prognosis, which is of importance in selection of therapeutic measures, and for the purpose of gathering valuable information which would lead to improvement in medical management. Greatest emphasis should be placed on leukocyte and platelet counts because changes in these elements most accurately reflect the severity of exposure; but since leukocyte counts are more directly and conveniently determined than is the case for platelet counts, they should receive the highest priority. The relatively long life span of erythrocytes eliminates red cell counts as reliable early indications of radiation sickness. Because of individual variations of leukocyte levels, complicating sub-clinical infections, inaccuracies inherent to the counting method, especially under emergency con-

ditions, only large variations in leukocyte counts can be regarded as significant (suggested significant levels: less than 1,000 white blood cells per cu. mm.; 1,000 to 5,000 white cells per cu. mm.; over 5,000 white cells per cu. mm.).

Treatment

Present information indicates that when dosages exceed 600 roentgens, there is no specific effective treatment. With dosages of 400 roentgens or less, treatment offers the possibility of saving many lives. The principles of treatment include:

1. Immediate hospitalization to insure complete rest.
2. Wholeblood transfusions, as required.
3. Adequate nourishment, including intravenous feeding when necessary (sugars, proteins, vitamins).
4. Measures to control infection (antibiotics, antitoxins, immune sera, prompt treatment of local infection).
5. Measures to combat the coagulation defect (toluidine blue) (?).
6. Measures to control capillary bleeding (?).

Special Feature of the Medical Problems.—Present knowledge of the effects of specific treatment of the hematopoietic tissue lesions is meager. The following observations on the effectiveness of specific measures for the control of the hematologic aspects of postirradiation sickness are based mainly on experimental evidence.

Factors Related to Hemorrhage:

1. Thrombocytopenia: No substitute for platelets is available. The deficiency cannot be corrected with transfusions.
2. Prothrombin: Not significantly altered after irradiation.
3. Circulating anticoagulants: In some experimental animals, anticoagulants of a heparinoid nature are present. These animals respond partially or completely to administration of toluidine blue intravenously.
4. Capillary hemorrhage: Whole blood transfusions have not been shown to be effective. In some experimental animals, both hemorrhage and clotting time were increased immediately after transfusions. Rutin and vitamin C have a theoretical application, although evidence is lacking as to their effectiveness.

Factors Related to Infection:

1. Leukopenia: No therapeutic agent is at present available for preventing or treating leukopenia.
2. Antibodies: Passive transfer of certain antibodies has not been effective in dogs, although the evidence is conflicting and incomplete at present.
3. Antibiotics: Antibiotics represent the main line of defense against infections secondary to the reduced resistance of the irradiated individual. In dogs, the combination of whole blood and aureomycin is more effective than aureomycin alone.

Factors Related to Anemia:

1. Whole blood: Transfusions of whole blood or red cell suspensions constitute the only effective treatment in patients with anemia secondary to damage of the bone marrow.
2. Hematinics: Supplemental iron, VitaminB_{12}, and folic acid may be useful in patients without severe atrophy of bone marrow.
3. Oxygen: Oxygen therapy may be useful in some cases.

Recommendations

1. Dissemination of information: The widest possible distribution among the medical profession of information regarding the clinical signs of postirradiation sickness is advisable.

2. Segregation of casualties by means of estimated dosages of ionising radiation: Arrangements for personnel and equipment for segregating casualties on the basis of probable degrees of exposure, determined by distance of victims from the center of explosions, should be planned.

3. Diagnostic laboratory procedures: Efforts should be directed toward the development of minimal standardized laboratory procedures requiring the least equipment and personnel.

4. Stockpiling of strategic materials. The stockpile should include:

 (1) Whole blood or red cell suspensions, or facilities for their rapid procurement; 1,000 cc. per day, per patient, for three to four weeks.
 (2) Glass tubes for clot retraction.
 (3) Antibiotics.
 (4) Antitoxins, antisera.

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Blood Clotting Mechanisms and Acute Radiation Injuries

By Walter H. Seegers, Ph.D.

Detroit, Michigan

FROM THE observations of irradiation injuries in Japan, it was believed that hemorrhage was one of the most frequent causes of death. This prompted extensive investigations about the nature of the hemorrhagic disorder. Some of these investigations were on biological materials exposed to atomic radiation itself but, for the most part, it was necessary to resort to the use of x-rays to produce the injury.

The chief investigators of this problem have been J. Garrott Allen of the University of Chicago and Eugene P. Cronkite, Naval Medical Research Institute. Recently, Kenneth M. Brinkhous of the University of North Carolina, Leandro Tocantins of the Jefferson Medical College, Philadelphia, and the associates of C. H. Best of the Department of Physiology, University of Toronto, have reported an experimental work concerned with radiation injury. These investigators recently reviewed part of their work at the Josiah Macy, Jr., Conference on Blood Coagulation and Allied Problems, New York City, January 21 and 22, 1952. My interpretation of their views is given below.

During one period of the investigation, it was found that heparin or a heparin-like substance appears in the plasma in abnormally high concentration. It was possible to give the animal toluidine blue, which combines directly with heparin to neutralize its action, and improve the clotting potential of the blood sample. This seemed to suggest that the radiation causes the release of heparin, presumably from the mast cells located in the walls of the blood vessels themselves. But, heparin may also be released as the result of other stimuli, as, for instance, in shock caused by the experimental injection of peptone or anaphylactic shock. It was recalled that the radiated animals were given blood transfusions to keep them alive. This leaves the possible interpretation that incompatible blood caused shock reactions and the release of heparin. So, it may be that heparin or heparin-like substances found in the blood of irradiated animals were there as the result of the blood transfusions involving incompatible blood and not as the result of the ionizing radiation. Doctor Best's associates at the University of Toronto have irradiated animals and caused the release of heparin by anaphylactic shock after the radiation injury. The experiment thus shows that radiation leaves the animal in a condition which will still permit the release of heparin. This was an important point to have covered because it might have been found that heparin could not be released by challenging with shock-producing materials after radiation injuries.

The work of Tocantins indicates that the inhibitor found in the blood of irradiated animals is antithromboplastin. This anticoagulant was discovered by him a number of years ago and is a lipid found not only in plasma but also in other biological materials. To test for the presence of this inhibitor, blood is drawn by silicone technique so that it is not mixed with tissue thromboplastin and the platelets do not come in contact with rough or wettable surfaces. Such blood clots very slowly, but if it is diluted with saline, the clotting times are reduced. With the blood from irradiated dogs, dilution with saline must be carried much farther than with the control blood samples. The interpretation is that the lipid inhibitor is present in higher concentration after irradiation.

Doctor Cronkite placed emphasis on the importance of platelets in the hemorrhagic manifestations. He believes they are of major importance. Attempts to transfuse platelets have been made with some success. The technical difficulties encountered, however, make that approach to the problem laborious and time consuming. Measurements of the prothrombin utilization showed that the conversion of prothrombin to thrombin becomes progressively slower as the platelet count diminishes after radiation injuries. In the animals that survive, the prothrombin utilization returns to normal far in advance of the return of the platelet count to normal. It seemed as if only a few platelets were required for restoring the normal activation rate of the prothrombin. The experiments on that point were not extensive, and the interpretation may be that the large young platelet is not exactly the same with respect to clotting factors as the average normal platelet population. The work of this investigator leads him to the view that fresh whole blood should be of great value after atomic radiation injuries.

From the Department of Physiology and Pharmacology, Wayne University College of Medicine.

The comments made herein are based on the interpretation of the views expressed by the investigators cited.

Industrial Medical Services and Civil Defense

By A. F. Lecklider, M.D.
Detroit, Michigan

THE MEDICAL SERVICES of industry constitute an important part of Civil Defense in a city like Detroit, where a large number of industries maintain such services. Doctors associated with industry in Detroit early recognized the fact that the medical services of industry could and should play an important part in the care of the injured among the general population resulting from an atomic bomb attack. Initial steps to formulate a plan of co-operation between industrial medicine and the Civil Defense Plan were taken by a group of doctors in industry in February, 1951. Plans were developed in co-operation with the Wayne County Medical Society, and eventually industrial medical services were integrated into the Medical Care Branch of Civil Defense as the Industrial Medical Aid Section. Medical personnel of the industrial services are given Civil Defense assignments.

In the event of an atomic bombing every available medical facility in the area would be required for the care of the thousands of injured. Existing hospitals may be destroyed. In any case, they would be swamped in a few minutes by the influx of wounded. Emergency organizations, to replace destroyed hospitals and supplement surviving ones, require time for organization, for the assembly of personnel and supplies, and for the preparation of quarters. Any medical facility already in existence becomes, therefore, of inestimable value in the earlier hours of the emergency.

Industry, in the Detroit area particularly, has much to offer. Over 200 industries maintain medical services, many quite large, well staffed and equipped. These facilities are scattered throughout the city, so that some of them would likely survive unless the city were entirely destroyed. Scores of doctors and hundreds of nurses are allied with the industry of the area. The personnel of these medical services is accustomed to the emergency treatment of injured people.

Industry has available auxiliary forces which will be helpful to the operation of emergency medical installations of the size required by such an emergency. Plant protection forces, trained supervision, and numbers of war veterans experienced in the medical branch of the armed services can be assembled at a moment's notice to take part in the handling of large groups of injured people, in the preparation of suitable areas for their care, and even to assist in dressing wounds. These industrial medical services and their staffs serve as the experienced nuclei around which the larger organizations required by the atomic bomb can be gathered.

Each medical service, of course, maintains a stock of supplies. Under the Detroit plan industrial medical services carry a reserve of basic supplies equal to three months' normal usage.

Because they are always staffed, many of them day and night, industrial medical services will be the first medical units, aside from surviving general hospitals, which will be available to care for the injured immediately following an attack. They will instantly swing into action, bringing out reserve supplies and occupying adjacent plant areas such as cafeterias, auditoriums, et cetera, which are immediately cleared for the purpose. Adequate entrances will be set up and preparations made to handle wounded in large numbers. Regular and auxiliary personnel will report to previously assigned posts. Plant rescue teams, already organized among those with first aid training, will assemble.

When the plant itself is not involved in the catastrophe, its medical personnel, supplies, and rescue teams will be made available, wherever needed, through the channels of the zone leader and Medical Care Branch of Civil Defense.

In order to integrate the industrial medical services of Detroit and vicinity into the over-all defense plan, a survey was made of all industry in the Detroit area. Its objective was to determine the size, location, accessibility and personnel of each facility. As a result of this survey, forty-five of the larger services were designated as Casualty Care Stations. About 150 have been designated as first aid posts. Under the medical care plan, a Casualty Care Station receives seriously injured cases brought in by ambulance and rescue teams on litters and extends definitive treatment for shock, hemorrhage and burns. It does emergency surgery on cases requiring immediate intervention to save life. Its patients are eventually evacuated to emer-

Dr. Lecklider is Chief, Industrial Medical Section.

gency hospitals, or to hospitals outside the Detroit area. Medical services were designated as Casualty Care Stations when their facilities were large enough to care for a considerable number of accident cases simultaneously, and when they were staffed by physicians and a number of trained personnel. It is necessary that such facilities have easy access from the street and, also, that they be readily expansible to large size by taking over adjacent areas of the plant. An industrial first aid post cares for ambulatory cases only, and after emergency treatment directs its patients to the rear for further care. First aid posts will fly a Red Cross flag to designate their location.

Under the conditions prevailing after a bombing attack, with thousands of wounded flooding every medical facility, it is certain that additional help of medical personnel and supplies will be required by the industrial facilities after a short period. Under the Detroit medical care plan, such help will be forthcoming through the operations of the zone leaders in control of the emergency medical facilities of the ten zones into which the city has been divided. The zone commander will dispatch necessary personnel from emergency hospitals and Casualty Care Stations assembling in school or other buildings of his zone.

Industrial medicine in Detroit is awake to the problem of medical care after atomic bombing. It has supplied necessary information as to personnel, facilities and supplies. It has accepted assignments. It is stockpiling some basic supplies. Its medical personnel is studying the latest methods in the care of injuries and burns peculiar to atomic bombs. In varying degree, industry has in effect programs for giving first aid training to certain groups of employes; key personnel have been advised of plans for expansion of medical departments and their duties established; plans for quick conversion of vehicles to ambulances have been prepared; some plants have arranged for typing the blood of employes. Its efficiency and final contribution will be measured in large part, however, by the amount of help it receives from management in organizing for sudden expansion, and in having available the services of auxiliary plant personnel, properly informed and instructed in their assignments, when the day comes.

To summarize the contribution which industrial medicine can make to civil defense:

Industrial medicine is already there, on the job;

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Public Health in Civil Defense

By Paul T. Salchow, M.D.
Detroit, Michigan

THE FUNCTIONS of this section are:

1. To organize and maintain adequate defenses against biological warfare or sabotage.
2. To protect the health of the community against communicable diseases in the event of a large-scale disaster.
3. To receive and protect vital records during disaster periods.
4. To plan for the care of pregnant women and newborn infants during a large-scale disaster.

General Principles

The health of a community following an atomic bombing or other major disaster will, to a great extent, depend upon its health before the bombing occurs. It follows then that the well-known proved protective methods of communicable disease control should be intensified in the time available before a disaster occurs.

The serious public health problems will arise several weeks after a bombing. This means that most of the field personnel of the Public Health Branch may be released for casualty care during the period immediately following the bomb drop. It also allows time for the procurement of biologicals, whose stockpiling is not practical, from more distant points.

Section on Biological Defense.—This is an entirely new field in civil defense and can only be done adequately on a national basis. The Detroit area is fortunate in having readily available a large number of highly trained bacteriologists, together with three universities and several biological supply houses. The local branch of the Society of American Bacteriologists has co-operated in organizing this section into thirteen teams, one of whose tasks is to standardize diagnostic tests and adapt them for emergency use. Other special studies will be conducted which will not be published.

Industrial Hygiene Section.—In this area, a number of plants produce or use products which are potentially dangerous. Such plants have been

Dr. Salchow is assistant director, Public Health Branch.

spot-mapped, and field workers will be sent to the area after the incident to evaluate the hazard and recommend measures for the protection of the community.

Communicable Disease Section.—The advisability of immunizing the entire population against certain of the communicable diseases has been carefully considered. However, such a plan is not practical until and unless backed by state or federal authorities, since these agencies will have to arrange for the distribution of antigenic agents. In the meantime, normal immunization programs should be intensified as a civil defense measure. This section also will receive reports of unusual incidence of disease from physicians, industry and others, and conduct epidemiological investigations to determine the possibility of sabotage. After a bombing, diagnostic teams will be assigned to making inspections of people in shelters. Herman Kiefer Hospital or, as an alternate, Maybury Sanatorium facilities will be used for isolation and hospitalization when needed.

Maternal and Child Health Section.—Experience indicates that a large number of pregnant women will go into premature labor following an atomic bombing. It is expected that most of these will be treated as casualties in emergency hospitals, or delivered at shelters or in homes outside the affected area. After the acute phase of a bombing, evacuation of remaining pregnant women should be considered. All living babies will be kept with their mothers insofar as possible.

Laboratory Section.—The immediate need for the personnel of this section will be in blood typing and cross-matching. Intensive training is under way to provide as many persons as possible who are able to do this work accurately. An additional problem, later on, will be the huge number of laboratory and bacteriological examinations for contaminants in food and water, and for communicable disease in patients. Space is planned in the Herman Kiefer Hospital laboratory with several large private laboratories as alternates or additions.

Environmental Sanitation.—This section will be responsible for procuring pure water, safe food, proper waste and sewage disposal, and insect and rodent control. Such a task will require the combined specialized personnel of the city health department, the county health department, and also from the state. Local teams, which will form the nucleus, have been designated according to function. Possible sources for emergency supplies of water and milk have been surveyed, in great detail, with names and addresses of owners and operators of milk and food processing plants in the area. There will be close co-operation with the Welfare Department in inspection of food and sanitation of shelters after the bombing. Not the least important function of this section will be the dissemination of information through the proper channels to the public regarding safety of food and water supplies, and measures to be taken by individuals for their own safety. This should help to minimize mass hysteria.

ACUTE RADIATION INJURY

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(5) Toluidine blue.

(6) Rutin, vitamin C, vitamin B_{12}, folic acid, iron salts.

(7) Sugars, proteins for intravenous feeding; 2,000 cc. per day, per patient, for three to four weeks.

(8) Equipment for intravenous infusions.

(9) Hematological laboratory equipment (microscopes, slides, hematological pipettes, Wright's stain, counting chambers, et cetera).

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INDUSTRIAL MEDICAL SERVICES

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it is staffed and functioning in 200 locations; it is a going concern. It is widely distributed. It is manned by staffs accustomed to emergencies. It has supplies and facilities. Finally, it is a part of thoroughly organized, closely knit industrial organizations, having the ability and personnel to cope with situations. It is this association with the manufacturing organization of industry which give industrial medicine its greatest potential in atomic disaster.

The Formula Works

By Joseph R. Hainline
Detroit, Michigan

IN THE HEADLINES this morning is a single topic, which already is the subject of discussion among realistic citizens throughout the State of Michigan. It is the Formula for Freedom—the title of an educational effort on the part of the Michigan State Medical Society. And it means just what it says. The medical men, alarmed at the threat of the loss of freedom in their own profession and confronted with the accomplished loss of freedom in others, have dedicated their efforts to a wider dissemination of the meaning of freedom. In their scientific language, they call it a "formula." But for the layman, it's simply a plan or a program which embraces three vital categories.

The first of these is "know yourself.". . . Before any man can hope to fit himself into his community and his government, he must know where he stands, where his ambition may take him logically, and he must be aware of his own limitations. The Formula for Freedom seeks to reduce that self-evaluation down to a mass science through which the average man can get better to "know himself."

The second category is "know how to live." Psychiatry is, perhaps the most inexact science outside meteorology. But it is making great strides toward one goal—teaching people how to live together—how to adjust themselves to our complicated society.

The medical profession in its Formula for Freedom seeks to aid the individual in this adjustment problem.

The third and last category in the formula is "know your government." And for practical purposes, at least, a knowledge of the processes of government, the pressures at work and how to counteract those pressures by the use of counter-influence, is the most important single function of the Formula for Freedom. That subject I will take up at greater length later. But first we must dwell briefly for purposes of explanation on the two steps which by necessity must precede "knowledge of government."

Read at the Annual County Society Public Relations Conference, Detroit, January 27, 1952.

To begin with, the Michigan State Medical Society has appointed a joint committee with the Michigan Health Council. This group is charged with the preparation of a standard chart which will be called the Periodic Health Appraisal. The chart will be one of four in a series dealing with religious, economic and legal appraisals . . . the other three to be prepared and distributed by the representative professional organizations involved. The four pages will constitute a check-list for the individual to complete. Upon completion it should give the individual a reasonably accurate accounting of himself in those four basic fields of living. It is planned that the four-page leaflet will be made available to the public on as wide a scale as possible. The appraisal is to be kept by the individual and referred to periodically as the need arises, in order that he may better "know himself."

This is just the beginning. Man does not live in his personal thermos bottle. He lives in a big jug with a lot of other people. All those people are—like himself—struggling to climb up the slippery sides of the jug to the top where the air is cleaner and the view is better. In this struggle, some people get hurt. The degree of injury is in direct ratio to the man's overestimation of his own prowess. The injury can be lessened, the struggle made more equitable, if each man can learn to "know himself." Only then can he know where his rightful place in the jug is. That's the second point in the medical society's Formula for Freedom. If a man knows himself, he stands a better chance of knowing how to live with others. The medical society's program in this respect can be especially valuable. Because in America, we've never learned to live with one-another. The incredibly high crime rate is one proof of that fact. We have not learned how to live with each other because until recently it wasn't necessary. The vast expanses of land, which were free for the taking, provided a safety valve for the men who needed elbow room. For instance, even to this day it's not clear whether Daniel Boone regarded himself as an advance agent for civilization or a refugee from it. In any event, his aim was to get away from the people who bothered him. And that was all right in Daniel Boone's day. But it's no longer possible to get away. We've got no place to go. We've reached the point where the British were 500 years ago and where the Japanese were 2,000 years ago. They had no place to go. And over the years, they built-up a code of behavior

which enables them to live with each other in harmony, greater than any place else in the world. The Japanese social code is particularly noteworthy as a long-evolved procedure, through which neighbors, although they may be bitter personal enemies, may live in harmony side by side. The crowded conditions on the island made the development of such a social code absolutely necessary.

Western man—that is, the western hemisphere man—is only now reaching that point of necessity. The medical society has recognized the need for a moral code of restraint which is certainly preferable to a legal code of restraint. The Formula for Freedom is that code, which if pushed to its logical conclusion can head off the trend toward the coward's refuge in government-planned security through coersion.

The Very Reverend William T. Reeves of St. Marks Cathedral in Grand Rapids has paid a high clerical tribute to the medical profession. Said he: The doctor's influence is tremendous. I beg that you use it and not abuse it, because using it depends a great deal on whether or not we shall keep our freedom.

The point which is not being brought home to the average citizen is that when he gains a measure of security, he loses a measure of freedom. The formula is as absolute as the law of supply and demand. Men who are thinkers and not doers have tampered with the law of supply and demand in this country with disastrous results. They are seeking now to tamper with basic freedoms. One of these freedoms is the right to choose or reject the man who will be responsible for an individual's health. These planners make wide use of the phrase "welfare of the common man." I submit that there is no such creature as the "common man." Historically, Americans have refused to admit that, as individuals, they are the same as the fellow next door or the man working the next lathe.

Those of us who value freedom now are engaged in a running battle with those who would destroy it. Historically, this is the second time the battle has been joined. In labor circles the socialist movement reached its peak in 1903. That was when Samuel Gompers stamped it out in the American Federation of Labor. Nationwide, socialism reached its peak in 1920, when Eugene Debs polled nearly a million votes for President from the Atlanta penitentiary. But the movement failed then—as it must fail now—because the workingman refuses to admit that he's a proletarian for life. He reserves for himself the freedom to progress within the bounds of his native talents.

Although Americans need guidance in the art of living together, they are past masters at the art of self-government. And that comes from a deep heritage of necessity. Fredrika Bremer, a German visitor, noted that characteristic of our culture back in 1835. Said she: These people associate as easily as they breathe. The smallest common problem has always produced a spontaneous committee. The west bound wagon trains gathering at Independence automatically organized their own schedules and elected their own leaders. Even before the day of the labor union, mechanics' societies had their own job information service. The "club law" of the squatters was self-enforced against formal law.

So now, in spite of the vastly expanded activities of government, spontaneous associations of citizens still keep alive the self-government habit in all parts of American life. Every year, ten million Americans travel to one or more of some 17,000 national or state conventions. And practically all Americans belong to one or more of the country's 200,000 clubs, societies and organizations. Such activities are the guts of American self-government.

Through these regional clubs, fraternities and societies, Americans learn to "know their government." By and large, Americans know and believe what they are told by responsible leaders. Although the individual may—and often does—reserve for himself the right to accept or reject a statement of fact, he is nevertheless swayed in his judgment by what he hears. And the mental impression he gets about his government *from* his government may be vastly different from what his neighbor or doctor or lawyer believes to be the truth.

In recent years, those of us who are engaged in the reporting of news have discovered a strange and alien philosophy creeping into the federal government. It's a bureaucratic philosophy that they, in their intellectual ignorance, know what's best for the people and intend to see that their own desires are carried out. To accomplish their purposes, they have accumulated in the past fifteen or twenty years, a corps of 45,000 public relations experts. These public relations people spent $74,800,000 of the taxpayers' money last year, according to a report by the Hoover Commission. On

the record, these public relations people are charged with keeping the people, through the press and radio, informed of the activities in their separate agencies. And if that were true, the expenditure of $74,000,000 of the taxpayers' money might be justified. Because it's the right of every citizen to "know his government."

However, in many instances, these hired publicity people must devote themselves to covering-up for their departments or pleading the special cause of their bosses.

For example, on January 14, 1951, the Veterans Administration issued a handout on the appointment of Vice Admiral Joel T. Boone as the administration's chief medical director. A single paragraph far-down in the six-page handout said that Boone succeeded Dr. Paul B. Magnuson, whose resignation previously presented had been accepted.

One enterprising news service dug behind the handout and found out that the well-liked Dr. Magnuson had been fired in a political hassel with Veterans Administrator Carl Gray. Boone, a retired navy doctor, got the job.

It was later revealed that the entire Veterans Administration was under investigation. And a Senate committee vindicated Dr. Magnuson. But the public wouldn't have known that if it depended on government press agents to present the facts.

Back in 1948, a House committee was investigating the administrative branches of the government for evidence of propagandizing. And Chairman Forrest Harness of that committee said on the House floor: "The sole legal and ethical function of a federal information service is to issue factual, objective and studiously unbiased information." He quoted the federal statute to support his statement.

"But," he continued, "the law has been and is being violated repeatedly by numerous administrative agencies. In hundreds of ways, some devious, some blatantly open, federal agencies, officials and employes are ignoring or flaunting this legal safeguard, often for the deliberate purpose of fostering sentiments or support for administrative policy or viewpoint." And Representative Harness continued: "We need only to remember, that if the power of federal propaganda is applied for good and wise purposes on one occasion, it can be applied to another purpose, mischievous and dangerous." And he concluded: "Whether the immediate purpose of government propaganda is good or bad, the fact remains that individual liberty and free institutions cannot long survive when the vast powers of the government can be marshaled against the people to perpetuate a given policy or a particular group of office holders."

And if anyone doubts that some elements of our government are above such practices, let me cite a couple of examples—one of them probably painfully well known to this group. For ten years, six federal agencies have been carrying on an unlawful campaign in behalf of the so-called national health insurance plan, which many choose to call socialized medicine. These agencies are led by the Social Security Administration. Also in on the act are the U. S. Public Health Service, the Children's Bureau, the U. S. Office of Education and the Department of Agriculture. Over the years, these six agencies have released hundreds of pamphlets, booklets and press handouts, all favorable to the program of socialized medicine. Not one pamphlet was issued pointing up the weaknesses of state medicine as practiced by such countries as Russia and Great Britain.

One pamphlet issued by the Public Health Service went so far as to advise the public: "You can write a letter to the readers' column of your local newspaper and tell your editor why the readers of the paper should back the national health insurance bill." That statement and thousands like it on the same subject are, in my opinion, clear violations of Section 201, Title 18, of the United States Code. But nobody protested, and so far as I know, that propaganda continues today.

Another example of government propagandizing involves the ill-starred Brennan Farm Plan. It was a hodge-podge of political hackery, rejected first by Congress and later by such authoritative farm organizations as the National Farm Bureau and the National Grange. But Agriculture Secretary Brennan, whose job it is to carry out the orders of Congress, stumped the country for months trying to take the issue to the people over the heads of their elected lawmakers. He was hooted down wherever he went, but he never admitted defeat, and the Brennan farm subsidy plan at this moment is resting quietly on a shelf from where it will no doubt be brought out again sometime.

And so, it is not enough to know your govern-

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Detroit Physiological Society

Meeting of January 17, 1952

Analysis of Central Nervous System Depression Induced by Hypnotic Drugs

Graham Chen,
Parke, Davis and Company, Detroit

The central nervous system depression of certain hypnotic drugs has been investigated by their antagonistic action toward a central nervous system stimulant (a convulsant). By plotting the CD_{50}s of Metrazol against the corresponding doses of the depressant, three straight lines are obtained for sedation, hypnosis and general anesthesia. The slopes and the intersects of the lines represent the sedative, hypnotic and anesthetic potencies of a hypnotic agent and its minimal hypnotic and anesthetic doses respectively. The depth of the three stages of depression is indicated by its anticonvulsant effect.

A comparison of the sedative, hypnotic and anesthetic effects was made of the following compounds: pentobarbital-sodium, phenobarbital-sodium, barbital-sodium, carbromal, and ethyl alcohol. While the barbiturates are potent hypnotic and anesthetic agents, they are less effective than carbromal in sedation. Ethyl alcohol is a very poor sedative and hypnotic agent.

The joint effect of pentobarbital and phenobarbital and that of pentobarbital and carbromal were also determined. An additive and a synergistic effect were obtained respectively with the former and the latter combinations.

Goiter Prophylaxis with Iodized Salt

Brock E. Brush,
Henry Ford Hospital, Detroit

In 1923 a survey of the school children in four Michigan counties was made by the State Health Department and the State Medical Society. It revealed a 38.6 per cent incidence of goiter in 65,537 students. A close and constant relationship was noted in each instance in that in each county the incidence of goiter was in inverse proportion to the available iodine. In the mining county of Houghton there was no iodine in many areas and the incidence of goiter was 64.4 per cent, while in Midland, an agricultural county, the iodine present was 7.3 parts per billion and the goiter incidence 32.7 per cent.

Following this, iodized salt was advertised extensively. This salt was placed on the market in 1924 through the co-operation of the Michigan Salt Producers Association. Subsequent surveys showed a remarkable decrease in goiter incidence. In 1928 the overall incidence was 9.9 per cent, and in 1951 only a 1.4 per cent incidence. Records indicated that there was a marked decrease in goiter where iodized salt had been used regularly.

The importance of iodine as a food essential must be kept continually in the minds of the people and the medical profession of a goiter area. The minute quantity of iodine has been proven not to cause any deleterious effect and is not detectable when the salt is used for cooking and canning foods.

Projection of Afferent Fibers To the Cerebral Cortex

Ernest Gardner and Benjamin Haddad,
Wayne University, Detroit

Experiments have been carried out on cats under barbiturate anesthesia. This type of anesthetic suppresses spontaneous cortical activity to such an extent that impulses entering the cerebral cortex can be detected as surface positive potential changes. This type of change, following stimulation of various peripheral nerves, has been used as an index of impulses reaching the cortex. Nerves from muscles, joints and skin were stimulated electrically and cerebral cortex explored with recording electrodes. Various incisions were made in the spinal cord in attempts to abolish the evoked activity. The results indicate that for all the nerves studied, there are bilateral pathways in the spinal cord other than the classical route, the dorsal funiculi. Furthermore, it is quite doubtful whether any impulses from muscle afferents ascend in dorsal funiculi. The results are in accord with the work of other investigators on the monkey.

Wayne University College of Medicine

Postgraduate Continuation Courses

March 10-June 7, 1952

These courses are open to all qualified persons. Veterans receiving benefits under the GI Bill should contact Dr. Arthur Johnson, Veterans Administrator at Wayne University, 5524 Cass Avenue.

Registration for these courses should be made in the office of Postgraduate Medical Education at the College of Medicine, 1512 St. Antoine.

ANATOMY

Surgical Anatomy (Last half)	College of Medicine	Tuesday 3-5	$35.00
Selected Readings in Physical Anthropology	College of Medicine	Hour to be arranged	$15.00
Regional Anatomy			
a. Head & Neck	College of Medicine	Friday 1-5	$50.00
b. Thorax, Abdomen and Pelvis	College of Medicine	Thursday 1-5	$50.00
c. Back and Extremities	College of Medicine	Wednesday 1-5	$50.00

(Regional Anatomy open also to graduates of Dentistry)

MICROBIOLOGY

Parasitology and Medical Entomology	College of Medicine (Minimum of 4)	Friday and hours to be arranged	$50.00
Virology	College of Medicine (Minimum of 4)	M. W. F 1-5	$50.00
Bacterial Physiology	College of Medicine (Minimum of 4)	Tu. & Thur. 1-5	$50.00

PHYSIOLOGICAL CHEMISTRY

Nutrition	College of Medicine	M. W. F. 11-12	$35.00
P. Chemistry Seminar	College of Medicine	Weds. 3:30-4:30	$15.00
Physical Biochemistry	College of Medicine	M. W. F. 1-3	$45.00

PATHOLOGY

Neuropathology	College of Medicine	Friday 1-5	$50.00

DERMATOLOGY

Seminar in Dermatology	Receiving Hospital	Weds. 10-11:30	$15.00
Dermopathology Seminar	College of Medicine	Weds. 12-1	$15.00
Conference on V. D.	Social Hygiene Clinic	Thurs. 12:30-2	$15.00

Wayne University Postgraduate Continuation Courses (Continued)

INTERNAL MEDICINE

Medical Conference	Receiving Hospital	Thurs. 11-12	$15.00
Gastroenterology	Receiving Hospital	Sat. 8-9 a.m.	$15.00
Medical X-Ray Conference	Receiving Hospital	Tuesday 11-12	$15.00
Allergy Clinic & Conf.	Receiving Hospital (Minimum of 4)	Tues. 8-11 a.m.	$25.00
Hematology Clinic	Receiving Hospital	Thurs. 2-3	$15.00

SURGERY

Surgery Seminar	College of Medicine	Monday 4-5	$15.00

COMPREHENSIVE UNIT COURSES

Obstetrics	Herman Kiefer Hospital Pavilion 5 (Limit 10)	Weds. 2:30-5	$50.00

OPHTHALMOLOGY

Basic Ophthalmology	College of Medicine (Limit 10)	Full Time (9 months)	$900.00

This class in Ophthalmology will begin in September, 1952. Applications must be in immediately. Applications can be secured from the Postgraduate Department at the College of Medicine, 1512 St. Antoine, Detroit 26, Michigan.

NORTHERN TRI-STATE POSTGRADUATE MEDICAL ASSOCIATION

April 15, 1952

Amphitheater of Engineering Building

University of Notre Dame

South Bend, Indiana

Registration—8:00 A.M.

Morning Session—8:45 A.M.

Greeting—L. G. Erickson, M.D., President of the Saint Joseph County Medical Society. Introduction by James E. McNeel, M.D., President of the Northern Tri-State Medical Association.

Welcome to Notre Dame—Reverend J. J. Cavanaugh, C.S.C., President of the University of Notre Dame.

"Treatment and Management of Burns"—W. H. Steffensen, M.D., Grand Rapids, Michigan.

"The Management of the Arteriosclerotic"—Wm. A. Thomas, M.D., Chicago, Illinois.

"Your Feet and Mine"—Gordon W. Batman, M.D., Indianapolis, Indiana.

"Pathological Conference"—Associates of the South Bend Medical Laboratory, South Bend, Indiana.

Luncheon in Faculty Dining Hall—12:15 P.M.

Speaker—Doctor Clarence Manion, Dean of the School of Law, Notre Dame University—"The Key to Peace."

Afternoon Session—2:00 P.M.

"Angiography." Motion Picture prepared by the Searle Company.

"Mechanism of Loss of Consciousness and its Management." (Head Injuries)—Edgar A. Kahan, M.D., Ann Arbor, Michigan.

"Proctology"—Louis J. Hirschman, M.D., Detroit, Michigan

Business Meeting

Tour—4:15 P.M.

Tour of The Lobund Institute for Research in the Life Sciences under the direction of James A. Reyniers, Director of Lobund at Notre Dame University.

For hotel reservations, contact Joseph J. Lang, M.D., 730 J.M.S. Building, South Bend, Indiana.

Editorial

IT IS LATER THAN YOU THINK

EVERY SENSIBLE American hopes, and most of them pray, that all Civil Defense activities will prove to be a waste of time and energy. *Let not the wish be father to the thought!* For should this bright expectancy be fallacious—should the horrors of the Atom-bomb become a stark reality in this nation, in this state—then these preparations of an alert citizenry will be found to have averted needless deaths, disabilities, and tragedies. Perhaps the Kremlin can foretell which side of the coin will face up.

This issue of THE JOURNAL contains articles dealing with certain medical problems that appertain to Civil Defense. It is about these, the life-saving aspects, that we as doctors of medicine are basically affected, as it is here that we can make our best contribution to society in the event, that awful event, of disaster.

In an adequate Civil Defense program, there is a place for every man, woman, and child to perform some service or make some contribution. Informed authorities agree that every doctor of medicine will be called upon for tremendous, hazardous, and difficult assignments. The duration of this emergency may extend over a considerable interval of time. All elective medical and surgical procedures will be postponed; our hospitals, our services, our supplies will be taxed to the breaking point. The A-bomb does not permit any semblance of "business as usual," especially for physicians and surgeons.

Thus, every doctor of medicine can hardly avoid the responsibility of being, and keeping, informed about all that can be learned so as to equip him to do his best job. Most of the people of the State of Michigan have been conditioned to expect not just good but the best of medical care. Your participation in some form of organization as a medical team or unit in the Civil Defense program will be solicited. Let none be complacent to that degree as to sink his ostrich-like head into the sands of "Unlikely Occurrence."

RALPH A. JOHNSON, M.D.

COMMUNITY ACTIVITIES

IN THE PAST we have invited the attention of our members to the need for physicians to take an active part in community and civic activities. This is especially urgent for several reasons. First and foremost is the fact that physicians are among the best educated and best trained people, and for that reason owe their neighbors the benefit of their counsel and services. Their pre-medical and medical studies have been directed to make them better able to survey and analyze a situation and make proper deductions from the facts found.

In this rapidly changing world, there is no outlined route of procedure or established objectives. The world is getting more social and more socialized every day, and it is the duty of those citizens having the capacity and the knowledge to direct and lead the way. In almost every public gathering, there is some planning for the future or some consideration of what we as a community are trying to accomplish. Helpful suggestions and guidance are always in order, and are likely to be followed.

Many large groups of men and women are active in social thinking. We need only mention a few: the American Legion, the Veterans of Foreign Wars, the Michigan Health Council, the various Women's Clubs, Parent-Teachers Associations and the many business and service clubs. Every one of these has a place for our membership, with our special knowledge and skills, and if we take no part in guiding their thinking we have no right to complain if they come up with the wrong answers. This might happen when matters of especial interest to the medical profession are considered—as they often are.

The American Medical Association *PR Bulletin,* in urging physicians to take their rightful place in the community, pleads with them to exercise leadership in solving local health problems, to work with local health councils, and to help improve existing health facilities. According to a New York physician, a man who serves his community faithfully not only as a doctor but as a citizen will "inevitably convince a thinking populace that physicians are vitally concerned with the public good . . . and that their thoughts on controversial subjects are of distinct import to all."

THE SIXTY-FIVE YEAR PROBLEM

FIFTEEN years ago, when social security legislation first was placed on the books, the country was in the midst of a great depression, such as we had never seen, an effort was made to assure jobs for the young and healthy, as well as to provide security in the old age of the people who were still holding jobs which the younger people wanted. During the growing years of our republic our people worked for their security, scorned a handout, and searched for jobs to support their families. They attempted to provide for the future by saving when and if they could, and a goodly proportion did provide for their declining years, either by savings, investments, insurance, or establishing a business which would carry them through their years of lessened earnings.

During the years of depression, all such earnings and savings were wiped out. People had to cash their resources to supply their maintenance needs. There were no jobs, no industry to speak of, and the largess of the government set a support rate of needed earnings at sixteen dollars a week. If a person could not make that much, he was given a job raking leaves there and back again. Ambitious men wanted better conditions and agitated until the Federal Government adopted social security, providing for retirement at sixty-five, and giving younger people a chance at their jobs.

The allowances of this plan were absolutely inadequate, as everyone found out when a sufficient number of our people were in that retirement bracket. Two objectives were primary in this social legislation: (1) to care for the old retired person, and (2) actually the most activating reason, to create more jobs by putting the aging person out of work. Two things must happen. The allowances must be raised to a semblance of a living, and secondly the "old" person must not spend his life in idleness.

During the first third of this century, when the foundations were being made for our outstandingly marvelous economy, 68 per cent of people over sixty-five were gainfully employed; at the present time that number is only 43 per cent and the percentage of persons over sixty-five is constantly increasing.

Now comes the interest of the medical profession, other than economic. We must prescribe for the aged. Activity of mind and body are essential, if they are to be healthy or happy. Continued inactivity with loss of interest and ambition can only lead to deterioration of mind and body. We recognize that productive work of some amount will maintain alertness and a better prospect of good health. It is probably up to the medical profession to lead a resurgence of providing or promoting suitable work for those who are not wanted in industry.

This is a challenge worthy of our best thought.

OUR SOCIAL SECURITY

INCREASING MILLIONS of our population are coming under the social security laws. Other millions are now beginning to draw benefits, especially because of the amendments made by the last Congress. Outside of the industrial and other employes who are covered, about four and a half million self-employed are eligible. Not included are farm owners, doctors of medicine and other healers in private practice, lawyers, clergymen, dentists, architects, funeral directors, and professional engineers.

Workers who will have been covered for six quarters after January 1, 1951, and who have earned an average of $300.00 per month, will be eligible if sixty-five or over to retire and draw $80.00 per month for the rest of their lives, and the wife if over sixty-five will draw $40.00 per month. The self-employed, if he was wise and enrolled himself, will profit likewise. The worker will have paid into the Social Security "kitty" a total of $81.00 if he became enrolled and eligible during this last eighteen months which began January 1, 1951. Those who have been covered by the plan for years will have paid more. There is, however, a possibility for this extreme case, and there are many such cases—those who were not included until the last amendment, who are now eligible and whose inclusion is mandatory.

In setting up the plan, the Congress proceeded to make sure the beneficiary would leave the work for others, and provided that if he earns as much as fifty dollars a month at an employment covered, he will not be allowed to draw his rightful monies. However, he may earn as much as he likes or can and at any calling if he is past seventy-five. Why was the age set at seventy-five? And why any restrictions at all? If a man is willing to work and help produce to keep up the national economy, he should be allowed to do so without penalty.

The only justification to compel retirement at

sixty-five must have been the inability of such people to do acceptable work. If they can so do, they should be so allowed. We advocate the repeal of this one feature of the law. We know the whole law is vastly socialistic, and we believe very un-American. But we contend there should be permission for these workers to work after sixty-five, if they so desire and still can.

CEREBRAL PALSY

WE HAVE RECEIVED a mass of material from the chairman of the Cerebral Palsy Division of the Crippled Children's Hospital of Waco, Texas, calling attention to the increased interest in cerebral palsy and reporting work done in that hospital. There are an estimated 350,000 cases in the United States. Most of these are hopelessly handicapped. There is no known and recognized treatment. Formerly, these patients were mostly considered as total idiots. Many could not even hold up their heads, and never did more than mumble. Dr. Herbert H. Hipps, of Waco, has been working for ten years teaching these children to accomplish one thing at a time. The ordinary child acquires new powers one at a time—to hold up the head, to sit, to use the hands, to stand, later to walk. He also learns to talk. That is, he does these things if he can, and after long, devoted effort.

It is now known that some palsy children are capable of being taught many things. Talking is often very difficult and acquired with utmost effort, Dr. Hipps does not yet carry these children very far, for he has been working on these cases only six years. However, he is willing to correspond with anyone who wishes his advice.

In the few cases we have known, the problem of domiciliary care has been great. We can testify, however, that with determination and persistent care some of these cases will well repay the effort. We know a boy who learned his few possible activities gradually, finally began to walk at about five, went to the special local schools, was sent with another boy as attendent to private school where he finished the grades, the high school, then went to college and was graduated. He was able to use a typewriter with one finger, and could talk with difficulty. He next studied law, with another year for his Master's degree. When he came to take the bar examination in Michigan, he had special permission to take a typewriter and a stenographer. He passed the first attempt, and is now practicing law.

If any of our members come in contact, as advisors, with one of these apparently hopeless cases, do not give up. The possibilities are amazing.

ON THE RUN . . .

Mongolism rarely appears more than once in a single family.

. . .

Cold moist hands are noted in individuals who are anxious to undertake some kind of activity.

. . .

Female hemophilia is an established entity and may appear when the father is hemophiliac and the mother is a carrier.

. . .

Mitral stenosis, by itself, rarely causes angina.

. . .

Low back pain may occur because of a wish to carry out some action involving the whole body, such as running away.

—Selected by W. S. Reveno

MISCONCEPTIONS ABOUT UTERINE CANCER

(Continued from Page 294)

able to kill such cells that have spread to the surrounding tissues are dangerous to normal tissue; therefore, surgery might stimulate and spread the otherwise "sick" malignant cells. In treatment of cancer of the endometrium, experience shows that surgical treatment alone has resulted in a 50 to 55 per cent five-year salvage. By adding preoperative x-ray and/or intrauterine radium therapy this percentage has been increased to 67 to 90 per cent. Such improved results effectively support the employment of preoperative irradiation.

This worth-while paper of Doctors Scott and Reagan adds emphasis to the efforts of the Cancer Control Committee, MSMS, to secure more careful and complete examinations for cancer, especially cancer of the cervix. The slogan: "Rule out cancer in every diagnosis," is increasingly applicable to the physical examination practices of the present-day physician.

The public is becoming more critical of the physician who does not make the examinations they have been taught to expect. The physician who omits the female pelvis from his physical examination subjects such patients to a needless and dangerous risk and his diagnostic ability to merited criticism.

Annual Session of The Council

January 25-26, 1952, Detroit

HIGHLIGHTS OF THE COUNCIL

- The auditors' report for 1951, and the budgets for 1952 were approved. See pages 366-370.
- Annual Reports of Secretary, Treasurer, Editor and of three Standing Committees of The Council accepted.
- Secretary L. Fernald Foster, M.D., and Editor Wilfrid Haughey, M.D., re-elected. Treasurer A. S. Brunk, M.D., re-elected (deceased February 3, 1952).
- Progress report on Michigan Medical Service presented by R. L. Novy, M.D., Detroit, President.
- Progress report on Michigan Hospital Service presented by Wm. S. McNary, Detroit, Executive Vice President.
- Official report of MSMS Delegates to American Medical Association on Los Angeles Clinical Session (December, 1951) accepted.
- Committee reports presented by: (a) Hospital Relations Committee; (b) Advisory Committee to Michigan Social Welfare Commission; (c) Committee on Improvement of Nursing Services; (d) Legislative Committee; (e) Study Committee on "Little Hoover Commission" Report No. 8 (including statement of positive principles approved by MSMS; (f) Emergency Medical Service Committee; (g) Committee on Uniform Fee Schedule for Governmental Agencies; (h) Mental Hygiene Committee; (i) Periodic Health Appraisal Committee; (j) Preventive Medicine Committee; and (k) Rheumatic Fever Control Committee.
- Monthly reports of President Otto O. Beck, M.D., Birmingham; President-Elect R. J. Hubbell, M.D., Kalamazoo; Secretary L. Fernald Foster, M.D., Bay City; Rheumatic Fever Co-ordinator Leon De Vel, M.D., Grand Rapids; Legal Counsel J. Joseph Herbert, Manistique; and Public Relations Counsel H. W. Brenneman, Lansing, were accepted.
- Annual reports of individual Councilors on condition of profession in their Districts were presented.
- Mutual problems were discussed with Michigan Health Commissioner A. E. Heustis, M.D.
- Problem of over-utilization of hospital services for non-emergency cases, especially patients having Blue Cross-Blue Shield contracts, was presented by M.H.S. Executive Vice President Wm. S. McNary.
- Appeal from a county medical society decision in a matter of ethics was referred to the MSMS Ethics Committee for immediate action.
- Resolution re guest editorials in Bulletin of American Academy of General Practice of Wayne County was adopted.
- Appointments: E. W. Merritt, M.D., of Port Huron to Mediation Committee; R. C. Kingswood, M.D., Detroit, E. C. Long, M.D., Detroit, and R. A. Frary, M.D., Monroe, to the Committee on Television; John M. Wellman, M.D., Lansing, to Liaison Committee with Michigan Medical Service; E. F. Lutz, M.D., Detroit, H. M. Pollard, M.D., Ann Arbor, and O. T. Mallory, Jr., M.D., Ann Ar-

bor, to the Committee on Periodic Health Appraisal; Dean A. C. Furstenberg, M.D., Ann Arbor, and Dean G. H. Scott, Ph.D., Detroit, to the Emergency Medical Service Committee; G. B. Saltonstall, M.D., Charlevoix, as MSMS representative to the American Medical Education Foundation meeting in Chicago, February 17.

- A scroll of commendation to the Hillsdale County Medical Society on the development of its unique and successful cancer detection program was authorized.
- Progress report on Beaumont Memorial Restoration was presented by President Otto O. Beck, M.D., Birmingham; he stated that all MSMS members soon will receive a brochure and a letter from the President urging contributions to this worthy project sponsored by the Michigan medical profession.
- An invitation to the American Medical Association to hold the National Rural Health Conference in Michigan in 1954 was authorized.
- Invitation from Michigan Department of Corrections to make a re-survey of health and hospital facilities in Michigan prisons, as a follow-up to the MSMS-Michigan Hospital Association survey of a decade ago, was presented and approved.
- MSMS representatives to the Conference on Housing and Living Arrangements for Older People, to be held in Ann Arbor, July 24-25-26, 1952, were appointed.
- Otto O. Beck, M.D., Birmingham, R. L. Novy, M.D., Detroit, and H. B. Zemmer, M.D., Lapeer, were nominated for the Board of Trustees of Michigan Hospital Service.
- All county societies were urged to approve the Adult Education Program and to actively participate in it.
- The study of lung cancer, as developed by the American Cancer Society, was approved.
- Artificial insemination. The Council adopted the following motion: "The therapy idea of artificial insemination is an accepted medical procedure. It is up to the individual doctor of medicine or hospital staff as to when and where and if they wish to carry out such a procedure."
- The Council noted, with high commendation to the MSMS membership, that 96 per cent of Michigan's doctors of medicine paid AMA dues during 1951.

SECRETARY'S ANNUAL REPORT—1951

To The Council of the MSMS:

I herewith submit the report of the Secretary for the year 1951.

Membership

The Michigan State Medical Society membership for 1951 showed a total of 5,214 members, including 273 Emeritus and Life members, 39 Retired members and 196 Associate members. The total paid membership was 4,815 with net dues of $94,965.00. The 1951 membership was at the highest peak in the history of the society. The number of members with unpaid dues for 1951 was 84.

Deaths During 1951

Allegan County—J. Howard Van Ness, M.D., Allegan.

Bay, Arenac, Iosco County—Vanny H. Dumond, M.D., Bay City; Nina M. Ely, M.D., Bay City; Virgil L. Tupper, M.D., Bay City.

Berrien County—John C. Strayer, M.D., Buchanan; H. B. Anderson, M.D., Watervliet.

Calhoun County—Carlon R. Hills, M.D., Battle Creek; Bertha Moshier, M.D., Battle Creek.

Delta-Schoolcraft County—Gustavus W. Moll, M.D., Escanaba; George A. Shaw, M.D., Manistique.

Eaton County—George C. Stucky, M.D., Charlotte.

Genesee County—A. C. Edgerton, M.D., Clio; R. Bruce MacDuff, M.D., Flint; Vern N. Richeson, M.D., Flint.

Huron County—Charles B. Morden, M.D., Bad Axe.

Houghton-Baraga-Keweenaw County—A. D. Aldrich, M.D., Houghton.

Ingham County—F. C. Dunn, M.D., Lansing; Kenneth P. Hodges, M.D., Lansing; Fred M. Huntley, M.D., Lansing.

Ionia-Montcalm County—T. Jefferson Cox, M.D., Ionia.

Jackson County—R. H. Alter, M.D., Jackson; F. G. Ransom, M.D., Jackson.

Kalamazoo County—Glenn C. Andersen, M.D., Kalamazoo; Charles C. Bilodeau, M.D., Kalamazoo.

MEMBERSHIP RECORD—1951

County Medical Society	PAID		SPECIAL MEMBERS				DEATHS		NET MEMBERSHIP		1951		UNPAID	
	1950	1951	Emer.	Life	Ret'd	Assoc. Mil	1950	1951	1950	1951	Gain	Loss	1950	1951
Allegan	21	20	—	2	—	1	—	1	24	22	—	2	2	—
Alpena, Alcona, Presque Isle	23	22	—	2	—	1	1	—	24	25	1	—	—	—
Barry	12	12	—	3	—	—	—	—	15	15	—	—	—	—
Bay, Arenac, Iosco	70	70	3	4	2	2	2	3	78	78	—	—	—	—
Berrien	76	71	1	1	1	1	6	2	74	73	—	1	6	6
Branch	22	21	—	2	—	—	—	—	23	23	—	—	—	—
Calhoun	97	94	—	11	—	25	2	2	114	128	14	—	—	1
Cass	10	8	—	1	—	—	—	—	10	9	—	1	1	2
Chippewa-Mackinac	25	21	2	1	1	—	1	—	26	25	—	1	—	—
Clinton	15	15	1	—	1	—	1	—	15	17	2	—	—	—
Delta-Schoolcraft	25	26	1	1	—	—	1	2	26	26	—	—	—	—
Dickinson-Iron	20	20	—	—	—	1	—	—	21	21	—	—	—	2
Eaton	19	19	—	—	—	—	1	1	18	18	—	—	—	—
Genesee	187	189	2	20	2	3	5	3	204	213	9	—	1	3
Gogebic	20	21	—	—	—	—	—	—	20	21	1	—	2	—
Gd. Traverse, Leelanau, Benzie	42	37	—	1	3	—	4	—	38	41	3	—	1	—
Gratiot, Isabella, Clare	37	37	1	1	—	—	1	—	38	39	1	—	—	3
Hillsdale	17	16	—	3	—	—	1	—	19	19	—	—	—	—
Houghton, Baraga, Keweenaw	28	20	5	3	1	2	2	1	32	30	—	2	—	3
Huron	13	14	—	1	—	—	—	1	14	14	—	—	—	1
Ingham	162	174	1	4	6	1	3	3	172	183	11	—	—	2
Ionia-Montcalm	35	33	—	3	—	—	—	1	38	35	—	3	—	1
Jackson	101	100	5	6	—	3	—	2	113	112	—	1	—	—
Kalamazoo	139	135	5	3	3	2	4	2	145	146	1	—	1	1
Kent	274	287	7	17	2	6	5	5	296	314	18	—	9	2
Lapeer	13	13	3	—	—	—	—	—	16	16	—	—	—	—
Lenawee	40	38	3	—	—	2	1	1	42	42	—	—	2	—
Livingston	18	18	—	—	—	1	1	—	17	19	2	—	3	—
Luce	5	5	2	—	—	—	—	1	7	6	—	1	—	2
Macomb	51	54	—	2	—	—	—	1	52	55	3	—	1	—
Manistee	11	10	1	—	1	—	—	1	13	11	—	2	—	—
Marquette-Alger	39	38	1	3	—	—	1	1	40	41	1	—	1	—
Mason	13	11	—	—	—	—	2	—	11	11	—	—	1	1
Mecosta, Osceola, Lake	14	14	1	1	—	—	—	—	16	16	—	—	—	—
Menominee	15	17	1	—	—	—	—	1	16	17	1	—	—	—
Midland	23	23	—	—	1	—	—	—	23	24	1	—	—	1
Monroe	36	36	2	—	—	—	1	1	37	37	—	—	2	—
Muskegon	83	83	1	3	1	4	4	1	87	91	4	—	—	—
Newaygo	10	9	—	—	—	—	—	—	10	9	—	1	—	—
North Central Counties	23	19	—	—	1	1	1	—	23	21	—	2	1	—
Northern Michigan	35	31	1	—	—	—	2	—	33	32	—	1	1	1
Oakland	211	194	1	8	—	1	—	2	216	202	—	14	1	15
Oceana	7	6	2	—	—	1	—	—	10	9	—	1	—	1
Ontonagon	4	4	—	—	—	—	—	—	4	4	—	—	—	—
Ottawa	38	38	1	1	—	1	1	—	40	41	1	—	—	—
Saginaw	114	121	3	7	3	4	1	2	125	136	11	—	1	1
St. Clair	53	53	1	1	2	1	1	1	56	57	1	—	—	2
St. Joseph	24	25	1	—	—	—	—	—	25	26	1	—	2	—
Sanilac	12	13	—	—	—	—	—	—	12	13	1	—	—	1
Shiawassee	23	21	2	—	—	—	1	—	24	23	—	1	1	—
Tuscola	21	19	1	2	—	—	1	1	24	21	—	3	—	—
Van Buren	18	22	3	—	1	—	—	2	23	24	1	—	—	—
Washtenaw	183	176	3	6	2	90	1	1	279	276	—	3	1	5
Wayne	2,165	2,176	25	55	5	42	19	30	2,219	2,273	54	—	25	27
Wexford-Missaukee	17	14	—	1	—	—	—	1	17	14	—	3	2	—
TOTALS	4,809	4,783	93	180	39	196	78	77	5,114	5,214	143	43	68	84

Kent County—Paul W. Bloxsom, M.D., Grand Rapids; M. E. Cuncannan, M.D., Grand Rapids; James M. DeKraker, M.D., Grand Rapids; Henry J. Pyle, M.D., Grand Rapids; Leon E. Sevey, M.D., Grand Rapids.

Lenawee County—Periam B. Hardy, M.D., Tecumseh.

Luce County—Archie Jones, M.D., Newberry.

Macomb County—W. D. Lane, M.D., Romeo.

Manistee County—Ward H. Norconk, M.D., Bear Lake.

Marquette-Alger County—Richard A. Burke, M.D., Negaunee.

Menominee County—Thomas R. Whitmarsh, M.D., Stephenson.

Muskegon County—Clarence J. Durham, M.D., Muskegon.

Monroe County—William F. Acker, M.D., Monroe.

Oakland County—A. L. Brooks, M.D., Pontiac; John B. Schoenfeld, M.D., Birmingham.

Saginaw County—Joshua A. McLandress, M.D., Saginaw; Edward A. Pillsbury, M.D., Frankenmuth.

St. Clair County—William G. Wight, M.D., Yale.

Tuscola County—Robert L. Dixon, M.D., Caro.

Van Buren County—John Charles Maxwell, M.D., Paw Paw; N. D. Murphy, M.D., Bangor.

Washtenaw County—John Sundwall, M.D., Ann Arbor.

Wexford County—Sair C. Moore, M.D., Cadillac.

Wayne County—Charles D. Aaron, M.D., Detroit; James B. Blashill, M.D., Grosse Pointe; Canute G. Constable, M.D., Detroit; Langdon T. Crane, M.D., Detroit; James H. Dempster, M.D., Detroit; David H. Fauman, M.D., Detroit; B. F. Freeman, M.D., Detroit; Joseph D. Hayes, M.D., Detroit; Thomas N. Horan, M.D., Detroit; Reginald G. Huff, M.D., Wayne; Herbert S. Karr, M.D., Detroit; Joseph B. Kass, M.D., Detroit; Alex W. Lescohier, M.D., Detroit; Nelson MacArthur, M.D., Detroit; Edward G. Martin, M.D., Detroit; Robert M. Martin, M.D., Detroit; Roy D. McClure, M.D., Detroit; W. V. McIntosh, M.D., Detroit; W. Bede Mitchell, M.D., Detroit; Willard Monfort, M.D., Highland Park; Arthur K. Northrop, M.D., Detroit; Samuel H. C. Owen, M.D., Detroit; Morris Rand, M.D., Detroit; Alexander Thomson, M.D., Detroit; Harry Van Heldorf, M.D., Detroit; George F. Ward, M.D., Detroit; A. B. Wickham, M.D., Detroit; Josephus N. Wills, M.D., Detroit; Lennart W. Wiren, Jr., M.D., Eloise; Louis Zlatkin, M.D., Detroit.

The Journal

The following financial information relative to THE JOURNAL is found in the annual audit of MaDan and Bailey:

Income was $57,749.69 which is $2,349.69 over the tentative budget for 1951.

Expenses were $58,535.59 which is $3,135.59 over the tentative budget.

These figures indicate a net loss for the year 1951 of $785.90. This is accounted for by the fact that for the last three months of the year THE JOURNAL was operated under increased printing costs which were not anticipated in the original budget.

THE JOURNAL during 1951 continued the policy of special distinctive covers to emphasize some of the major activities of the Society; e.g., Cancer, Heart Disease, Michigan Medical Service, et cetera.

The Publication Committee and Editor have continued the practice of bringing to the members of the MSMS matters of special interest, both scientific and economic.

Finances

An audit of the books of the Society was completed by MaDan and Bailey as of December 24, 1951. This has been submitted to the Finance Committee for study and is available to any member of the society for perusal at the Executive offices, 606 Townsend Street, Lansing, Michigan.

A brief summary of the audit produces the following information:

Assets:	
Cash	$ 74,640.50
Accounts Receivable	11,286.15
Investments	66,164.12
Property	44,100.00
Prepaid Expenses	879.72
Other Assets	415.00
Total	$197,485.49
Liabilities:	
Accounts Payable	$ 6,491.31
Unearned Income	10,674.52
Reserved for Special Purposes	109,396.01
Unallocated equity	58,268.41
Net Income for the Period	12,655.24
Total	$197,485.49

From the income and expense statement we find that the total income was $100,345.27 with total expenses of $87,690.03, indicating a net income of $12,655.24.

The Income and Expense Summary sheets indicate that of the following items—

Equity—General Fund, Annual Session, Postgraduate Institute, THE JOURNAL, Contingent Fund, Building Fund, Beaumont Memorial, Lecture Grant, Public Education Program, Public Education Reserve, Rheumatic Fever Program—all show a gain except THE JOURNAL, which was mentioned before, and the Lecture Grant, which is not replenished.

Of the 1951 income, $30,000.00 was earmarked by action of The Council for the Public Education Reserve Fund. This amount is in addition to the $30,000.00 in bonds held for the Public Education program.

1951 Annual Session

The 1951 Annual Session held in Grand Rapids in September showed a total registration of 2,901, which was a record for an outstate meeting.

The General Assembly type of program with daily discussion conferences was continued as in recent years and brought to Michigan thirty essayists.

The exhibit during this Annual Session was comprised of 109 Technical Exhibitors in 125 spaces, which established another exhibit record. There were also eighteen Scientific Exhibits.

The policy of bringing to the Scientific Assembly out-of-state essayists of national and international reputation was continued and no expense was spared in making the meetings as interesting and instructive as possible. In spite of the rapidly rising costs of operation a modest gross profit, before proration of salaries, accrued to the society from the Annual Session.

To the 109 Technical exhibitors, the registrants showed their usual appreciation and gave them very generous attention.

1951 House of Delegates

The House of Delegates transacted the legislative business of the society with as much dispatch as possible consistent with thoughtful deliberation. Some of the highlights of the transactions of the House of Delegates were:

1. Adopted with commendation the Annual Reports of The Council, including recommendations re yearly visit to Washington, D. C., on the occasion of Michigan Day; that continued active tangible co-operation with the American Medical Association be maintained by every MSMS member, especially through contributions to the American Medical Education Foundation; that a Liaison Committee with Michigan Medical Service be created. The House of Delegates complimented the Council on its administration of the Society's finances; on the continued high quality level of THE JOURNAL; for its support of the Medical Examiner system; and for The Council's continued support of the Woman's Auxiliary. The House paid tribute to The Council for the progressive program of public relations it sponsored during the past year. Finally, the House expressed gratitude for the successful effort of The Council in providing a "home" in Lansing for the Michigan State Medical Society.

2. Adopted Resolutions concerning:
 (a) Past Speaker H. J. Pyle, M.D., Deceased.
 (b) L. G. Christian, M.D., Lansing, for service as AMA Delegate.
 (c) Matters for Mediation Committee (as amended).
 (d) Contributions to American Medical Education Foundation which may be earmarked for Michigan's two medical schools (Two resolutions presented; substitute resolutions adopted).
 (e) Objecting to "Little Hoover Commission's" recommendations re health (substitute resolution).
 (f) Comprehensive Physical Examination.
 (g) Fluoridation of water.
 (h) Congratulations to Trustees of Grand View Hospital, Ironwood.
 (i) Dues Collection Expense (1 per cent on both AMA and MSMS dues).
 (j) Teaching Civil Defense in Medical Schools.
 (k) Teaching Ethics in Medical Schools (substitute resolution).
 (l) Beaumont Memorial Restoration.
 (m) Alternate Delegates to attend AMA Sessions.

3. Disapproved three Resolutions:
 (a) Concerning Act 59 of P.A. 1937.
 (b) Favoring "Little Hoover Commission" recommendations re health.
 (c) Moral Degeneration in Government.

4. Discussed two matters in Executive Session (Resolution re Act 59 of P.A. 1937; and Annual Report of Committee to Study Medical Practice Act).

5. Adopted four amendments to the MSMS By-Laws as follows:
 (a) Chapter 8, Section 1, re composition of House of Delegates (excluding associate members in delegate count).
 (b) Chapter 5, Section 5, re qualification of Emeritus Members.

(c) Chapter 8, Section 10-d, re election of Alternate Delegates.
(d) Chapter 9, Section 12, re change in Councilor Districts.

6. Disapproved proposed amendment to MSMS By-Laws:
Chapter 8, Section 1 re composition of House of Delegates (including associate members in delegate count).

7. Two proposed Amendments to MSMS Constitution were referred to 1952 House of Delegates:
(a) Article X, Section 2, re Treasurer being a member of Executive Committee.
(b) Article X, new Section 3, re Vice Speaker being member of The Council and its Executive Committee, when Speaker is absent.

8. Urged Michigan's component county societies to study any necessary changes in their By-Laws to the end that physicians who wish to become members of the American Medical Association (which now has annual dues) may be provided this opportunity.

9. (a) Heard John W. Cline, M.D., San Francisco, President of the American Medical Association, deliver an address to House of Delegates on September 25, and made Dr. Cline an Honoraray Member of the Michigan State Medical Society:
(b) Heard Robert C. Page, M.D., New York, speak on "Doctors and the Federal Medical System";
(c) Heard Grover C. Penberthy, M.D., Detroit, report on "Procurement of Medical Officers for Armed Services."

10. Approved the new MSMS sound/color film "To Save Your Life."

11. Elected Clayton Willison, M.D., Sault Ste. Marie, as Michigan's Foremost Family Physician for 1951.

12. (a) Elected twelve members to Emeritus Membership:
(b) Elected thirty-nine members to Life Membership:
(c) Elected fourteen members to Associate Membership:
(d) Elected fifteen members to Retired Membership:
(e) Elected two members to Honorary Membership:

13. Elected:
(a) L. W. Hull, M.D., Detroit, as Councilor of 1st District (1956).
(b) Ralph W. Shook, M.D., Kalamazoo, as Councilor of 4th District (1956).
(c) J. D. Miller, M.D., Grand Rapids, as Councilor of 5th District (1956).
(d) H. H. Hiscock, M.D., Flint, as Councilor of 6th District (1956).
(e) B. M. Harris, M.D., Ypsilanti, as Councilor of 14th District (1954).
(f) R. A. Johnson, M.D., Detroit, (1953), W. A. Hyland, M.D., Grand Rapids (1953), J. S. DeTar, M.D., Milan (1953), as Delegates to the American Medical Association.
(g) E. F. Sladek, M.D., Traverse City (1953), E. D. Spalding, M.D., Detroit (1953), W. W. Babcock, M.D., Detroit (1953), E. C. Texter, M.D., Detroit (1953) as Alternate Delegates to the American Medical Association.
(h) R. J. Hubbell, M.D., Kalamazoo, as President-Elect.
(i) R. H. Baker, M.D., Pontiac, as Speaker, House of Delegates.
(j) J. E. Livesay, M.D., Flint, as Vice Speaker, House of Delegates.

Organizational Activities

Michigan Postgraduate Clinical Institute and Heart Day

The fifth annual scientific institue held under the sponsorship of the Michigan State Medical Society in cooperation with the University of Michigan Medical School and Department of Postgraduate Medical Education, Wayne University College of Medicine, the Michigan Foundation for Medical and Health Education, Inc., and the Wayne County Medical Society was held in Detroit on March 14, 15, 16, 17, 1951.

This Institute, designed to provide a high type scientific program, encourage Michigan Physicians to prepare presentations and to publicize Michigan as a medical center, this year featured twenty-five Michigan doctors of medicine on the program and fourteen out of Michigan essayists.

The Institute was an outstanding success as evidenced by the fact that it produced a total registration of 1,579 with physicians present from Michigan, all nearby states and Canada.

County Secretaries—Public Relations Conference

A Conference of County Secretaries and other officers and members of component county groups was held in Detroit on January 21, 1951. This all-day conference was attended by over 200 County Society Officers, County Society Public Relations Committee Chairmen, Members of the Michigan State Medical Society Council, Legislative Committee and Public Relations Committee and Officers of the Woman's Auxiliary.

The year 1951 saw a continuation of the successful press conferences throughtout the state. Through these friendly conferences with newspaper editors, radio executives and their family physicians much mutual understanding and co-operation has developed.

In 1951 Michigan was accorded another delegate (making six in all) to the House of Delegates of the AMA Dr. Ralph A. Johnson, Detroit, was elected to this position by The Council.

On January 20, 1951, G. B. Saltonstall, M.D., Charlevoix, was appointed Councilor of the Ninth District to serve the unexpired term of E. A. Oakes, M.D., Manistee, resigned.

The Woman's Auxiliary celebrated its twenty-fifth Anniversary in 1951. Two issues of The JMSMS featured this event and a scroll and silver gavel were presented to the Auxiliary in September, 1951, at the Annual Session.

Public Relations

The membership of the Michigan State Medical Society continues to be the driving force of the Public Relations Program. The collective scientific knowledge of the membership is a quantity coveted by all media such as press, radio, television, cinema, and publication. This is a giant pool of information.

The Public Relations Program of the Michigan State Medical Society transforms this pool of socio-scientific and socio-economic knowledge into interesting and informative radio programs, television productions, news releases, motion pictures, and local, state and national publications. The MSMS has utilized all media available to bring mutual understanding between the public and the doctors of medicine.

This program was carried forward in 1951—just as it will be in 1952—with new projects and with projects which have proved important in the past.

The total value of this program if estimated at current commercial advertising costs approximates over one million dollars.

One of these media is the press of the state and nation. Newspaper coverage of the 86th Annual Session

and the Michigan Clinical Institute, for example, was widespread and complete. Column inches of news space amounted to 1,687. In addition to advanced news releases and assistance to science writers covering the two events, publicity was obtained through appearances by doctors of medicine and MSMS representatives who gave speeches at four service clubs during the 86th Annual Session. Four special radio broadcasts, marked by the participation of eight doctors of medicine and two members of the Woman's Auxiliary, aired highlights of the Annual Session. In addition, frequent radio newscasts on the sixteen radio stations featured scientific news and statements by Michigan doctors of medicine and guest speakers who attended the Annual Session from other states.

Other activities in newspaper publicity included local meetings of the press by MSMS representatives, visits by the Public Relations Field Secretaries to newspapers in their assigned areas and 23 major releases issued at periodic intervals to all Michigan daily and weekly newspapers on newsworthy events of the Michigan State Medical Society. The MSMS also served as a source of health information on queries for newspaper stories by reporters as well as maintaining individual contact with science writers from major newspapers. MSMS continued its co-operation in publicizing special projects such as the work of special committees of MSMS and the Rural Health Conference. Excellent publicity was received on the occasion of the selection of Clayton Willison, M.D., Michigan's Foremost Family Physician for 1951. Dr. Willison subsequently was one of the three nominees chosen by the Board of Trustees of the American Medical Association to be voted upon by the AMA House of Delegates for the General Practitioner Gold Medal Award of 1951.

Besides activity in newspaper publicity, the story of the medical profession was graphically told in work accomplished by the Cinema Committee. In September of last year a new film "To Save Your Life" was completed. The 16 mm, sound, color motion picture is thirty minutes in length. It traces the steps necessary to become a doctor of medicine as well as showing representatives events in the life of a practicing M.D. Since it was offered for release in November for showing before such organizations as service clubs, Parent-Teacher Associations, vocational guidance classes in high schools and colleges, and television, there has been a heavy demand for the film. Already sixty-seven separate organizations have requested, "To Save Your Life," for screenings in Michigan in addition to requests from other states. The film is being offered to other state and county medical societies (outside Michigan) at a price of $300 a print.

The other two films of the Michigan State Medical Society were widely circulated. These films are, "Lucky Junior" and "To Your Health." As 1951 came to a close, "Lucky Junior" had been viewed by an audience of 380,622 theater patrons. "To Your Health" had been seen by an audience of 322,799 theater patrons. These are in addition to the persons seeing the picture in local showings. These films, along with "To Save Your Life" will continue to be scheduled in 1952.

Last year, the Cinema Committee began the first exploratory step to furnish additional services to doctors of medicine by the production of medical education films which would be used for instruction in medical schools and in postgraduate courses of study.

As the medium of television grew to gigantic proportion, the need became apparent that a new committee would have to be appointed which would be able to devote its energies exclusively to television. Such a television committee has been appointed as a subcommittee of the Public Relations Committee. The Michigan State Medical Society now has two television programs in the Detroit area. These programs are "It's Your Life" and "Your Medical Mailbox." The first television program is produced on WJBK-TV, Detroit, each week. The other show, "Your Medical Mailbox," is produced weekly on WXYZ-TV Detroit. Both programs feature Michigan doctors of medicine who discuss a variety of medical topics of interest to lay audiences. Each week these two programs reach an audience estimated at 1,000,000 persons. Special television shows have been made of our motion pictures over other television stations in Michigan and in other states.

Although the medium of television gained wide popularity, the Michigan State Medical Society did not overlook the continued importance of radio. The "Tell Me Doctor" five-minute health shows were broadcast on twenty-six Michigan radio stations. Several of these stations were located in areas not reached by television. This popular health show was launched by MSMS in 1946. In addition to the Michigan radio stations, transcriptions of the broadcast are aired by the medical societies of Oklahoma and North Carolina. Scripts for the broadcast of the program are also used by the Dade County Medical Association in Miami, Florida. Many other medical societies outside of Michigan have expressed an interest in these programs. Scripts numbering 1,488 have been written and 36,673 individual broadcasts of the program have been made in Michigan alone as of today.

During 1951 the radio committee also laid the groundwork for the production of a dramatic half-hour radio broadcast. Negotiations are already under way to produce this dramatic health show on a major Detroit radio station in September, 1952.

The MSMS Public Relations Program reached into the schools, colleges and universities. This was carried on under the auspices of the Committee on Education Programs in Schools and Universities.

One of the most far-reaching projects developed by this committee in 1951 was the Adult Education Program. This program was planned through the co-operation of the Adult Education Division of the Department of Public Instruction and the Michigan State Medical Society. As planned by this Committee, the component County Medical Societies of MSMS co-operate with their local Adult Education Directors in preparing a six-to eight-week lecture or discussion series on medical topics. This course was enthusiastically accepted by Adult Education Directors and is being carried forward successfully in several counties of the State.

A program to recruit medical associates was carried out by the distribution of the brochure, "In Planning Your Career" through vocational guidance classes of educational institutions.

Talks by MSMS representatives before school groups also proved beneficial in this program as well as on other subjects of the socio-health variety.

Many persons became aware of the activities of the Michigan State Medical Society by reading of these activities in publications published by both lay and medical organizations. Assistance was given the Woman's Auxiliary by the Public Relations Department in publishing their News Bulletin.

Other publications also expressed an interest in MSMS projects; *Parade, Newsweek,* Labor papers and special interest magazines. Noteworthy among these was the magazine *Inside Michigan* which is published in Detroit. The October, 1951, issue of this magazine carried a seven-page cover article, on the Michigan medical profession. This article was titled, "Return of the Family Doctor."

A total of 108,000 copies of this issue of the magazine were sent to Europe for distribution. Because of its popularity, 10,000 reprints were ordered by MSMS for distribution by doctors of medicine. These reprints were also circulated through the regular distribution channels of MSMS.

The Public Relations Department also offered services generally to officers and members of the Michigan State Medical Society in the preparation of arrangements for meetings, speeches, and brochures. Liaison with volun-

tary health agencies and other lay groups was also carried out in the Public Relations program. In addition, MSMS served the American Medical Association by participation in that organization's Public Relations Conference which included activity by Willis H. Huron, M.D., Iron Mountain. Other participation with the AMA encompassed the services of Hugh W. Brenneman, MSMS Public Relations Counsel, on the AMA Public Relations Advisory Board.

As in the past, the MSMS Public Relations Program continued to be recognized nationally as an outstanding PR effort. While new projects and programs were developed during 1951, the entire public relations effort has been included under the Formula For Freedom program in 1952. To energize the membership as well as to inform it in respect to this new program, the MSMS has organized a schedule of presentations before all the county medical societies of Michigan. These Formula For Freedom Nights began the last part of 1951 and are continuing into 1952. To date nineteen county societies have made firm commitments for Formula For Freedom Nights and three major societies (Kent, Kalamazoo and Saginaw) have been served in this respect.

Committees

Limitation of time and space makes it impossible to detail in this report the activities of all the committees contributing to the many splendid programs of the State Society. The accomplishment of the committees of the Society were achieved at the expense of many hours of personal sacrifice on the part of the personnel of the various committees. During 1951 the 62 committees of the Michigan State Medical Society held a total of 81 meetings and practically every meeting was attended by your Executive Director or Secretary. A total of 646 fellow members in your State Medical Society gave freely of their time to attend these meetings and assist in the operational activities of the State Society. Too much commendation cannot be accorded the committee members who contributed their time and effort to develop and execute constructive programs—both scientific and economic—for the public welfare and to maintain the position of leadership of the Michigan State Medical Society in the field of progressive medical planning.

Legislation

The pattern as set forth by the sixty-seventh (1951) Michigan Legislature was indicative of increasing attention to health matters. A total of 849 bills were introduced during the five-month session and sixty-nine of those bills were of primary concern to, or dealt directly with, the practice of medicine. The fight to retain the high standard of medicine for the people of this state was hard and long. It required many hours of time by Michigan doctors of medicine to accomplish this difficult task. No measure endangering the health of the people was passed. Much valuable progress, however, was made in legislation during the 1951 session.

Rather than attempt to review these I refer you to the Annual Report of the Legislative Committee (1950-51) copies of which you have all received in the Handbook of the House of Delegates.

One item might be mentioned, however, as an example of the outstanding *positive* work done. Out of the $306,000,000 state Budget, the first installment to Wayne University of $1,000,000 was granted and $3,500,000 authorized for construction of the Wayne University Medical Science building. As an example of the *protective* work done may I cite the activity that resulted in the refusal on two occasions of the Senate to confirm the appointment of an osteopath to the Michigan Crippled Children Commission.

The results of these two types of legislative activity are important and far-reaching.

However, victories in one session are past history in the next session. The year of 1952 sees us faced with an even greater task ahead. This session in the first two weeks produced 211 bills and of these forty-one concern doctors of medicine directly. Many of them are vicious pieces of proposed legislation. In addition we have much important legislation of our own to promote.

We are faced again with the need of "back home" support for it is politically naïve to fail to recognize that politicians listen most closely to their most enthusiastic and effective supporters in their home areas.

Rheumatic Fever Program

This Society-sponsored program of consultation and diagnosis in the field of Rheumatic Fever demonstrates the voluntary approach in the field of preventive medicine. The Michigan Society for Crippled Children and Adults, Inc., has continued its financial support of this program as has the Michigan Heart Association.

We must emphasize that the Rheumatic Fever program is a voluntary effort of the medical profession of this State, aided financially by three other voluntary groups, to demonstrate its ability to conduct successful programs in the field of Public Health; that it is an educational effort both for physicians and the public; that it is being viewed with interest and sometimes envy by other groups and agencies; and that if it fails for lack of support by the individual physicians and county medical societies of the state the medical profession will be open to ridicule and further attempts to bring into the doctors' supervision the remaining modern procedures of medical practice—(viz., Rheumatism, Arthritis, Cerebral Palsy, Epilepsy, et al) will be impossible. During 1951 considerable progress has been made toward expanding this program with new centers throughout the state.

Contacts With Governmental Agencies

During 1951 your Society maintained active and friendly contacts with many governmental agencies at local county, state and national levels. Included in these contacts were:

The Governor of Michigan
The Michigan Crippled Children Commission
The State Board of Registration in Michigan
Michigan Civil Service Commission
Michigan's Attorney General
The State Department of Public Instruction
The University of Michigan
The Michigan State College
Wayne University
Michigan Social Welfare Commission
The U. S. Senators and Congressmen from Michigan
White House Conference on Children and Youth
The State Health Commissioner
National Emergency Medical Service
The Michigan Mental Health Commission
Procurement and Assignment
Little Hoover Commission
EMIC Program.

Contacts With Non-Governmental Agencies

During 1951 the usual active contacts were maintained with many non-governmental agencies—especially

Michigan Medical Service
Michigan Hospital Service
Michigan Society for Crippled Children and Adults, Inc.
Michigan Health Council
The Michigan Tuberculosis Association
The Michigan Foundation for Medical and Health Education
The Michigan Heart Association
The Rural Health Conference and its ninety-eight other groups
The National Foundation for Infantile Paralysis
American Cancer Society
American Red Cross

National Conference on Medical Service
Conference of Presidents and Other Officers of State Medical Associations
Associated Postgraduate Committee and numerous other groups

Society Activities

Many contacts were made during the year with members of the Society at Councilor District Meetings and County Society Meetings. These contacts were made by various members of the administrative personnel and were designed to publicize the various activities of the State Society and to allow a discussion of any question propounded by the members present. These meetings developed a critical discussion of the problems of the local and State organizations, problems of the public relations, the "dispractices" of medicine and other subjects bearing upon the development and maintenance of activities necessary to the establishment of medical practice on its deserving high plane.

Officers attended numerous Michigan county and district medical society meetings during the year and were honored by being invited to speak before many other organizations in and out of the state. Their presentations before lay and civic organizations during the past twelve months, as part of the Good Citizenship Campaign, totaled hundreds of appearances, with messages beamed to the theme that voluntary medicine has achieved the best results for the people's benefit and is to be preferred to a compulsory federally operated type of political foreign medicine.

Especially to be commended are the high quality scientific postgraduate "clinic days" being offered by county and district medical societies annually including: Bay, Calhoun, Grand Traverse, Genesee, Ingham, Jackson, Kent, St. Clair, and Wayne Counties and by the Upper Peninsula Medical Society.

Secretary's Letters

As part of the Society's general educational program for individual members and component County Societies there were issued during the year 1951, twelve Secretary's Letters, nine to county secretaries and keymen and three to all members of the Michigan State Medical Society.

Office Personnel

During 1951 the Executive Office Personnel has discharged its many duties with extra loyalty and untiring effort.

During 1951 several additions were made to the stenographic staff. Mr. Jack Kantner was employed as Assistant Public Relations Counsel to replace Mr. Russell F. Staudacher who resigned to accept a position with the AMA.

The previously crowded and scattered condition of our Executive Offices was on its way to solution in 1951 by the purchase of a new home at 606 Townsend Street, Lansing. When all the necessary alterations and improvements will have been made, the already high standard of efficiency in the Executive Offices should be greatly enhanced.

The new building will enable the Society to house its personnel in one building and city. Dr. Rector, Secretary of the Cancer Committee, has already moved his office from Jackson to the new home of the Society.

Foremost Family Physician Award

The fifth annual "Foremost Family Physician Award" was accorded Clayton Willison, M.D., of Sault Ste. Marie. The award will be officially made in March, 1952, on the occasion of the Michigan Clinical Institute.

Recommendations

As a result of a careful analysis of the Society's activities, the prospective economic conditions and the attitude of the public toward medical organizations, I respectfully submit the following recommendations for your consideration: That

1. Continued efforts be put forth to develop and maintain strong organizations (County Medical Societies) at the grass-roots level.
2. The Medical Organizations continue the further development and execution of the Good Citizenship campaign through the "Formula For Freedom" for 1952 and 1953.
3. Members of Hospital Staffs be contacted with a view to solving in each institution the problems of over-utilization of Blue Cross-Blue Shield.
4. Consideration be given to the proper type of exploration of mutual problems facing labor and the medical profession.
5. An MSMS Brochure "Guide to Services" be developed by the Public Relations Department for distribution to all MSMS Members, with extra copies to County Society Officers.
6. That cost items of 606 Townsend Street, Lansing, be segregated and be indicated in the annual budgets and in the books and audit as a separate item in the General Fund section of the budget and books.
7. That after a reasonable length of time to determine amount of funds coming in, if deemed necessary, a professional organization be employed to manage the Beaumont Memorial Restoration campaign for funds in order to achieve the aim in 1952, and that appreciation be expressed to Mr. W. F. Doyle, Chairman, and to the Mackinac Island State Park Commission for their splendid co-operation.
8. A questionnaire survey regarding M.D. availability be made, per the presentation as made recently to the Executive Committee.

Your Secretary desires to express to the members of The Council his sincere appreciation for their fine personal and collective co-operation and the encouragement they have accorded him during 1951.

To the Executive Office personnel, to Mr. H. W. Brenneman, Public Relations Counsel, Mr. John B. Kantner, assistant counsel, Mr. J. Joseph Herbert, Legal Counsel, Dr. Wilfrid Haughey, Editor, and Mr. Robert J. Roney, Assistant Executive Director, your Secretary is particularly grateful for their loyalty, willing application to their many tasks, and many constructive suggestions. To Executive Director Mr. Wm. J. Burns, I wish to express a special appreciation for his wise counsel, helpful co-operation, and dynamic inspiration.

To all those who have aided so generously in the discharge of the duties of his office, your Secretary is most grateful.

Respectfully submitted,
L. Fernald Foster, M.D.
Secretary

EDITOR'S ANNUAL REPORT—1951

The Journal of the Michigan State Medical Society has completed the fiftieth year of publication. Research during the year has disclosed that The Journal was first published in September instead of January, 1901, as we had supposed, and that we will publish the 600th number in August, 1952. We are entering the fifty-first year of continuous publication. During all these years The Journal has been the expression and workshop of the Councilors and Publication Committee, carrying to our members the plans, ambitions, hopes, and accomplishments of the medical profession of the great State of Michigan. It has been the responsibility of your officers,

TREASURER'S ANNUAL REPORT—1951

SECURITIES IN POSSESSION OF THE TREASURER
January 1, 1952

Description	Interest Rate	Maturity	Interest Paid To	Principal Amount	Cost	Market or Redemption Prices 12-31-51	Market or Redemption Prices 12-22-51	Interest Received For Period	
Bonds held for general purposes:									
U. S. Savings Bonds, Series G	2½%	3-1-60	9- 1-51	$ 5,000.00	$ 5,000.00	$ 4,740.00	$ 4,780.00	$ 125.00	
U. S. Savings Bonds, Series G	2½%	5-1-58	11- 1-51	5,000.00	5,000.00	4,760.00	4,735.00	125.00	
U. S. Treasury Bonds, Series A	1½%	3-15-55	9-13-51	15,000.00	14,993.79	14,728.13	Note B	225.00	
U. S. Treasury Note, Series A	1⅜%	3-15-54	9-13-51	3,000.00	2,965.07	2,955.00	Note B	20.61	
U. S. Treasury Bond, Series B	2¾%	4- 1-80/75	10- 2-51	8,000.00	8,000.00	7,790.00	Note C	110.00	
Bonds held for Public Education Program:									
U. S. Savings Bonds, Series G	2½%	8- 1-58	8- 1-51	30,000.00	30,000.00	28,470.00	28,410.00	750.00	
Bond exchanged May 7, 1951:									
U. S. Treasury Bonds ($8,000.00)	2½%							58.79	
Group of Bonds redeemed Aug. 1, 1951:									
U. S. Savings Bonds, Series G, 2½% Principal Amount $17,600.00								440.00	
U. S. Savings Bond, Series G, 2½% Principal Amount 5,000.00								62.50	
U. S. Savings Bond, Series G, 2½% Principal Amount 5,000.00								62.50	
U. S. Savings Bond, Series G, 2½% Principal Amount 1,000.00								12.50	
U. S. Savings Bonds, Series F, A Principal Amount 2,500.00									
U. S. Savings Bonds, Series F, A Principal Amount 700.00									
U. S. Savings Bonds, Series F, A Principal Amount 12,400.00									
U. S. Savings Bonds, Series F, A Principal Amount 6,000.00									
U. S. Savings Bonds, Series F, A Principal Amount 500.00									
				$50,700.00	$66,000.00	$65,958.86	$63,443.13	$37,925.00	$ 1,991.90

Note A—Bonds purchased on discount basis. Do not bear interest.
Note B—Bonds purchased in 1951
Note C—Bond received in exchange for Treasury Bonds, Series A

CHANGES IN BONDS IN POSSESSION OF TREASURER DURING THE YEAR WERE AS FOLLOWS:

BALANCE AT JANUARY 1, 1951 (Principal Amount)....$98,700.00

ADDITIONS

Purchase of U. S. Treasury Bonds, Series A, 1½%, maturing Mar. 15, 1955, Principal Amount$15,000.00
(This Bond was purchased at the Home Office Mar. 29, 1951, paid for out of the general funds of the Society, and transmitted to the Treasurer for safekeeping.)

Purchase of U. S. Treasury Note, Series A, 1⅜%, maturing Mar. 15, 1954, Principal Amount$ 3,000.00
(This Bond was purchased Apr. 30, 1951, out of interest received on interest bearing Bonds.)

In exchange U. S. Treasury Bond, Investment Series B, 2¾%, maturing Apr. 1, 1980/75, Principal Amount....$ 8,000.00
(This Bond was received in exchange for U. S. Treasury Bond, Series A, 2½%, Principal Amount $8,000.00. It is not marketable but may be exchanged for 1½% 5-yr. U. S. Treasury Notes, which are marketable—the market quotation of 5-yr. notes as of Dec. 31, 1951 is 97-12/32.)

$ 26,000.00

$124,700.00

DEDUCTIONS

Group of Bonds redeemed Aug. 1, 1951, Principal Amount$50,700.00
(Above Bonds sold for Redemption Price)....$44,512.60
Less bank service fee.... 3.95

$44,508.65
(The proceeds derived from sale of Bonds was transmitted to the general funds of the Michigan State Medical Society for the purchase of a "Home Office."

U. S. Treasury Bonds, Series A, 2½%, maturing Dec. 1972/76, Principal Amount....$ 8,000.00
(This Bond was exchanged for a U. S. Treasury Bond, Investment Series B, 2¾%, May 7, 1951, and maturing April 1, 1980/75)

58,700.00

TOTAL PRINCIPAL AMOUNT OF BONDS....$ 66,000.00

REPRESENTED BY—

Bonds for general purposes....$36,000.00
Bonds designated for Public Education Program 30,000.00

INCOME

CASH BALANCE IN BANK, January 1, 1951....$ 2,556.39
EARNINGS ON BONDS (Jan. 1, 1951 to Jan. 1, 1952)....$ 1,991.90
PROCEEDS FROM GROUP OF BONDS SOLD (Aug. 1, 1951)....$44,508.65

$46,500.55

TOTAL INCOME....$49,056.94

EXPENSE

The Detroit Bank charges for safekeeping of Bonds:
Jan. 3, 1951....$ 48.85
May 10, 1951.... 50.00
Nov. 9, 1951.... 41.50
Cost of purchasing U. S. Treasury Note, Series A, 1-⅜%, due March 15, 1954....$ 2,965.07
Transfer of proceeds from sale of Group of Bonds to general fund for purchase of "Home Office"$44,508.65

$47,614.07

CASH BALANCE IN BANK January 1, 1952 $ 1,422.87

CASH BALANCE IN THE DETROIT BANK, January 1, 1952....$ 1,422.87
MARKET or REDEMPTION PRICES OF ALL BONDS, in possession of the Treasurer, January 1, 1952....$63,443.13

TOTAL CASH and REDEMPTION VALUE OF BONDS....$64,866.00
(as of January 1, 1952)

Respectfully submitted,

A. S. BRUNK, M.D., *Treasurer*
(Deceased February 3, 1952)

and especially of your editors, to present a constant flow of scientific medical articles, to give our membership the latest thought in medical economics and medical news, and to stimulate the meeting of minds which determines and directs the advance of the profession.

Again THE JOURNAL has published an average number of pages commensurate with the policy of recent years. The years and number of pages follows:

1942—1090; 1943—1022; 1944—1134; 1945—1414; 1946—1692; 1947—1478; 1948—1446; 1949—1566; 1950—1526; 1951—1470.

The increase in numbers of pages from a hundred or less per issue to the present approximate one hundred twenty pages was an expression of the increased threat of socialized medicine, and our efforts to uncloak the monster. We have not begrudged the time and "pages." We believe the Michigan State Medical Society through its combined fighting spirit has given its full share to the fight.

During the year 1951, we published papers from 161 authors. A number of these papers had more than one author, but there were only eleven name repeats during the year, showing that the authorship of papers was as widely spread as possible, covering 150 separate names. Eighty-one book reviews have been presented, most of which have been by reviewers in the home city of the editor, for obvious reasons. During the years, the editor himself has reviewed many of these books and placed them in the library of one of our hospitals.

Forty-four editorials have been prepared with the single thought in mind to express the considered program, opinion and considered deductions of The Council which is our governing body, under whose egis THE JOURNAL was established and has been maintained. We hope we have, in a measure, succeeded.

We have again continued to make each number of THE JOURNAL some special expression of a co-ordinate part or function of the Society. For many years, there have not been two identical covers. In fact, we have made the covers entirely different from each other, but attractive and suggestive. The covers and THE JOURNALS from 1951 have been as follows:

January: The Clinical Institutes announcement, with pictures of nine of the speakers.

February: "Please give a hand—Help Crippled Children," with the picture of a girl in braces.

March: The first Atomic Energy Journal ever published, with an atomic burst through a blue sky with complicated atomic formulae.

April: Completely devoted to papers on cancer, with a cover illustration of the first use of television in medicine, a Michigan accomplishment.

May: Featuring Michigan's Foremost Family Physician, Dr. Lunette I. Powers; this number also greeted the American Medical Association on its having attained the entrance into its second century.

June: Devoted as for several years to Michigan's Blue Shield, commemorating its 2,000,000 subscribers.

July: The annual roster number, again featuring the Michigan map with the divisions into county or local societies, with membership numbers inserted.

August: The program number for the annual session, featuring the hospitality booth.

September: This was the Rheumatic Fever and Arthritis number, devoted exclusively to that subject. The cover was outstanding. A nurse wheeling a patient out of a dark room into the light of arthritis research. One reader from Chicago thought this cover should be reprinted and hung in every doctor's office.

October: The Michigan Foundation for Medical and Health Education, featuring a construction job.

November: In this number we complimented our most efficient and the nation's most beloved and admired lay medical executive. A beautiful picture of Mr. Burns.

December: The "Serving the Hearts of Michigan," a number devoted completely to papers prepared in conjunction with the grants, subsidies and research projects of the Michigan Heart Association.

Plans are in the making to continue the feature numbers and covers. We believe THE JOURNAL of MSMS, by its novel arrangement, has established a place in the sun.

Respectfully submitted,

WILFRID HAUGHEY, M.D., *Editor*

REPORT OF MADAN AND BAILEY, C.P.A.

January 12, 1952

The Council, Michigan State Medical Society,
Lansing, Michigan
Gentlemen:

In accordance with our engagement, we have examined the books and records of the Michigan State Medical Society, Lansing, Michigan, for the period December 23, 1950 to December 24, 1951, and we present herewith our report of examination.

Your attention is directed to the following comments respecting some of the more important items appearing in your records.

The Michigan State Medical Society was organized on September 17, 1910, under the laws of the State of Michigan, as a non-profit corporation. The charter has been extended for a period of thirty years from September 17, 1940. The Society is affiliated with the American Medical Association, and it charters county medical societies within the State of Michigan. The purposes of the Society are the promotion of the science and art of medicine, the protection of the public health, and the betterment of the medical profession. In the furtherance of these purposes, the Society publishes THE JOURNAL of the Michigan State Medical Society.

The balance on deposit in the Michigan National Bank, Lansing, Michigan, was reconciled by us and further confirmed by direct correspondence with the bank. The Treasurer's account maintained at the Detroit Bank, Detroit, Michigan, was confirmed by direct correspondence with the depository. Office cash was counted by our representative and found to be in agreement with the ledger account.

Accounts Receivable were confirmed by direct correspondence with the debtors. To date of this report we have not heard from all persons who were written. Some small differences have been noted, and are to be followed up by your representatives. The aging of the accounts by month of charge is as follows:

October, November and December, 1951	$11,219.45
July, August and September, 1951	302.87
January to June, 1951	57.83
Prior to 1951	0
TOTAL	$11,580.15

U. S. Government securities are set forth in detail in Schedule. The changes in the balance of the bond account during the period are as follows:

Balance December 23, 1950		$93,823.89
Bonds Acquired:		
U. S. Treasury Bonds, "A", 1½%	$14,993.79	
U. S. Treasury Note, Series "A", 1-⅜%	2,965.07	
U. S. Treasury Bonds 2-¾%, 1980/75 exchanged	8,205.26	26,164.12
TOTAL		$119,988.01
Bonds Disposed Of:		
Sale per Note "A" Schedule 6	$45,605.80	
U. S. Treasury Bonds 2½%, 1972/67 exchanged	8,218.09	53,823.89
Balance December 24, 1951		$66,164.12

All securities are held in safekeeping in The Detroit Bank, Detroit, Michigan, and were confirmed by direct correspondence with the bank.

The deeds for the Home Office Building, 606 Town-

send Street, Lansing, Michigan, are dated July 10, 1951. Depreciation has been computed on a twenty-five (25) year life. Six months' depreciation was taken for 1951.

Insurance is carried on the Home Office Building in an amount of $49,000.00, and $10,000.00 on contents.

During the period under review, the Society received $115,647.50 in collections of assessments levied by the American Medical Association on its members. All such collections were paid to the American Medical Association, and this amount is not reflected in the Society's financial statements.

Membership dues received during the year were reconciled to the 5,137 membership cards issued.

Sales of booth space at the Annual Session and the Michigan Clinical Institute were traced to the income accounts in the ledger.

Changes in the various reserves for special purposes, and the addition of such reserves during the period are set forth in Exhibit "C".

It is our recommendation that more expenses be charged to specific expense accounts rather than to "Miscellaneous Expense." This can be accomplished by not restricting the purpose of some of the accounts. Travel Expense could include Entertainment. Your accountant is limited in his charges for certain special activities, such as the Michigan Clinical Institute and Annual Session. This can be corrected when setting up the 1952 budget, thereby simplifying the work and allocation problems of your Accounting Department.

Respectfully submitted,
MADAN AND BAILEY,
Certified Public Accountant

STATEMENT OF ASSETS, LIABILITIES AND EQUITIES

December 24, 1951

ASSETS

Cash on Hand and in Banks:		
Michigan National Bank, Lansing, Mich.	$73,161.02	
Treasurer's Account, The Detroit Bank, Detroit, Michigan	1,442.87	
Office Cash	36.61	$ 74,640.50
Accounts Receivable:		
Booth Space at 1952 Postgraduate Clinical Conference	$7,825.00	
Advertising and Other Items	3,755.15	$11,580.15
Less: Allowance for Doubtful Accounts	294.00	11,286.15
Investments:		
U. S. Government Securities (Schedule 6) (Note 1) (Market or Redemption Price $63,443.13)		$ 66,164.12
Property:		
Office Building, Lansing, Michigan	$45,000.00	
Less: Depreciation Allowance	900.00	44,100.00
Prepaid Expenses:		
Expenses of 1952 Postgraduate Clinical Conference	$ 629.72	
Advances for Meeting December 27, 28 and 29, 1951	250.00	879.72
Other Assets:		
Furniture Held for Resale		415.00
TOTAL ASSETS		$197,485.49

NOTE 1. United States Government Bonds in the amount of $30,000.00 have been designated as applicable to the Public Education Program.

LIABILITIES

Accounts Payable:		
Federal Unemployment Taxes	$ 331.98	
Michigan Unemployment Taxes	51.74	
Current Expenses	4,967.45	
Refunds Due Counties on American Medical Association Dues	1,151.72	
Michigan Hospital Service (credit)	11.58	$ 6,491.31
Unearned Income:		
January 1952 Advertising	$ 64.52	
Booth Space at 1952 Postgraduate Clinical Conference	10,610.00	10,674.52
Society Equities:		
Reserve for Special Purposes:		
Public Education Reserve	$30,000.00	
Public Education Program	32,055.98	$ 62,055.98
Rheumatic Fever Control Program		26,431.80
Lecture Grant		300.00
Beaumont Memorial Fund		4,000.00
Contingent Fund		7,117.81
Building Fund		9,490.42
		$109,396.01
Unallocated Equity	$58,268.41	
Net Income for the Period (Exhibit "B")	12,655.24	70,923.65
		180,319.66
TOTAL LIABILITIES AND EQUITIES		$197,485.49

STATEMENT OF INCOME AND EXPENSE

December 23, 1950 to December 24, 1951

Income:		
Membership Fees	$95,367.75	
Miscellaneous Income	344.10	
Interest Income:		
On Securities (Less Amortization of $12.83)	1,979.07	
On Savings Deposits	8.01	$ 97,698.93
Other Income:		
Annual Session (Schedule 2)	$ 1,546.34	
Postgraduate Clinical Institute (Schedule 2)	1,885.90	
"THE JOURNAL" (Schedule 3) (loss)	785.90	2,646.34
TOTAL INCOME		$100,345.27
Expenses:		
Administrative and General (Schedule 1)	$44,216.73	
Society Activity (Schedule 1)	19,408.04	
Committee Expenses (Schedule 1)	22,827.76	
Loss on Sale of Bonds	1,097.15*	
Fees for Safekeeping of Bonds	140.35	87,690.03
NET INCOME		$ 12,655.24

*Not including interest gained since purchase.

INCOME AND EXPENSE SUMMARY

December 23, 1950 to December 24, 1951

	Balance 12-23-50	Income for the Period	Expenses for the Period	Net Gain or Loss	Balance 12-24-51
Equity—General Fund	$ 58,268.41	$ 97,698.93	$ 87,690.03	$ 10,008.90	
Annual Session		22,610.00	21,063.66	1,546.34	
Postgraduate Institute		11,510.00	9,624.10	1,885.90	$ 70,923.65
"THE JOURNAL"		57,749.69	58,535.59	785.90 (Loss)	
Contingent Fund		7,117.81	0	7,117.81	7,117.81
Building Fund		9,490.42	0	9,490.42	9,490.42
Beaumont Memorial Fund		4,000.00	0	4,000.00	4,000.00
Lecture Grant	400.00	0	100.00	100.00 (Loss)	300.00
Public Education Program	59,600.98	95,726.00	93,271.00	2,455.00	32,055.98*
Public Education Reserve	0	0	0	0	30,000.00
Rheumatic Fever Control Program	23,467.55	23,373.15	20,408.90	2,964.25	26,431.80
TOTALS	$141,736.94	$329,276.00	$290,693.28	$ 38,582.72	$180,319.66

*Attention is directed to the Note on Page 368 under Public Relations Program.

EXPENSES

December 23, 1950 to December 24, 1951

Administrative and General:	
Office Rent & Light (Property Taxes $580.50)	$ 1,738.25
Printing and Mailing	256.36
Office Supplies	1,905.36
Postage	1,978.60
Insurance and Fidelity Bonds	4,349.78
Auditing	840.04
Salaries—Administrative	7,500.00
Salaries—General Office	10,555.84
General Counsel Retainer	3,960.00
General Counsel Expenses	310.20
Equipment and Repairs	2,833.99
Telephone and Telegraph	3,092.65
Payroll Taxes	1,618.23
Miscellaneous Expenses	1,117.44
Building Maintenance	1,259.99
Depreciation (4% for 6 Months)	900.00
TOTAL ADMINISTRATIVE AND GENERAL	$44,216.73
Society Activity:	
Council Expense	$ 9,614.01
Delegates to American Medical Association	2,150.83
General Society Travel and Entertainment	4,281.53
Secretary's Letters	1,082.63
Woman's Auxiliary	969.10
Officers' Travel	1,309.94
TOTAL SOCIETY ACTIVITY	$19,408.04
Committee Expenses:	
Legislative & Legislative Advisory Committee	$ 2,227.24
Postgraduate Medical Education	3,573.69
Preventive Medicine	91.15
Cancer Control	5,000.00
Child Welfare	111.20
Geriatrics	142.28
Industrial Health and Industrial Health Day	361.29
Maternal Health	847.12
Mental Hygiene	311.63
Scientific Radio	22.50
Venereal Disease Control	193.56
Tuberculosis Control	238.99
Distribution of Medical Care	215.31
Michigan Health Council	7,500.00
Rural Medical Service	332.10
Emergency Medical Service	228.22
Committees of House of Delegates and of The Council	1,431.48
TOTAL COMMITTEE EXPENSES	$22,827.76
TOTAL EXPENSES	$86,452.53

INCOME AND EXPENSE

December 23, 1950 to December 24, 1951

ANNUAL SESSION

Scientific Meeting	$ 3,658.36
Registration	414.75
Exhibit Expense	3,146.82
Hotel Expense (MSMS Staff)	538.20
Officers' Night and Biddle Lecture	452.42
State Society Night	2,783.25
Printing, Mailing and Postage	2,639.51
Press Expense	1,043.77
Projection Expense	81.50
Salaries	4,299.98
House of Delegates Expense	1,040.60
Miscellaneous Expense	964.50
TOTAL ANNUAL SESSION EXPENSE	$21,063.66
Less: Income from Booth Sales	22,610.00
GAIN ON ANNUAL SESSION	$ 1,546.34

POSTGRADUATE CLINICAL INSTITUTE

Scientific Meeting	$ 2,029.72
Committee Meetings	184.22
Printing, Mailing and Postage	1,561.11
Exhibit Expense	1,587.75
Press Expense	656.48
Registration	151.51
Hotel Expense (MSMS Staff)	1,260.21
Salaries	2,100.12
Miscellaneous Expense	92.98
TOTAL POSTGRADUATE CLINICAL INSTITUTE EXPENSE	$ 9,624.10
Less: Income from Booth Sales	11,510.00
GAIN ON POSTGRADUATE CLINICAL INSTITUTE	$ 1,885.90

THE JOURNAL

December 23, 1950 to December 24, 1951

Income:	
Subscriptions from Members	$ 7,163.77
Subscriptions—Others	475.41
Advertising Sales	45,080.25
Reprint and Cut Sales	4,355.24
Cash Discounts Received	675.02
TOTAL INCOME	$57,749.69
Expenses:	
Editors' Expense	$ 1,800.00
Printing and Mailing	32,419.17
Reprint and Cut Expense	3,081.50
Salaries	10,839.98
Discount and Commissions on Advertising Sales	10,093.49
Miscellaneous Journal Expense	120.34
Cash Discounts Allowed	181.11
TOTAL EXPENSE	$58,535.59
NET LOSS ON "The Journal"	$ 785.90

PUBLIC EDUCATION PROGRAM

December 23, 1950 to December 24, 1951

Income from Memberships	$95,525.00
Miscellaneous Income	201.00
	$95,726.00
Expenses:	
Clipping Service	$ 200.03
Committee Meetings	879.22
Equipment and Repairs	934.17
Postage and Mailing	2,181.36
Printing	754.62
Office Supplies	910.75
Rent and Light	700.00
Rent to Wayne Co. Med. Soc.	240.00
Salaries	38,927.46
Telephone and Telegraph	2,306.05
Travel	9,239.99
Cinema	6,577.77
Display Advertising	469.00
Publications and Pamphlets	964.02
Radio "Tell Me, Doctor"	23,933.09
National Meeting Expense	752.28
County Secretary's—P. R. Conf.	2,522.21
Miscellaneous Expense	348.85
County Society Meetings	413.54
Field Secretary	16.59
TOTAL EXPENSES	$93,271.00
NET OPERATING GAIN BEFORE APPROPRIATION	$ 2,455.00

Note: Your Committee, at the beginning of the year, allocated $30,000.00 of 1951 income to a Public Education Reserve. This amount has been set aside, and is not reflected in the above statement of Income and Expense.

RHEUMATIC FEVER CONTROL PROGRAM

December 23, 1950 to December 24, 1951

Income:	
Grant from Michigan Heart Association	$19,873.15
Michigan Society for Crippled Children and Adults, Inc.	3,500.00
TOTAL INCOME	$23,373.15
Expenses:	
Central Office:	
Committee Meetings	$ 594.28
Equipment and Repairs	6.24
Payroll Taxes	125.19
Printing and Mailing	544.69
Administrative Salaries	8,800.00
Central Office Salaries	699.96
Travel	1,122.60
Miscellaneous	98.90
Fellowships	2,000.00
TOTAL CENTRAL OFFICE EXPENSE	$13,991.86
Control Centers:	
Ann Arbor	$ 400.00
Bay City	625.00
Detroit	78.10
Grand Rapids-Muskegon	2,598.95
Kalamazoo	811.09
Lansing	306.58
Marquette	162.67
Pontiac	500.00
Traverse City	734.65
Northern Michigan	200.00
TOTAL CONTROL CENTER EXPENSE	$ 6,417.04
TOTAL EXPENSES	$20,408.90
INCREASE	$ 2,964.25

MICHIGAN STATE MEDICAL SOCIETY
BUDGETS—1952

GENERAL FUND

Income:	
4500 Members @ $45.00	$202,500.00
Less: Allocation to THE JOURNAL @ $1.50	6,750.00
Allocation to Public Education @ $20.00	90,000.00
Allocation to Surplus @ $1.50	6,750.00
Allocation to Building Fund @ $2.00	9,000.00
Balance to General Fund @ $20.00	$ 90,000.00
Interest Income	800.00
Miscellaneous Income	300.00
TOTAL FUNDS AVAILABLE	$ 91,100.00
Expenses:	
Administrative & General:	
Printing & Mailing	$ 250.00
Office Supplies	2,500.00
Postage & Express Charges	2,500.00
Insurance & Fidelity Bonds	3,750.00
Auditing	350.00
Salaries—Administrative	8,700.00
Salaries—Office	12,740.00
General Counsel Retainer	3,960.00
General Counsel Expenses	350.00
Equipment & Repairs	2,000.00
Telephone & Telegraph Charges	3,000.00
Payroll Taxes	1,800.00
Miscellaneous Expense	500.00
Total Administrative & General Expense	$ 42,400.00
Society Activity:	
Council Expense	$ 8,000.00
Delegates and Alternates to AMA	4,000.00
Gen. Society Travel & Ent	3,500.00
Officers Travel	3,000.00
Secretary's Letters	1,200.00
Woman's Auxiliary	250.00
Nat. Conf. on Medical Service	150.00
Sundry Society Expense	150.00
Total Society Activity Expenses	$ 20,600.00
Committee Expenses:	
Legislative	$ 2,200.00
Postgraduate Medical Education	4,000.00
Preventive Medicine	100.00
Cancer Control	4,580.00
Child Welfare	100.00
Geriatrics	150.00
Industrial Health & Industrial Health Day	400.00
Maternal Health	700.00
Mental Hygiene	300.00
Mental Hygiene	300.00
Scientific Radio	50.00
Venereal Disease	150.00
Tuberculosis Control	150.00
Distribution of Med. Care	200.00
Michigan Health Council	7,500.00
Rural Medical Service	250.00
Emergency Medical Service	200.00
Procurement & Assignment	150.00
Beaumont Restoration	150.00
Courses on Medical Economics	200.00
Sundry Committee Expense (including House of Delegates & Council Committees)	1,000.00
Total Committee Expense	$ 22,530.00
TOTAL EXPENSES	$ 85,530.00
GAIN FOR THE YEAR	$ 5,570.00
BALANCE FROM 1951	$ 70,923.65
NET TO 1953	$ 76,493.65

BUILDING MAINTENANCE FUND

ACCOUNT TITLE	1952 Budget
Income:	
1951 Allocation of Dues	$ 9,000.00
1952 Allocation of Dues	9,000.00
	$18,000.00
Expenses:	
Replacements:	
Lighting	2,000.00
Decorating	2,000.00
Repairs to parking lot	2,000.00
Heating and Hot Water	600.00
Lighting	200.00
Water	70.00
Salary of Janitor	2,600.00
Janitor's Supplies	140.00
Taxes	600.00
Fire Insurance	500.00
Misc. Expense	400.00
General Repairs	500.00
Depreciation	1,800.00
	$13,410.00
Balance to 1953	4,590.00

ANNUAL SESSION—1952

Income:	
Booth Sales (99 spaces)	$20,000.00
Expenses:	
Scientific Meeting Expense	3,300.00
Registration	300.00
Exhibit Expense	3,000.00
Hotel Expense (MSMS Staff)	500.00
Officer's Night & Biddle Lecture	500.00
State Society Night	3,000.00
Printing, Mailing & Postage	2,500.00
Press Expense	800.00
Scientific Work Committee	200.00
Salaries	4,300.00
House of Delegates Expense	800.00
Telephone & Telegraph	200.00
Miscellaneous Expense	600.00
Total Expenses	$20,000.00

MICHIGAN CLINICAL INSTITUTE—1952

Income:	
Booth Sales (70 spaces)	$11,720.00
Expenses:	
Scientific Meeting Expense: (include Civil Defense Speaker)	2,300.00
Registration	150.00
Exhibit Expense	1,800.00
Hotel Expense (Include Entertainment)	1,540.00
Printing, Mailing & Postage	2,250.00
Press Expense	800.00
Salaries	2,100.00
Telephone & Telegraph	100.00
MCI Committee Meetings	180.00
Miscellaneous Expense	500.00
Total Expenses	$11,720.00

THE JOURNAL—1952

Income:	
4500 members @ $1.50	$ 6,750.00
Subscription of others	475.00
Advertising Sales	48,915.00
Reprint & Cut Sales	4,300.00
Misc. Income (Discounts taken)	700.00
TOTAL FUNDS AVAILABLE	$61,140.00
Expenses:	
Editor's Expense	$ 2,400.00
Printing, Mailing & Postage	34,000.00
Reprint & Cut Expense	3,000.00
Salaries	10,840.00
Disc. & Comm. on Adv. Sales	10,800.00
Miscellaneous Journal Expense	100.00
TOTAL EXPENSES	$61,140.00

PUBLIC EDUCATION PROGRAM—1952

Income:	
4500 members @ $20.00	$90,000.00
Other Income (Sale of films, pamphlets, "Tell Me, Doctor" radio programs, etc.)	1,200.00
TOTAL FUNDS AVAILABLE	$91,200.00
Expenses:	
Clipping Service	$ 300.00
Committee Meetings	1,500.00
Equipment & Repairs	800.00
Postage & Mailing	3,500.00
Printing	1,000.00
Office Supplies	1,000.00
Allocation of Bldg. Maintenance Expense	900.00
Rent to Wayne County Medical Society	240.00
Salaries	41,000.00
Telephone & Telegraph	4,000.00
Travel & Entertainment	8,000.00
Cinema	5,000.00
Display Advertising	500.00
Newspapers	2,500.00
Publications & Pamphlets (Purchased)	4,000.00
Radio "Tell Me, Doctor"	23,000.00
National Meeting Expense	1,500.00
1952 Co. Sec'y-P. R. Conf.	3,000.00
Co. Soc. Meetings (Including FFF Nights)	1,500.00
Woman's Auxiliary	600.00
Miscellaneous Expense	1,000.00
TOTAL EXPENSES	$104,840.00
LOSS FOR THE YEAR	13,640.00
Balance from 1951	32,055.98
Balance to 1953	$18,415.98
Balance in P.E. Reserve (bonds)	30,000.00

RHEUMATIC FEVER CONTROL PROGRAM—1952

Income:		
Michigan Heart Association		$15,000.00
Michigan Society for Crippled Children and Adults, Inc.		5,736.40
Total Income:		$20,736.40
Balance from 1951:		26,431.80
TOTAL FUNDS AVAILABLE		$47,168.20
Expenses:		
Central Office Expense:		
Committee Meetings	$ 800.00	
Equipment & Repairs	400.00	
Payroll Taxes	125.00	
Postage & Mailing	100.00	
Printing	800.00	
Office Supplies	100.00	
Publications & Pamphlets (Purchased)	100.00	
Administrative Salaries	8,800.00	
Office Salaries	1,000.00	
Travel	1,600.00	
Fellowships	3,000.00	
Special Equipment	3,800.00	
Furniture & Fixtures (For New Centers)	1,500.00	
Reserve for Contingencies	10,000.00	
Miscellaneous Expense	100.00	
Total Central Office Expense		$32,225.00
Control Centers:		
Alpena	$ 200.00	
Ann Arbor	600.00	
Battle Creek	500.00	
Bay City	800.00	
Benton Harbor	500.00	
Detroit	1,000.00	
Flint	500.00	
Grand Rapids & Muskegon	3,000.00	
Kalamazoo	800.00	
Lansing	350.00	
Petoskey	500.00	
Pontiac	1,500.00	
Port Huron	500.00	
Saginaw	600.00	
Sault Ste. Marie	500.00	
Traverse City	750.00	
Total Expenses—Control Centers		$12,600.00
TOTAL EXPENSES		$44,825.00
BALANCE TO 1953		$ 2,343.20

THE FORMULA WORKS

(Continued from Page 350)

ment by your government's own words. On occasions, those words can reflect the thinking of only a small group, a minority, or special interest lobby. To "know your government," any group with a bill of goods to sell, or a wrong to be redressed, must depend on its own efforts. No group is equipped by nature to be more influential in this respect than the medical profession. Numerically and economically it is strong. But as the Reverend Reeves said, the doctor's influence on the community is far out of proportion to his numbers. His advice is respected, his counsel is sought. He can maintain that position of eminence only as long as he behaves in a manner to warrant it. Medical societies must be quick and public to expel unworthy members from their membership. Doctors must accept the responsibilities as well as the blessings that come with freedom from government control. That, in essence, *is* the Formula for Freedom . . . although it was Jimmy Durante who had another definition of freedom. He said: "Don't put no constrictions on da people, just leave 'em ta hell alone."

THIRD MICHIGAN INDUSTRIAL HEALTH DAY

May 7, 1952

Hurley Hospital, Flint, Michigan

Registration—9:30 A.M.

Morning Session—10:00 A.M.

Otto Preston, M.D., Flint, Moderator, President, Michigan Association of Industrial Physicians and Surgeons.

1. Welcome—W. W. Stevenson, M.D., Flint, President, Genesee County Medical Society.
2. Management of Traumatic Neurosis—Joseph Shapiro, M.D., Flint.
3. Skin Coverage of the Hand—H. W. Woughter, M.D., Flint.
4. Film—"Your Ear and Noise." The Use of the Audiometer In Industry—W. Z. Rundles, M.D., Flint.

Luncheon—1:00 P.M.

Afternoon Session—2:00 P.M.

Otto Preston, M.D., Moderator.

1. Venous Stasis of the Lower Extremities—E. A. Osius, M.D., Detroit.
2. Review of Abnormal Chest Films Which Do Not Preclude Gainful Employment—R. M. Engelman, M.D.
3. The Romance of Trauma—G. J. Curry, M.D., Flint, Chairman of the Michigan Committee on Trauma of the American College of Surgeons.
4. Present Status of Industrial Medical Education—Speaker to be announced.

Business Session—4:30 P.M.

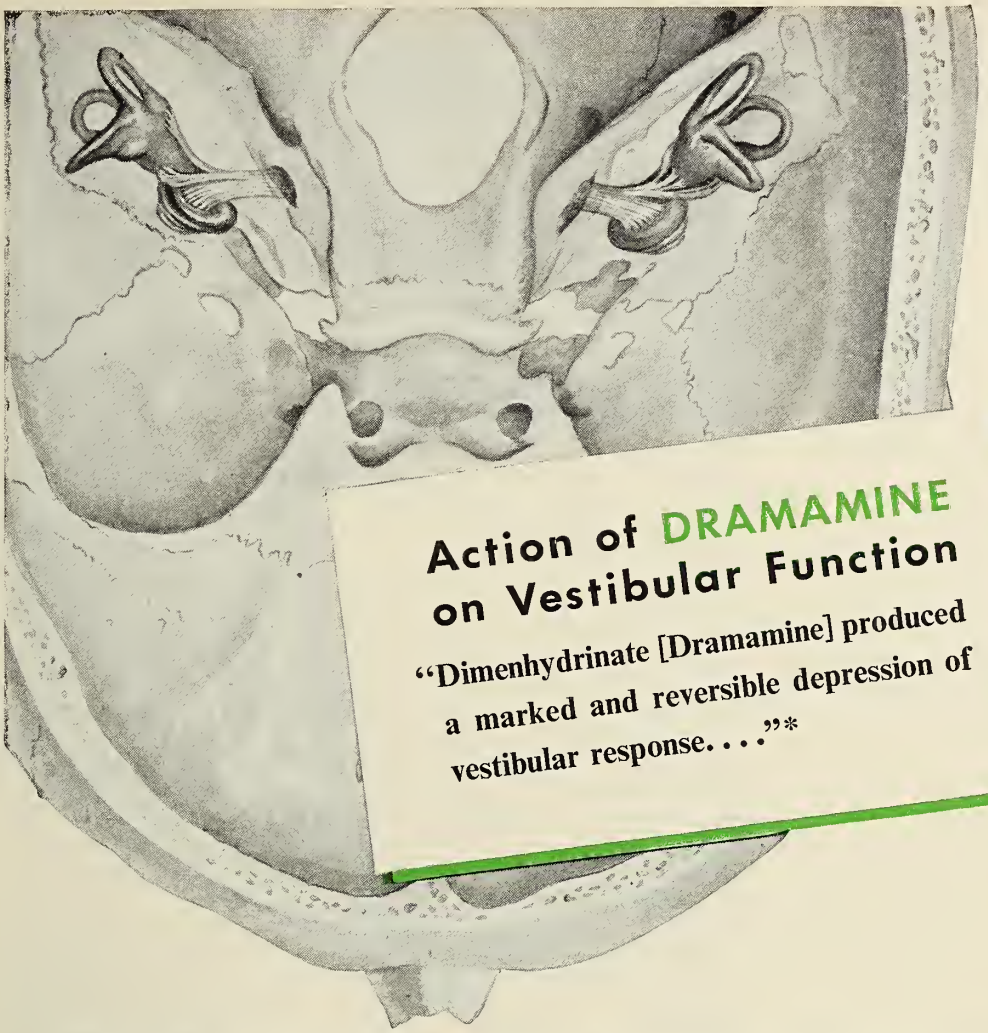
Annual Business Meeting, Michigan Association of Industrial Physicians and Surgeons.

Cocktail Hour—6:30 P.M.—Hotel Durant

Dinner—7:30 P.M.

Max R. Burnell, M.D., Detroit, Toastmaster.

"Recent Advances in Artificial Respiration."—A. C. Ivy, M.D., Chicago, Professor of Physiology, University of Chicago, Vice-president University of Illinois.



Action of DRAMAMINE on Vestibular Function

"Dimenhydrinate [Dramamine] produced a marked and reversible depression of vestibular response. . . ."*

In a study of the action of Dramamine on vestibular function, Gutner and his associates found that Dramamine "significantly delayed the onset of nystagmus, shortened the duration of nystagmus and increased the milliamperage necessary to effect tilting."

The great effectiveness of Dramamine in motion sickness, they state, ". . . is probably related primarily to its ability to depress vestibular function. . . ."

DRAMAMINE®

BRAND OF DIMENHYDRINATE

—for prevention and treatment of motion sickness—

Now available in these dosage forms: { Tablets — 50 mg. / Liquid — 12 mg. per 4 cc. / Average dose — 50 mg.

ACCEPTED COUNCIL ON PHARMACY AND CHEMISTRY AMERICAN MEDICAL ASSOCIATION

*Gutner, L. B.; Gould, W. J., and Batterman, R. D.: Action of Dimenhydrinate (Dramamine) and Other Drugs on Vestibular Function, Arch. Otolaryng. *53*:308 (March) 1951.

RESEARCH IN THE SERVICE OF MEDICINE **SEARLE**

Michigan's Department of Health

Albert E. Heustis, M.D., Commissioner

Nearly all the directors of Michigan's full-time local health departments gathered in Lansing, February 6, 7 and 8 at the invitation of the state health commissioner to make their recommendations for future conduct of state and local health department programs. This Third Annual Commissioner's Conference of Local Health Officers resulted in 58 recommendations.

The health officers recommended that local health departments assume responsibility for interesting young people in their communities in the career opportunities in public health; that the state health department and local health departments make every effort to promote fluoridation of public water supplies; that approved sanatoria in the state provide periodic progress reports on all tuberculosis patients under their care to the health officers from whose jurisdiction they come.

They recommended, too, that the state health commissioner delegate responsibility wherever practicable to local health departments to carry out the maternity hospital licensing program; that the state health department furnish information relative to: (1) recognized immunization practices for different age levels against smallpox, diphtheria, whooping cough and tetanus and (2) the minimum standards for immunization status for adequate community protection.

They recommended that the commissioner of health ask the Michigan State Medical Society and the Michigan Medical Service to include provision for immunization among their services; and that the Maternal and Child Health Committee of the Michigan State Medical Society be asked to develop a plan for providing obstetrical consultation services to practitioners in areas where there are no specialists available in this field.

The local health directors favored the development of local health departments in those counties not now covered and they endorsed the principle of regrouping existing health departments to service a larger population unit. They also favored a general public health appropriation of federal funds rather than categorical grants; and the establishment of local health councils.

They endorsed the idea of having an annual Commissioner's Conference.

They were informed that Social Security benefits could be made available to all full-time employes of local health departments by proper action of their local boards of supervisors or by their district boards of health.

These and the other recommendations to the Commissioner have been submitted to all full-time local health officers and to the Division Directors of the State Health Department for consideration and application in the health programs of the state.

* * *

Results of a recent survey of birth registrations in Michigan are now being studied on a county-to-county basis to find out where and why births are not being registered and to take positive action toward securing 100 per cent registration.

The state-wide survey showed that one out of every hundred babies born in Michigan does not have a birth record filed with the Michigan Department of Health. The exact figures show that 98.7 per cent of Michigan births were registered in 1950, which is an improvement over 1940 when a similar survey disclosed a registration of 97.8 per cent.

Twenty-six states and the Territory of Hawaii had better registration records than Michigan.

The study of Michigan birth registrations was part of a nationwide survey conducted by the United States Public Health Service, state health departments and the Bureau of the Census.

* * *

A new film catalog issued by the Department describes 209 films, eighty-seven film strips and seven slide sets now available for loan throughout the state. Approximately 500 prints on forty-five health subjects are in constant use during the year. Last year, 741,085 persons saw films from the Department's loan library in 10,460 showings. Some of the films are designed specifically for professional audiences—physicians and nurses. Most are for the average club or school use.

* * *

Fluoridation of water supplies as a means of preventing tooth decay in children continues to gain in popularity throughout the state. Twenty-one cities are now fluoridating their water supplies. A dozen others have plans approved and are awaiting the installation of equipment or delivery of chemicals. At least thirty other communities are in the investigating and planning stage.

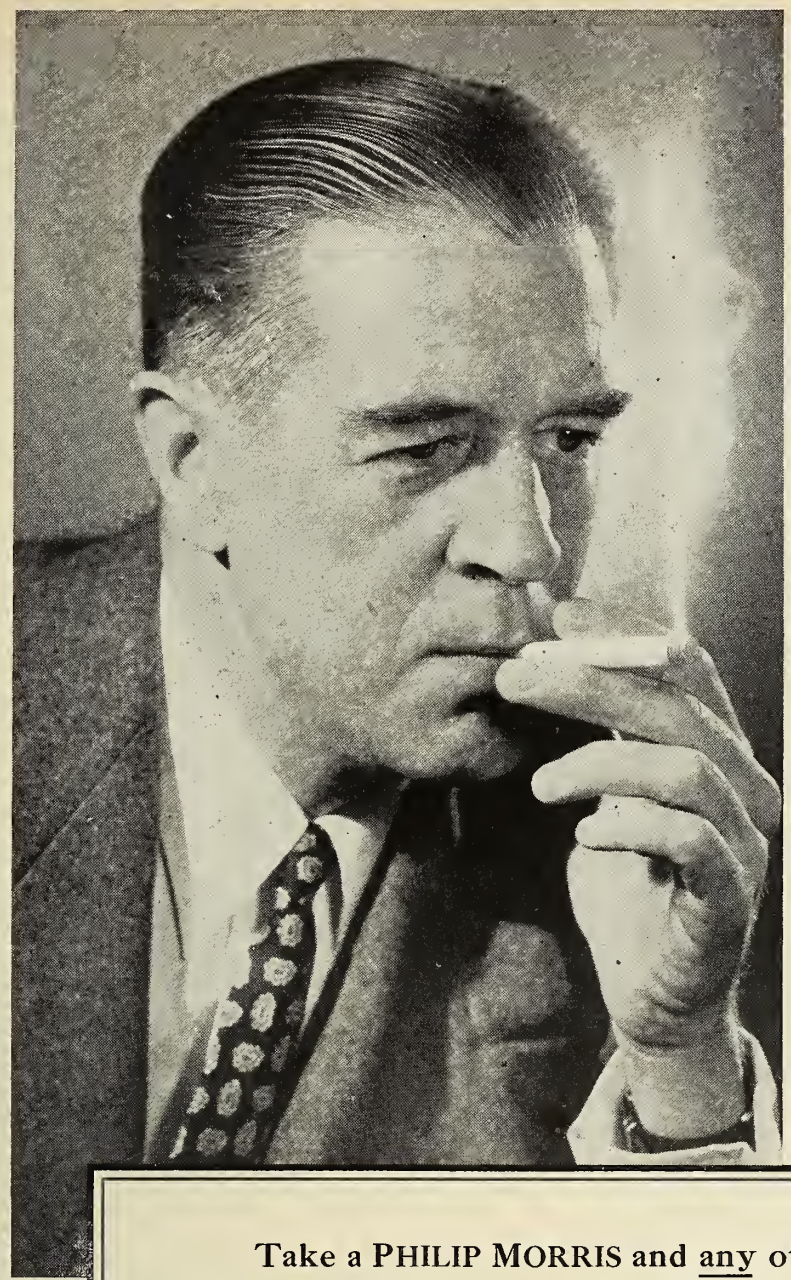
* * *

A new film, "Uterine Cancer: The Problem of Early Diagnosis," can be borrowed from the film loan library of the Michigan Department of Health. The film, jointly sponsored by the American Cancer Society and the National Cancer Institute, shows how deaths from cancer of the uterus can be drastically reduced through adherence in general office practice to the routine pelvic examination of all adult women.

The film is for professional audiences—medical societies, medical schools, hospital staffs and physicians' or nurses' groups. It is a 16 mm. sound film, in color, with a running time of 21 minutes and is rich in clinical and laboratory material.

* * *

Interest in the problems of the later years is at a high level in Michigan as evidenced by more than 1,000 requests for the November issue of the Department's magazine which dealt with this subject. For the first time in the history of its monthly bulletin, dating back to 1898, the Department had to resort to multilithing an issue to meet the requests that could not be filled by the printed edition.



Doctor, be your own judge... try this simple test

With so many claims made in cigarette advertising, you, Doctor, no doubt prefer to judge for yourself. So won't you make this simple test?

Take a PHILIP MORRIS and any other cigarette

1. Light up either one first. Take a puff—get a good mouthful of smoke—and s-l-o-w-l-y let the smoke come *directly* through your nose.
2. Now, do exactly the same thing with the other cigarette.

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In Memoriam

ANDREW S. BRUNK, M.D., Detroit, Past President and the Treasurer of the Michigan State Medical Society, who was active in medical organizations for nearly a quarter of a century, died February 3, 1952, in San Antonio, Texas. He was sixty-seven.



His twenty-four years of continuous service to medicine was milestoned by the contribution of his talents and energy in aiding the founding of several organizations of lasting value to the medical profession.

One of these organizations in which his influence and zealous action was felt was the Michigan Health Council. Working with others who recognized the need for such an organization in Michigan, he assisted in the founding of this Council in 1943. Doctor Brunk was elected its first president and served in that capacity until 1950. After leaving the president's chair, he continued to serve on the Health Council's Board of Trustees and its Executive Committee.

Another organization which received Dr. Brunk's active support at its founding was Michigan Medical Service. Doctor Brunk was a member of the Blue Shield Board of Directors from 1940 until his death.

The third association founded through the pioneering activities of Doctor Brunk was the Conference of Presidents and Other Officers of State Medical Associations. This organization resulted from a gathering of seventeen State Medical Society presidents who came to Detroit in April, 1945, at the telephonic invitation of MSMS President Brunk. The Conference was created in Chicago in December of that year, and Doctor Brunk was elected as its first president.

As one of the founders and strong financial supporters of the Michigan Foundation for Medical and Health Education, Inc., he contributed to the future of medical and health education in this state.

Doctor Brunk began his years of service as an official in organized medical circles by becoming president of the militant East Side Medical Society of Detroit just one year prior to his election as president of the Wayne County Medical Society in 1929. He was instrumental in revitalizing his County Medical Society and was influential in its decision to employ the services of a full-time executive secretary. After his presidential tenure, he also served on the Board of Trustees of the Wayne County Medical Society for five years.

From 1930 to 1952 Doctor Brunk was a member of The Council of the Michigan State Medical Society; and of its Executive Committee from 1939 to 1945. He was elected MSMS President and served the 1944-45 term. Following a successful year, he was chosen as MSMS Treasurer, which position he held until his death.

Besides these positions of responsibility in the medical societies, Doctor Brunk was also a member of the Board of Directors of Michigan Hospital Service (Blue Cross) and served on its Executive Committee from 1939 to 1948. He was Director of Martin Place Hospital, Detroit, which he established in 1930.

Among the many honors received by Doctor Brunk was Honorary Membership in the Colorado State Medical Society conferred in 1951 for his "services to the whole medical profession of the United States." Also in 1951, Michigan Medical Service presented him with a desk clock in commemoration of over ten continuous years of service on the Michigan Medical Service Board of Directors.

Doctor Brunk received his M.D. degree from Ohio State University in 1909. He was chief surgeon for the Southern Pacific Railroad in LaJunta, Colorado, from 1911 until he came to Detroit in 1924.

He is survived by a son, Perry E. Brunk, D.D.S., of Dearborn; three brothers, Clifford F. Brunk, M.D., Traverse City, Dr. Henry Brunk of Detroit, and Lloyd Brunk of Indian River; two sisters, Mrs. D. E. Stutzman of Lima, Ohio, and Mrs. O. G. Brenneman of LaFountain, Indiana.

In a eulogy to Doctor Brunk, a friend said:

"Doctor Brunk had numerous hobbies—one never understood where he found the time to devote himself to so many of them. He was a natural mechanic and upon his retirement eighteen months ago, Doctor Brunk kept himself busy with the development of labor-saving devices that made his home in Riverside, Ontario, a surprising experience to his many guests. He was the 'Henry Ford' of the Detroit medical profession, devising useful gadgets about his hospital, home and farm estate that contributed to his own and his many friends' conveniences and pleasure.

"Doctor Brunk was a quiet man, but his calm and unruffled manner generated confidence; his leadership was sought everywhere. He had deep humor and was 'good company'—a good listener who drew out the best in friend and acquaintance. In his gentle way, he urged all to greater effort and was constant in inviting the good qualities of those about him to all others in his vast acquaintance.

"Doctor Brunk was a good friend. His friends will miss him; his medical associations will miss him; and good medicine in Michigan and throughout the United States will miss him. It was good that he lived."

EARL J. FLICK, M.D., of Royal Oak, died January 24, 1952, at the age of forty-one.

Dr. Flick, originally from Pennsylvania, was graduated from the Wayne University College of Medicine in 1936. He practiced in Royal Oak with his brother, John R. Flick, M.D.

He is survived by his wife, Beth; four children, Janet, Susan, Gwendolyn and Earl, Jr.; and two brothers, Clair and Dr. John.

WILLIAM VERNE McINTOSH, M.D., of Highland Park, died January 1, 1952, at the age of sixty-one.

For the past twenty-three years, Dr. McIntosh was physician to the Highland Park Schools. He began his practice in Highland Park in 1916.

Dr. McIntosh was graduated from the Toronto College of Medicine in 1914. He served his internship at Harper Hospital, Detroit. He was a past president of the staff of Highland Park General Hospital and a member of the Wayne County Medical Society.

During World War I he served with the Canadian Army Medical Corps.

He is survived by his wife, Zella; a son, Donald; and his mother, Mrs. Margaret McIntosh.

WILLARD MONFORT, M.D., of Highland Park, died December 30, 1951, at the age of seventy-eight.

For the past thirty-nine years, he has served the community of Highland Park, limiting his practice to eye, ear, nose and throat. Previous to that, Dr. Monfort practiced medicine in Ithica, Michigan, for twelve years. He was graduated from the New York University College of Medicine in 1899.

Dr. Monfort was a member of the Wayne County Medical Society, the Detroit Otolaryngological Society and the Detroit Ophthalmological Society. He was elected an Emeritus member of the Michigan State Medical Society as well as a member of its "Fifty Year Club" in 1949.

He is survived by his two sons, Robert Monfort, M.D., of East Lansing, and Neal Monfort; two brothers, George and Frank; two sisters, Edith May, of Lapeer, and Mrs. Peter LaCamara; and four grandchildren.

F. GERALD RANSOM, M.D., of Jackson, died December 31, 1951, at the age of fifty-one while making a house call on a patient.

He was a graduate of the University of Michigan Medical School in 1923.

Dr. Ransom practiced medicine for twenty-five years and was a former treasurer of the Jackson County Medical Society. He was also a member of the staffs of the Foote and Mercy Hospitals.

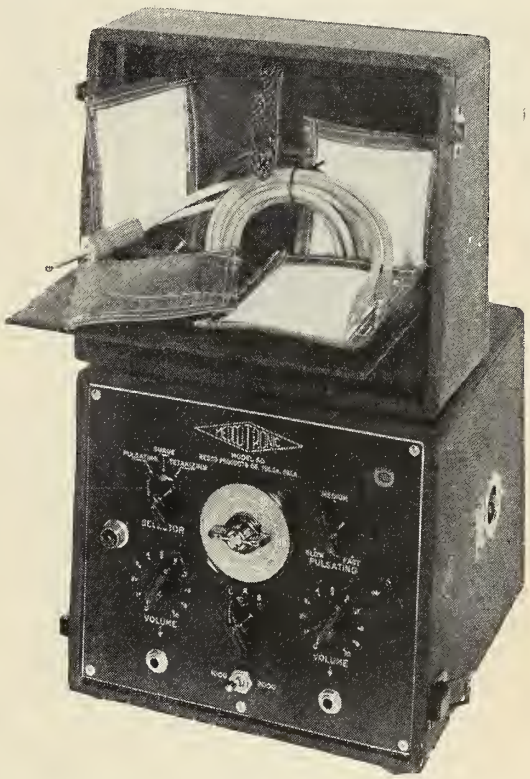
He is survived by his mother, Mrs. Fred C. Ransom, of Jackson, and his brother, Henry K. Ransom, M.D., Associate Professor of Surgery at the University of Michigan.

LEON E. SEVEY, M.D., of Grand Rapids, died December 26, 1951, at the age of sixty.

For the past thirty-six years he served the community of Grand Rapids as a surgeon. He was graduated from

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By means of the Medcotron Pad Electrodes the current from the Stimulator is applied to individual muscles or groups of muscles, with comparative freedom of discomfort to the patient. Control of stimulation is attained by the operator regulating the type of stimulus provided, and the voltage and frequency of the current.

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the University of Pittsburgh School of Medicine in 1913.

After graduation, Dr. Sevey interned at Mercy Hospital in Pittsburgh before he moved to Grand Rapids and became associated in 1915 with the late Richard Smith, M.D.

Dr. Sevey was a past president of the Kent County Medical Society and of the Michigan Association of Industrial Physicians and Surgeons. He was also a member of the Phi Rho Sigma medical fraternity.

Dr. Sevey was a member of the consulting surgical staffs at Blodgett Memorial and St. Mary's Hospitals and also at Butterworth Hospital. He was honored last spring by the Industrial Surgeons group for long service.

During World War I, Dr. Sevey served in Army Hospital Unit "Q" in the United States, England, and France as a captain.

He is survived by his wife, Lillian May, and his mother, Mrs. Rose Sevey, of Grand Rapids.

J. HOWARD VanNESS, M.D., of Allegan, died December 20, 1951, at the age of seventy-nine.

He served the community of Allegan for forty years before his retirement a few years ago. He was graduated from the University of Illinois Medical College in 1906.

He was first president of the Allegan Rotary Club and past president of the Kalamazoo Academy of Medicine.

He is survived by his wife, Betty; a daughter, Mrs. Stuart Geldholf, of Grand Rapids; two sons, George, of Constantine, and Sidney, of Middlesboro, Kentucky, two stepsons, George Maents, of Kalamazoo, and James Maentz, of Grand Rapids; seven grandchildren and two great grandchildren.

GEORGE F. WARD, M.D., of Detroit, died December 9, 1951, at the age of sixty-seven.

Dr. Ward practiced medicine in Detroit for thirty-three years. He was graduated from the Syracuse University College of Medicine in 1913.

Dr. Ward is survived by his wife, Evangeline; a brother, William; and a sister, Nell Ward, M.D.

HERBERT H. WILEY, M.D., of Utica and Algonac, died January 20, 1952, at the age of seventy-eight.

He practiced medicine in the community of Utica after his graduation from the Detroit College of Medicine in 1899 until his retirement six years ago.

Dr. Wiley was active in community affairs and served as a member of the Utica Board of Education for thirty years. Last September Dr. Wiley was elected a Life Member of the Michigan State Medical Society as well as being named to the MSMS "Fifty Year Club."

Dr. Wiley is survived by his wife, Ethel; two brothers, Arthur, of Blenheim and Edd, of Windsor, Ontario. He also leaves his nephew, D. Bruce Wiley, M.D., of Utica, MSMS Councilor of the Fifth District.

Legal Opinions

TWO LEGAL OPINIONS ON STERILIZATION

W. J. Burns, Executive Director
Michigan State Medical Society
Lansing, Michigan

Dear Mr. Burns:

Reference is had to the inquiry of July 24, 1951, concerning certain aspects of sterilization and containing eight specific questions.

I assume that the sterilization referred to is not the compulsory or statutory sterilization of mental defectives, but has reference to what might be termed voluntary sterilization. In this State, we have no statutes concerning voluntary sterilization bearing on the criminal or civil liability in connection therewith. Nor are there any reported decisions in this State bearing on the common law liability in relation thereto. In attempting to answer the specific questions, therefore, one is obliged to reply on general legal concepts and reasoning with some regard to the very few decisions reported in other jurisdictions. Nobody can safely predict a new decision of the Supreme Court, particularly when there are no guideposts of former decisions in this State.

Voluntary sterilization may be placed in three categories. The first, one may call eugenic sterilization. This is the type where one desires to be sterilized because he believes he has some serious defect and thinks there is a possibility it will be transmitted to the offspring. The second, one might call the therapeutic sterilization which is sterilization for medical reasons involving the health of the individual. The third may be termed contraceptive sterilization, which is from choice of the person sterilized and for his convenience or economic reasons.

From such research as I have made, it is my belief that as the law now stands in this State, it is most unlikely that there is any criminal or civil liability for the performance of voluntary sterilization if proper consent of necessary parties has been obtained and the operation is not negligently performed.

Answers to specific questions follow:

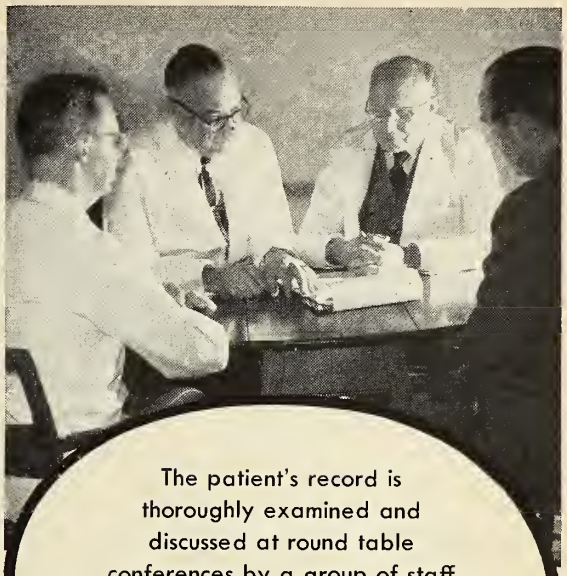
1. Is it necessary for the wife to sign when sterilizing the husband? For proper protection, the wife's written consent should be obtained.

2. Is it necessary for the husband to sign when sterilizing the wife? For proper protection, the husband's written consent should be obtained. In other words, both spouses should sign consents for the sterilization of either.

3. What is the physician's legal responsibility when sterilization is not specified in each sex? (i.e. before operation.) This question is not clear and I am not sure that I understand it.

4. What are the responsibilities relative to sterilizing people who are questionably mentally incompetent? Is the signature valid? A mentally incompetent person cannot in the eyes of the law give consent. The law in this regard is no different than that involving any contracts of incompetents. If it can be shown that at the time when a person entered into a contract he was incompetent, the contract is void. This question most commonly arises in the matter of making wills. If a physician has doubt about a person's mental competency, he should not rely on the consent given by such person. A person declared incompetent by a court may have his consent given by a properly appointed guardian.

5. What are the legal responsibilities for sterilization decided upon after anesthesia is given? In other words, without the patient's permission but when it is believed to be for the best interest of the patient. It is not safe to sterilize the patient without his consent. The form of written consent required to be signed by patients



The patient's record is thoroughly examined and discussed at round table conferences by a group of staff members which includes at least two physicians and one counselor.

Successful Management OF THE
PROBLEM DRINKER

The alcoholic, like the hypertensive or the diabetic, is an ailing man. He presents a medical problem.

For this reason the program of management at The Keeley Institute is based on sound medical principles developed through the years.

The treatment approach is positive rather than negative—encouragement rather than restraint; nutritional build-up rather than nauseants or alcohol reactors; happy surroundings rather than confinement—and the results have shown this to be a successful course to follow.

This intraduces a series in which we intend to describe the variaus phases af treatment from the patient's arrivol at The Keeley Institute to his ultimate departure therefram.

Full infarmation, including rates, will be furnished to physicians on request.

THE KEELEY INSTITUTE
DWIGHT, ILLINOIS

Therapy for Vascular Headache to Reverse the Physiologic Disturbance

Headache, a problem encountered in all kinds of medical practice, may occur in association with any of a variety of disorders, some organic, other purely functional.

Among the several types, functional headaches present the greatest problem because of their obscure etiology and recurrent nature.

Among these are:

Migraine (both classical and variant forms)
Tension headache
Psychogenic headache
Histaminic cephalgia

Wolff and his co-workers established that the pain of these headches is due to disturbance of the tonus of cranial blood vessels — hence the term *vascular headaches.*

The craniovascular changes associated with the several phases of the typical migraine attack are:

Vasoconstriction — to which the visual prodromata are attributable. It is possible to abort the attack during this phase in all but a few cases. (See treatment below.)

Vasodilatation — as the vessels lose their tone, exaggerated pulsations set in, resulting in the throbbing pain which characterizes vascular headache. Treatment for the attack is still effective during this phase. (See below.)

Vessel Edema — if the vasodilation continues for too long, vessel walls become edematous; this changes the character of the pain to a steady, intense aching. The attack can now no longer be checked, even with maximum dosage of specific drugs. *Moreover, sustained headache often induces reflex neck muscle tension, a source of residual pain.*

Therapy: 1. Reduce the frequency of attacks — psychotherapy and regulation of living habits to avoid fatigue and nervous tension.

2. Relieve the acute attack — of the numerous drugs which have been tried, ergotamine and its derivative preparations have proved most effective. The newest product is oral tablets of Cafergot®, N. N. R. (ergotamine with caffeine 'Sandoz'). When dosage is adjusted to the needs of the individual, Cafergot will give good relief in 85% of cases. It enables a greater number of patients to benefit from early administration since the oral route simplifies treatment as compared to parenteral therapy.

The dosage procedure is:

1. Take 2 tablets at first sign of the attack.
2. If attack continues, take one additional tablet every ½ hour until attack is terminated *(max. 6 tabs. per attack).*

Many migraine patients delay taking medication until the attack is at its height. Explicit dosage instructions may be forgotten unless the patient comes to realize their importance. Therefore, to encourage adherence to correct procedure, we have prepared pads outlining detailed dosage instructions. Supplies of these INSTRUCTION SLIPS will gladly be sent upon request.

GENERAL REFERENCES: DeJong, R.: Chicago M. Soc. Bull *54:* 106, 1951. Friedman, A.: Modern Headache Therapy, St. Louis, C. V. Mosby Co., 1951. Wolff, H.: Headache and Other Head Pain, N. Y., Oxford Univ. Press, 1948.

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in some of the larger hospitals is sufficiently broad to permit sterilization after anesthesia, should it become medically necessary.

6. What are the legal responsibilities or ethics associated with consultation? To my knowledge, there are no specific precepts established by the AMA concerning sterilization and consultations in relation thereto. Presumably, where there is a question as to the medical necessity for therapeutic sterilization, the physician would find it appropriate to take consultation. The consultations required by law in cases of therapeutic abortions have no application to sterilization.

7. Does the State Association have any ethical codes relative to ages, number of children, et cetera, which may be used in deciding on advisability of sterilization? No.

8. What are the hospital's legal responsibilities in regard to sterilization? If the consent indicates the hospital in which the operation is to take place, the hospital would be certainly no more liable than the surgeon.

Very truly yours,

J. Joseph Herbert
Legal Counsel
Michigan State Medical Society

August 14, 1951

Wm. J. Burns, Executive Director
Michigan State Medical Society
Lansing, Michigan.

Dear Mr. Burns:

Under date of January 29, 1952, you have made inquiry as to whether the Supreme Court of our state has recently ruled on the constitutionality of the Michigan statute concerned with sterilization of mentally defectives. Your request is based on a letter from the Medical Society of the State of North Carolina, dated January 24, 1952.

The only Michigan statute concerned with this subject, now effective, is Act 281, P.A. 1929 (C.L. 1948, Secs. 720.301-720.310). This statute is an Act to prevent the procreation of feeble-minded, insane, and epileptic persons, moral degenerates, and sexual perverts; to authorize and provide for the sterilization of such persons and payment of the expenses thereof.

There has been no case passing on the constitutionality of this statute. However, a similar statute which was repealed by the current one was Act 285, P.A. 1923. A portion of the 1923 statute was, in 1925, declared unconstitutional in the case of *Smith v. Probate Judge, 231 Mich. 409.* The portion declared unconstitutional, being Section 7, subdivision 2, of the 1923 Act, provided for the sterilization only of those feeble-minded persons who are unable to support any children they might have, and whose children probably would become public charges. The court held that the invalidity of this particular section did not affect the constitutionality of the balance of the law. Inasmuch as the current statute is, in wording, substantially the same as the 1923 Act, omitting therefrom, however, the invalid provisions, it may be said that the Smith case confirmed the constitutionality of the current Act by analogy.

The only other decision bearing on the constitutionality of the 1923 Act is the case of *In re Salloum, 236 Mich. 478.* This was, in effect, a memorandum decision referring to the Smith case, supra, which had been decided the year before.

I am unable to find any later decisions bearing on the constitutionality of the 1923 or 1929 Acts, and I am of the opinion that there are none.

Very truly yours,

J. Joseph Herbert
Legal Counsel
Michigan State Medical Society

February 6, 1952.

Say you saw it in the Journal of the Michigan State Medical Society

Correspondence

Otto O. Beck, M.D., President
Michigan State Medical Society
Lansing, Michigan

My Dear Doctor Beck:

We look forward with very real pleasure to reading the March 1952 Civil Defense and atomic warfare issue of THE JOURNAL of the Michigan State Medical Society.

Your previous Civil Defense issue was a worthy symposium, far in advance of most such materials. The March 1951 issue was and is still being read with considerable interest by Civil Defense workers. The authors, the editor and the Committee on Atomic and Allied Procedures certainly are to be commended.

We anticipate reading the March 1952 issue with equal enlightenment. Can you send me 12 copies for our reference use?

Very truly yours,

LESTER J. MAITLAND
State Director
Michigan Office of Civil Defense
Lansing, Michigan

February 11, 1952

Mr. Wm. J. Burns, Executive Director,
Michigan State Medical Society,
Lansing, Michigan

Dear Bill:

I thought you would be interested to know that we now have a doctor for next summer for Kalkaska—one of the fellows who finished at Wayne last summer. He is a splendid young fellow who was in the upper third of his class, and both he and his wife are going to fit in beautifully. Kalkaska now is one of our bare spots, having only two old men, both of them crippled and unable to make house calls.

They are letting out bids in March for the health center. The plans for the Center, plus the welcome the town folks gave them, are what decided the Kittis. Since their plans were in direct relationship to the State Society's activities in interesting students in rural areas, plus the Society's co-operation in working out plans for the Health Center, I thought at the State Office level you would be interested to know that as far as Kalkaska is concerned, we have had a good experience.

Sincerely,

JOHN R. RODGER, M.D.,
Bellaire, Michigan

January 30, 1952

Mr. William J. Burns,
Executive Director,
Michigan State Medical Society

Dear Sir:

I wish to bring to your attention the extreme need of the Air Force Reserve for all classes of medical personnel, such as doctors, dentists, nurses, sanitary engineers and hospital technicians in the Medical Group of the 929th Reserve Training Wing.

The 439th Troop Carrier Wing, an Air Force Reserve unit which was trained by the 2242D Air Force Reserve Training Center, Selfridge Air Force Base, was called into active Federal service on April 1, 1951, so again we have the task of building another Reserve Training Wing. To date, the Medical Group of the 929th Reserve Training Wing is far behind in reaching its goal. The Medical Group is authorized 26 officers and 67 airmen. Colonel Richard D. Mudd, a well-known doctor and Air Force Reservist of Saginaw, Michigan, is the Air Surgeon in command of the Reserve Medical Group.

This unit needs the following medical officers and technicians: doctors (M.D.'s) 5, dentists 2, nurses 10, sanitary engineer 1, dietician 1, administrative officers 2, meat and dairy inspector 1, plus a number of medical, dental, and laboratory technicians.

The training consists of one week end a month (2 days) for which one will receive four (4) days' pay, points toward retention in the Air Force Reserve, and at the completion of twenty years service one can retire with an income for life upon reaching age 60.

Anyone, especially doctors, who is interested is invited to write to the Commanding Officer, 2242D Air Force Reserve Training Center, Selfridge Air Force Base, Michigan, or contact Dr. Richard D. Mudd at 1001 Hoyt Street, Saginaw, Michigan, either in person or by letter.

The active Air Force Reserve has become a vital element in our national defense, and its maintenance is the responsibility of all our citizens. The Air Force organized Reserve is a vast voluntary organization without which our Air Force would suffer greatly. As in the past, it is hoped that the medical profession will continue to support the Reserves.

Your interest in this program, which is for our national security, will be greatly appreciated.

I assure you that all inquries will receive prompt and courteous attention by this headquarters.

Sincerely yours,

GEORGE L. ROSS
Lt Col, USAF
Commanding
Selfridge Air Force Base,
Michigan

18 January 1952





. NEWS MEDICAL

MICHIGAN AUTHORS

Frederick A. Coller, M.D., of Ann Arbor, is the author of an article entitled "Some Effects of Physiological Research Upon Surgical Practice," published in the *University of Michigan Medical Bulletin,* December, 1951.

G. G. Bole, Jr., M.D., B. L. Baker, M.D., D. J. Ingle, M.D., and **C. H. Li, M.D.**, of Ann Arbor, are authors of an article entitled "The Effect of Hypophyseal Hormones on the Lipid Content of Brown Adipose Tissue," published in the *University of Michigan Medical Bulletin,* December, 1951.

John Woodworth Henderson, M.D., Ph.D., and **Elizabeth Caroline Crosby, Ph.D.**, of Ann Arbor, are authors of an article entitled "An Experimental Study of Optokinetic Responses," published in the *Archives of Ophthalmology,* January, 1952.

Richard Coy Schneider, M.D., and **John Woodworth Henderson, M.D.**, of Ann Arbor, are authors of an article entitled "Penetrating Orbital Wound with Intracranial Complications," published in the *Archives of Ophthalmology,* January, 1952.

C. P. Hodgkinson, M.D., of Detroit, is the author of an article entitled "Hemorrhage From Ruptured Utero-Ovarian Veins During Pregnancy," published in *The Journal of the American Medical Association,* January 26, 1952.

Louis J. Gariepy, M.D., O. A. Capano, M.D., and **Lawrence W. Gardner, M.D.**, of Detroit, are authors of a paper, "Non-Traumatic Rupture of the Common Bile Duct," in *The American Journal of Surgery,* March, 1951.

Seymour K. Wilhelm, M.D., of Detroit, is the author of a paper, "Alterations in Serum Potassium and Sodium in Acute Myocardial Infarction," published in *The American Journal of Clinical Pathology,* February, 1951.

Howard K. Gray, M.D., James D. Frylogle, M.D., and **C. Allen Good, M.D.**, are authors of a paper, "Malignant Pulmonary Abscess," published in *The Surgical Clinics of North America,* August, 1951.

E. Stewart **Ryerson, M.D.,** and **Ralph A. Poirier, M.D.**, of Detroit, are the authors of a Manual for the Glaucoma Patient.

Ivan F. Duff, **James W. Linman,** and **Roberta Birch,** Department of Internal Medicine, Surgery, Gynecology and Obstetrics, of Ann Arbor, are the authors of an article, "The Administration of Heparin," published in the *University of Michigan Medical Bulletin,* January, 1952.

Russell N. DeJong, M.D., of the Department of Neurology, Ann Arbor, addressed the student body of the Marquette University School of Medicine on October 16, on the subject "Metastatic Involvement of the Central Nervous System."

Russell N. DeJong, M.D., A. Leslie Drew, Jr., and **Martha R. Westerberg, M.D.**, of Ann Arbor, participated in the conducting of the examinations of the American Board of Psychiatry and Neurology in New York City on December 16, 17, and 18. Dr. DeJong is a Director of the American Board of Psychiatry and Neurology.

Russell N. DeJong, M.D., of Ann Arbor, on January 8, addressed the Chicago Neurological Society on the subject, "The Syndrome of Hallervorden and Spatz."

Frederick A. Coller, M.D., of the Department of Surgery, Ann Arbor, gave a paper entitled, "Cancer of the Rectum: A Study of Long Term Survival," at the annual meeting of the Southern Surgical Association at Hot Springs, Virginia, in December.

Carl E. Badgley, M.D., of Ann Arbor, conducted a Crippled Children's Clinic at Bay City on December 4. On December 17, Dr. Badgley gave a paper on "Fractures in and about the Knee Joint" at the meeting of the Boston Orthopedic Society, in Boston.

J. W. Conn, M.D., of the Department of Internal Medicine, of Ann Arbor, took part in the conference on the adrenal cortex called by the National Academy of Sciences, meeting January 17 through 19 at New York City.

J. W. Conn, M.D., of Ann Arbor, gave the annual Sigmund Pollitzer Lecture at New York University Postgraduate Medical School, New York City. His subject was "The Influence of Adrenal Cortical Activity upon the Electrolyte Composition of Thermal Sweat."

Louis J. Gariepy, M.D., is the author of an article, "Your Doctor Leads Freedom's Fight Against Socialism," in the *Michigan Voter,* May-June, 1951.

Conrad R. Lam, M.D., F.A.C.S., Hartley H. Aram, M.D., and **Edward R. Munnell, M.D.**, of Detroit, are the authors of an article, "An Experimental Study of Aortic Valve Homografts," published in *Surgery Gynecology and Obstetrics,* February, 1952.

Robert E. L. Berry, M.D., of Ann Arbor, is the author of an article, "Diagnosis and Treatment of Acute Intestinal Obstruction," published in *The Journal of the American Medical Association,* February 2, 1952.

Ronald Yaw, Superintendent of Blodgett Memorial Hospital, Grand Rapids, is the author of an article, "Are Fire Insurance Rates Too High?" published in *Hospitals,* February, 1952.

Harry Becker, of Detroit AUW-CIO, is the author of an article, "A New Boost for Voluntary Prepaid Care," published in *Hospitals,* February, 1952.

Jacques H. Ahronheim, M.D., Jackson, is the author of a paper on "Mass Blood Typing" which was published in *JAMA* of November 10, 1951. Reprint received by MSMS.

Meyer O. Cantor, M.D., Earle Acker, M.D., Andrew Scharf, M.D., and **Keith Foster, M.D.,** Detroit, collaborated in writing a paper on "Effect of Variation in Length of Decompression Tube Upon Bowel Wall," published in *The American Journal of Surgery,* December, 1951.

Dr. John J. Grebe, Research Councilor of Dow Chemical Company and a member of the MSMS Committee on Atomic and Allied Procedures, is the author of an original article, "Atomic Energy as a Force for Peace," which was published in *Think* of December, 1951.

MSMS PAST PRESIDENTS' PHOTOGRAPHS

The Council has taken action to place photographs of all MSMS Past Presidents (from the year 1866 on) in the Past Presidents' Room of the new MSMS "home" at 606 Townsend Street, Lansing.

Photographs of the following have not as yet been located:

1867—J. H. Jerome, M.D., Saginaw
1868—Wm. H. DeCamp, M.D., Grand Rapids
1875—Wm. Brodie, M.D., Detroit
1880—J. R. Thomas, M.D., Bay City
1881—J. H. Jerome, M.D., Saginaw
1885—E. P. Christian, M.D., Wyandotte
1886—Charles Shepard, M.D., Grand Rapids
1915—A. W. Hornbogen, M.D., Marquette
1918—Arthur M. Hume, M.D., Owosso
1920—Angus McLean, M.D., Detroit
1921—Wm. J. Kay, M.D., Lapeer
1922—W. T. Dodge, M.D., Big Rapids
1923—Guy L. Connor, M.D., Detroit
1924—C. C. Clancy, M.D., Port Huron
1925—Cyrenus G. Darling, M.D., Ann Arbor

If you have a photograph of any of the above-listed Past Executives of the Michigan State Medical Society, The Council would appreciate your contributing a print for the Past Presidents' Room; or if you know of some person we could contact, please inform the MSMS Executive Office, 606 Townsend Street, Lansing.

Thank You,
The Council,
Michigan State Medical Society

Increasing Socialistic Trend in America Today.—In December AMA's president-elect, Dr. Louis Bauer, threw a challenge to American physicians in his keynote address at the AMA medical public relations conference. Said Dr. Bauer: "This country . . . is fast moving down the road marked Socialism." 1952, a presidential-election year, offers physicians an opportunity to whip socialism at the polls. Every physician, as a citizen, should resolve to become actively engaged in this campaign. The defeat of socialism must be accomplished at the community level because national opinion is the sum total of the public attitude of local communities. According





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to Dr. Bauer, "the tide can be turned in 1952, but we must work together to do it."

* * *

Michigan Medical Service.—The latest figures of members, policy holders of Michigan Medical Service, were for November 30, 1951. There were 2,331,039, of whom 66,377 hold the new $5,000 limit certificate.

Complaints are constantly being heard that the plan is not sufficiently inclusive. The plan was established primarily to care for the catastrophic illness which may strike a family of whatever means, and disrupt that family's finances or security. There was no attempt to cover everything that could occur. Such coverage could be written but would make the plan so expensive the really needy person could not have it. It is hoped that physicians will consider the soundness and stability of the plan when suggesting new features, and that insured members will consider their true security and be willing to pay some of their minor costs in order to afford the cost of the really important risk. How many doctors or patients carry "full coverage" on their automobile or on their house?

As of November 30, 1951, MMS had paid out to doctors $71,545,987.05. In the first eleven months of 1951, $17,352,599.57 was paid to doctors for care of patients, an increase of five million dollars over 1950.

* * *

The Fifth American Congress on Obstetrics and Gynecology will be held in Cincinnati's Netherland-Plaza Hotel, March 31 through April 4. It is sponsored by the American Committee on Maternal Welfare.

Techniques, conclusions and follow-up action in Chicago's recent study of 10,000 neonatal deaths will be revealed for the first time in a symposium on the public health program, chairmanned by Herman N. Bundesen, M.D., president of the Chicago Board of Health. This is the first study to gather enough statistical data for an epidemiologic approach to neonatal mortality.

John Paul Pratt, M.D., Detroit, will moderate the panel discussion on the RH and HR Sensitization. Charles S. Stevenson, M.D., Detroit, will discuss Lueitic Lesions in the Panel on Lesions of the Vulva.

A two-year contest to promote research on the so-called "toxemias of pregnancy" has been announced by the American Committee on Maternal Welfare, Inc.

Dr. Fred L. Adair, president of the Committee, stressed that all theses must be based upon original work done by the authors and must be submitted no later than January 1, 1954. First and second prizes of $500.00 and $250.00, respectively, will be awarded later in 1954 at the Sixth American Committee on Maternal Welfare.

* * *

Honors from the American College of Radiology.—At the annual meeting of the American College of Radiology, on February 8, 1952, in Chicago, the degree of Fellow of the American College of Radiology was conferred—in absentia—upon William G. Belanger, M.D.,

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of Detroit. This degree is conferred on the basis of outstanding contributions and service to radiology.

At a meeting of the Board of Chancellors of the American College of Radiology on February 7, 1952, James E. Lofstrom, M.D., of Detroit, was appointed a Trustee of the American Registry of X-Ray Technicians.

* * *

The Fifth Annual Michigan Rural Health Conference was held in Ann Arbor, at the University of Michigan Rackham Building, January 11 and 12, 1952. It drew its registration from practically every county of the lower peninsula and many of the upper peninsula. It has been judged the most outstanding conference held to date.

Unusual post-conference interest was expressed in the unique feature, "The Court of Public Appraisal," which brought representatives from five major areas of responsibility in health to the stand, to defend their program against the charge: *"Those primarily engaged in carrying out the health programs are failing to make adequate progress in discharging their responsibilities to the public."*

* * *

American National Red Cross, in a fourth anniversary review of its blood program, announces it has collected and turned over to the military forces 1,225,000 pints of blood since the start of the Korean War. Approximately 160,000 pints were shipped to the Far East as whole blood, the rest processed into plasma. During the same period, Red Cross collected and processed 1,861,000 pints for civilian use. Dr. George F. Lull, AMA Secretary and General Manager, renewed the pledge of America's physicians to "do everything possible to make the blood program a continuing success." E. Roland Harriman, Red Cross president, commented on the cooperation received from AMA, American Hospital Association, American Public Health Association and the American Association of Blood Banks. He said: "At every stage . . . we have had the unremitting aid and guidance of the American Medical Association and individual physicians."

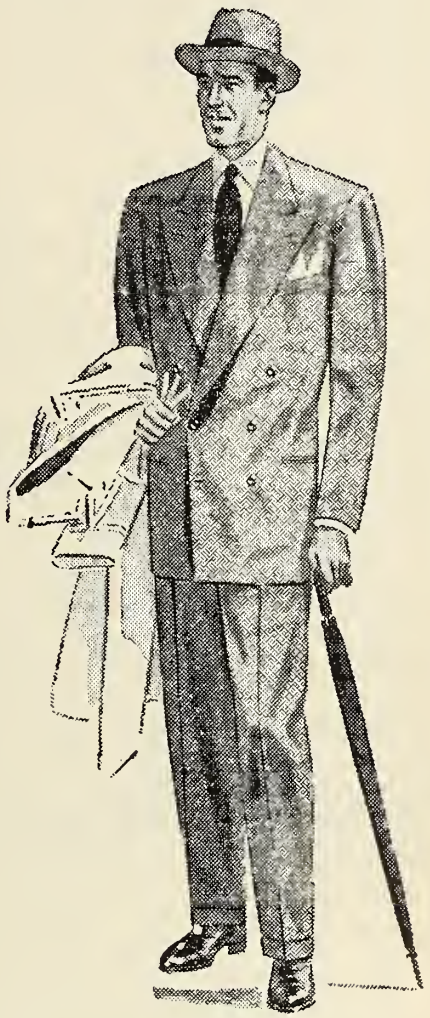
Red Cross and the co-operating blood banks will be the collecting agency in a National Blood Program now being set up under direction of a committee headed by Dr. G. D. Cummings. The group, which will report to the Health Resources Advisory Committee in the Office of Defense Mobilization, will co-ordinate all collecting, processing, distributing and research efforts.

Red Cross has set a goal of 300,000 pints per month for military use and 125,000 for civilian, for a total of 425,000. December collections reached 353,000.

* * *

Testifying in favor of the military pay raise bill, Assistant Defense Secretary Anna Rosenberg said the military services currently are able to give medical care to *fewer dependents* than in past years. She gave this as one reason why a pay increase is justified.

Technically, medical care is authorized for dependents *only when professional personnel and facilities are "available."* Mrs. Rosenberg explained that the present situation had developed because of (a) increasing numbers of military personnel who have first claim to medical care, (b) shortages of professional personnel and facilities, par-



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ticularly hospital beds, and (c) the necessity for keeping large numbers of beds ready for Korean casualties.

Also, Mrs. Rosenberg said the military departments' medical budgets were so low as to leave little money to provide care for wives, children and other dependents. For fiscal 1953, she declared, military departments were budgeted at an average of $120 or less for each uniformed member for a year's medical care (Army $107, Navy $120 and Air Force $117). Construction and maintenance costs of hospitals are not included in the totals.

* * *

Atomic Energy Commission, making its semi-annual report to Congress, states that "new knowledge has been gained in the last six months concerning the effects of radiation, and an increasing variety of radioactive substances, on life processes of man, animals and plants." The report summarizes a number of medical research projects under way at AEC's various laboratories and in universities supplied with AEC funds.

* * *

Paid AMA Dues.—In 1951 the members of the Michigan State Medical Society set a new record. Ninety-six per cent of them paid their AMA dues. We doubt if any other state exceeds that record.

* * *

Max K. Newman, M.D., delivered the following addresses: "The Organization of a Department of Physical Medicine and Rehabilitation" at the Midland Hospital, January 17, 1952; "Peripheral Nerve Injuries" at the University of Illinois School of Medicine, for the Chicago Society of Physical Medicine and Rehabilitation, on January 23, 1952.

Dr. Newman has been appointed to the Board of Counselors of the Latin-American Congress of Physical Medicine which met in Panama on February 25-28, 1952.

* * *

The Michigan School for the Deaf will conduct its twelfth annual Parent Institute-Nursery School for the Deaf, March 30 to April 5, 1952, on the campus at Flint.

The program for the parents, consisting of classes, observations, consultations, scheduled tours and lectures, has been planned to assist parents with their child during the preschool years. There is much the parent can do to train their child during these early years and help him to develop habits and patterns which will be important to him throughout his life.

The program for the children is one of attendance at a nursery school to help start them on the road to new experiences in learning.

The key speaker for the twelfth annual institute will be Dr. Helmer R. Myklebust, professor of audiology and director of the Children's Hearing Clinic at Northwestern University. He will climax the Parent Institute-Nursery School program of this year by summarizing many of the points made in his new book, "Your Deaf Child—A Guide for Parents," which parents of hearing-impaired children have found helpful.

Other fine speakers and their topics are as follows:

Bruce R. Siders, superintendent, Michigan School for

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the Deaf—*Aims and Purpose of the Parent Institute-Nursery School.*

Hyman D. Shapiro, M.D., otologist, Lansing—*Causes and Types of Deafness and the Service of the Otologist.*

Courtney D. Osborn, supervisor, Hearing Conservation Program, Michigan Department of Health, Lansing—*Conservation of Hearing.*

Francis E. Lord, Ph.D., director, Horace H. Rackham School of Special Education, Michigan State Normal College, Ypsilanti—*Social Adjustment of the Acoustically Handicapped Child.*

Mary A. Blair, consultant, Division of Special Education, Department of Public Instruction, Lansing—*Language Growth in the Young Deaf Child.*

There will be parent class discussions, special features. No charge.

* * *

Veterans Administration, reporting to Congress on its operations for fiscal 1951, lists approximately two-thirds of its cases as non-service connected and one-third as service connected, or about the present ratio. The period covered is July, 1950, through June, 1951. Data in the tabulation below are from the Veterans Administration report.

Illness	*Service Connected*	*Non-Service Connected*	*Average stay calendar 1950*	*Cost Per Patient Per Day 1951*	*Increase over 1950*
All Patients	35.0%	65.0%	60.8 days	$11.66	7.0%
TB	41.5%	58.5%	205.8 days	13.82	1.5%
Psychosis	51.0%	49.0%	482.1 days	7.22	4.5%
Other NP	24.5%	75.5%	60.3 days	7.22	4.5%
General M & S	12.2%	87.8%	30.8 days	16.47	9.2%

Hospital Entrance Report.—As reported in August, 1951, the Crippled Children Commission has supplied hospitals with extra copies of Form 56R (revised). Each hospital, which serves crippled or afflicted children cases, now can present a copy of the Hospital Entrance Report to the attending physician(s) either before or immediately after the service is rendered. This form gives the Doctor(s) of Medicine all pertinent information, including the patient's insurance coverage.

Such a procedure, made possible through the co-operation of the Crippled Children Commission and the hospitals, will assure the attending physician(s) of prompt receipt of fees—if billed within sixty (60) days after patient's discharge from hospital. The sixty-day billing provision is specifically provided by law.

If your hospital(s) have not developed a method of distributing the third copy (goldenrod) of Form 56R to the attending physician(s) and/or surgeon(s), so they are officially advised that patients are State cases, please contact the chief(s) of staff(s) of your hospital(s) at once. This arrangement took effect November 1.

* * *

Quiz Beneficiaries of Social Security.—We've heard that the Federal Security Agency is planning to place workers in the field to interview beneficiaries of social security and old age assistance.

An eight-page questionnaire has been prepared and these workers will find out, among other things, how often the beneficiary or a member of his family has been ill during the past year, both at home and in the hospital.

The long questionnaire covers many things pertaining to health.

Results of the survey should prove very interesting. It is believed the questionnaire survey was launched for the purpose of preparing propaganda to increase payments to beneficiaries and also to propagandize for the Federal Security Administrator's plan for "free hospitalization" for those over sixty-five.

* * *

AMA Dues.—In answer to several queries, the membership department has clarified a point in connection with the payment of dues by a member who is reinstated.

A member, dropped for nonpayment of membership dues and who wishes to have his membership reinstated, would owe membership dues for the year in which he became delinquent and the year in which his membership was reinstated, but he does NOT have to pay membership dues for the intervening years.

Here is an example: Doctor Blank was dropped in 1951 for nonpayment of 1950 membership dues. He applies for reinstatement of his AMA membership in 1952. To bring about this reinstatement, he would be required to pay his 1950 membership dues and membership dues for 1952. Membership dues for 1951 would NOT be required.

* * *

The new **Journal of the Student** has issued two numbers. It is well presented, on good paper, clearly printed, with plenty of color. It has a page of short spicy editorials, a guest editorial, a two-page news letter, two pages of Washington Wire, four very good scientific articles, five special features, and two other features, the Bucco-Anal Anastomosis, and Local Anesthesia. Many illustrations are used. If this pace is continued, the students bid fair to having a most interesting and stimulating journal.

* * *

A competitive examination for appointment of Medical Officers to the Regular Corps of the United States Public Health Service will be held on June 3, 4, and 5, 1952. Examinations will be held at a number of points throughout the United States, located as centrally as possible in relation to the homes of candidates. Applications must be received *no later than April 30, 1952.*

The Regular Corps is a commissioned officer corps composed of members of various medical and scientific professions, appointed in appropriate categories such as medicine, dentistry, nursing, engineering, pharmacy, et cetera.

* * *

Salary Stabilization Board has ruled that prepayment health and welfare plans approved for contract wage employes by Wage Stabilization Board may be extended to salaried employes without special approval. Federal Register of January 26, 1952, contains complete WSB regulation on health and welfare plans, including list of requirements if plan is to receive automatic approval. —AMA Capital Clinic.



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Wage Stabilization Board Rulings.—Voluntary prepayment medical and hospital care plans should be pleased with recognition they have received from Wage Stabilization Board. Chairman Nathan P. Feinsinger disclosed that Board has decided on policy to be followed in regulating, from standpoint of inflation control, provisions for health benefits granted to wage-earners by their employers.

The wage board voted unanimously to allow employer-paid enrolment in any hospital insurance plan that covers the hospital bill, without prior approval by WSB. Special action would be required only in cases where benefits beyond the usual Blue Cross pattern were proposed. Hospital service plans thus are uninhibited as far as broadening their scope is concerned. It can hardly be called restrictive that semi-private hospital accommodations are prescribed, since this is common in most Blue Cross contracts.

"Importance of WSB's ruling—its rapid approval and translation into official wage-control regulation are a certainty—cannot be overemphasized. Immediate impact on voluntary plans and commercial carriers, economic significance to hospitals and practitioners, influence on pending consideration of health services for servicemen's dependents—these are but a few of the ramifications. Note: Individual who, more than any other, nursed this project through to the end of achieving a decision most favorable to voluntary prepayment plans as well as to the worker was Harry Becker, now on leave from United Auto Workers welfare department to be assistant director of hospital financing study. Now being drafted is a new government form to be executed by employers seeking to cover their workers in health service programs. These forms also must be filled out in cases where out-of-ordinary benefits are proposed and WSB approval is required.—Washington Report on Medical Services, Dec. 17, 1951.

* * *

Leo H. Bartemeier, M.D., Detroit, was recently appointed a member of the Committee on Nervous and Mental Diseases of the American Medical Association.

Committee nominations came from the American Psychiatric Association, the American Psychoanalytical Association and several other organizations and individuals.

The committee is composed of Lauren Smith, M.D., Philadelphia, chairman; Francis M. Forster, Washington; Hugh Carmichael, Chicago; Leo H. Bartemeier, Detroit; Walter H. Baer, Springfield, Ill.; M. Ralph Kaufman, New York, and Maurice Levine, Cincinnati.

* * *

Teachers, Like Doctors, Find FSA Troublesome.—The nation's educators, like the doctors, are finding Mr. Ewing's Federal Security Agency a pain in the neck.

An Indianapolis teacher, Frank Hamilton, who spent a year in Britain as an exchange teacher under the Fulbright Act, has been "warned" because he came home to tell Americans that socialism in England is merely "doctored up communism." Hamilton expressed his views in lectures and newspaper interviews.

"Ewing," said the *Chicago Tribune,* "had one of

his fat boys, J. Harold Goldthorpe, of the FSA office of education, write Hamilton threatening that a continuation of the teacher's expressions would result in cutting off opportunities for Indianapolis teachers to receive Fulbright junkets to Europe."

"When this (FSA) outfit," said the editorial, "arrogates to itself the authority to circumscribe the exercise of free speech, it may well be wondered what liberty of expression it would permit teachers to retain if it ever succeeded in its ambition of obtaining control over the public school system of the United States."

* * *

Progress in Emergency Call Systems.—A report by the AMA Council on Medical Service shows that rapid strides are being made in developing emergency call systems. In 1948, only about sixty medical societies reported having a formal plan for handling emergency and night calls; in 1948 the number was estimated at between 100 and 120, and in 1950 it had risen to more than 350. There is still need for more work on the problem, especially among the smaller medical societies.

* * *

The Michigan Heart Association announces that more than $185,000 has been allocated during the past two and one-half years for research studies into diseases of the heart and circulatory system. This figure was contained in the Michigan Heart Association second annual report recently released by Douglas Donald, M.D., Detroit, President of the Association.

The Arthritis and Rheumatism Foundation, Michigan Chapter, recently presented to the Visiting Nurse Association of Detroit a motor car for use in home-care treatment of disabled arthritics. The car was presented by J. J. Lightbody, M.D., Detroit, Chapter Medical Director, to Emilie G. Sargent, R.N., Executive Director of the Visiting Nurse Association. The Chapter also provided the equipment for the automobile including a portable diathermy and infra-red units for treatment.

* * *

L. Fernald Foster, M.D., Bay City, Secretary of the Michigan State Medical Society, has been invited to address the Philadelphia Rotary Club on April 30. His subject will be "The Michigan State Medical Society's Formula For Freedom."

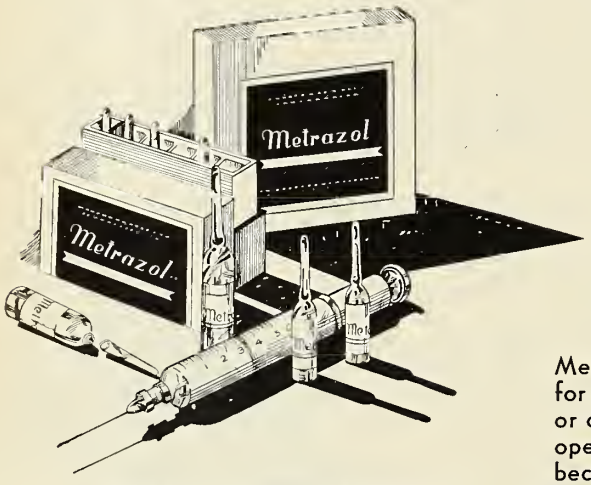
* * *

G. B. Saltonstall, M.D., Charlevoix, was appointed by Council Chairman William Bromme, M.D., as official MSMS representative to the American Medical Education Foundation "kick-off" meeting of February 17, 1952 in Chicago.

* * *

The Clara Elizabeth Fund-Genesee County Medical Society Lectures of 1952 are scheduled for October 8 in Flint. Two of the three speakers have been announced: John Parks, M.D., George Washington University School of Medicine, Washington, D. C.; and William F. Mengert, M.D., Southwestern Medical School, University of Texas.

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are cordially invited to hear the Clara Elizabeth Fund Lectures on October 8. For program, write David B. Treat, Director, 302 W. 2nd Ave., Flint.

* * *

The eighth annual meeting of the American College of Allergists will be held at the William Penn Hotel, Pittsburgh, on April 7-8-9. For program and full particulars, write the College at 401 LaSalle Medical Building, Minneapolis 2, Minnesota.

* * *

The Texas Medical Center, Houston, Texas, announces several meetings of interest to scientists and doctors of medicine to be held April 25-26, 1952: Sixth Annual Symposium on Fundamental Cancer Research; Cancer Pathology and Radiology Conference; South Central Section of the College of American Pathologists.

All meetings will be held at the Shamrock Hotel. For further information, write William O. Russell, M.D., 2310 Baldwin St., Houston 6, Texas.

* * *

The American Congress of Physical Medicine will hold its thirtieth annual scientific and clinical session at the Roosevelt Hotel, N. Y., August 25-29, 1952. For program and further information, write the Congress at 30 N. Michigan Ave., Chicago 2, Illinois.

* * *

Mac F. Cahal, Executive Secretary of the American Academy of General Practice, recently announced the five hospitals and the five medical schools selected to nominate candidates for the Mead Johnson General Practice Scholarship. They include Stamford Hospital of Stamford, Conn., Methodist Hospital of Indianapolis, Ind., Crawford W. Long Memorial Hospital of Atlanta, Ga., John Gaston Hospital of Memphis, Tenn., and Dr. W. H. Groves Latter Day Saints Hospital of Salt Lake City, Utah. These hospitals were selected as representing all sections of the country.

The five medical schools selected to name seniors eligible for the awards for residency work starting in 1953 are: University of Kansas, University of Wisconsin, Medical College of Virginia, University of Rochester, and the University of Washington.

* * *

Maurice G. Wynes, M.D., who was graduated from the University of Michigan Medical School in 1939 and took his internship at Grace Hospital, Detroit, has been appointed Assistant Medical Director of the Medical Consultant Service of Armour Laboratories, Chicago.

* * *

"The Making of Shoes" is the title of a 16 mm. sound film (12 minutes). This is an Encyclopaedia Brittanica production (owned by the Michigan Shoe Retailers Association), and depicts the various stages in the manufacture of shoes.

This film, of interest to many doctors, may be obtained by writing the Michigan Shoe Retailers Association, attention Morton Hack, Vice President, 28 West Adams Avenue, Detroit 26. No rental.

* * *

At the Annual Meeting of the Medical Staff of Providence Hospital, Harold Henderson, M.D., of the Obstetrics and Gynecology Department, was elected Chief

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of Staff-Elect, and Francis B. MacMillan, M.D., of the Department of Traumatic Surgery, was elected Secretary-Treasurer. Wm. L. Sherman, M.D., retired as Chief of Staff, turning over the office to W. B. Harm, M.D.

* * *

Qualifications of Parents.—Professional men have about twice as many distinguished offspring as business men, twenty times as many as farmers, forty times as many as skilled laborers and one thousand times as many as unskilled laborers.—STEPHEN S. VISHER, Ph.D., Geography Professor, Indiana University.

* * *

The Bureau of Indian Affairs in the Interior Department had 13,565 on its payroll last year. There were only 400,000 Indians in the United States, but one federal employe for every thirty Indians.

This is Social Security.

* * *

"Wish him a Happy Birthday at the President's Party."—That is the invitation to all members of the Wayne County Medical Society, annually, to attend its "President's Party." This year, the affair was held on February 2 in the Wayne County Medical Society club rooms (David Whitney House) at 4421 Woodward, Detroit. The affair honored Arch Walls, M.D., President of the Wayne County Medical Society. Over 200 members and their wives attended the social affair and gave honor to their leader of 1951-52.

This is a splendid manner in which to pay tribute to medical leadership, and deserves emulation by all Michigan county medical societies.

* * *

Income tax deduction and Postgraduate Courses.—The AMA has initiated correspondence with the U. S. Bureau of Internal Revenue regarding a review of the 1921 ruling which denied deductions to doctors of medicine for expenses incurred in taking postgraduate courses. A report to our membership in JMSMS will be made from time to time as the matter progresses.

* * *

From June, 1950, to February, 1951, the federal government filled new civilian jobs at the rate of more than 1,000 a day. Government civilian employment in February, 1951, exceeded 2,181,000.

* * *

Medical Family.—There's never a shortage of medical doctors when the family of Michigan Senator and Mrs. Haskell L. Nichols, of Jackson, stage a reunion.

Their oldest son, John W. Nichols, M.D., is practicing medicine at Galena Park, Houston, Texas, in association with his wife and father-in-law—both doctors, too. Dr. Nichols was graduated from Baylor University College of Medicine, Houston, in 1949. He served his internship and residency at Cleveland City Hospital before going to Texas. His wife, Ann Deaton Nichols, M.D., also received her medical degree at Baylor before interning at St. Luke's Hospital, Cleveland. Dr. Nichols' father-in-law is Grady Deaton, M.D.

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The oldest daughter in the Nichols family is serving her internship at Receiving Hospital, Detroit, following her graduation last June from the University of Michigan Medical School. But the medical relationship doesn't stop there. Her husband, Jack, is a Senior in the Wayne University College of Medicine. During World War II, he was a captain in the U. S. Air Force.

The two younger children of Senator and Mrs. Nichols, Ann and Don, are still at home. If they should decide to enter medical school, they can expect lots of help with their homework.

* * *

Two positions available at the State Prison of Southern Michigan: Associate Physician with starting salary of $818 per month with yearly increase to $929 per month at end of four years; Assistant Physician with starting salary of $704 per month with yearly increase to $814 per month at end of four years. Both positions are under Civil Service and are on a forty-hour-a-week basis; night and weekend duty is rotated. One day per month is allowed for vacation and sick leave. If interested, contact Russell L. Finch, M.D., Medical Director, State Prison of Southern Michigan, 4000 Cooper Street, Jackson, Michigan.

* * *

Bay City Medical Assistants.—To acquaint physicians' office personnel with the activities of the Michigan State Medical Assistants Society and the **Formula For Freedom** program, the Bay County Medical Assistants Society will sponsor a one-day conference at the Winona Hotel, Bay City, Sunday, May 18, 1952.

Patricia Kaczmarek, Bay City, President of the Bay County organization, states that all medical assistants in the northeast area, whether members of the Medical Assistants Society or not, will be invited to attend the meeting. Invitations will be issued to medical office personnel in the counties of Saginaw, Huron, Tuscola, Midland, Iosco, Arenac, Gladwin, Isabella and Genesee.

* * *

E. F. Sladek, M.D., Traverse City, Past President of the Michigan State Medical Society, has been appointed by the Governor to the Commission on Migrant Workers.

* * *

Establishment of the President's Commission on the Health Needs of the Nation is the latest maneuver in President Truman's campaign to socialize the medical profession. This commission, to be financed from emergency funds allocated for national defense, is a transparent fraud on the American people. Every physician and all others associated with us in caring for the health of the nation should clearly understand its absurdities and its dangerous political significance.—JOHN W. CLINE, M.D., President, American Medical Association.

* * *

Otto O. Beck, M.D., Birmingham, MSMS President, spoke on "The Beaumont Memorial Restoration" on the occasion of the Annual Clinic Day of Mt. Carmel Mercy

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Hospital, Detroit, January 30, 1952. Dr. Beck was guest speaker at the Hospital luncheon.

* * *

Hill-Burton Hospital Construction Program.—According to a year-end analysis of the Hospital Facilities Division of the U. S. Public Health Service, 58 per cent of the 1,023 new projects are located in communities of less than 5,000 population and 10 per cent are in cities of 50,000 or more. Of the new hospitals, 57 per cent have less than fifty beds and only 19 per cent have more than 100 beds. In the aggregate, estimated total cost will be $1,288,936,793, of which the federal share will be $466,014,715.

* * *

The Michigan Health Officers Association will hold its biennial meeting at the Statler Hotel, Detroit, on May 14, 15 and 16, 1952. For program, write V. N. Slee, M.D., Secretary, Hastings, Michigan.

* * *

Bond-A-Month Plan.— In the interests of the important defense effort, all members of the American Medical Association are urged by Dwight H. Murray, M.D., National Bond Chairman of the AMA, to participate in the "bond-a-month plan." Three letters are being sent to all AMA members by Dr. Murray urging practicing physicians to purchase Defense Bonds. The first letter in part states:

"Operation of the plan is simplicity itself. You merely decide how much you wish to put aside each month, and what type of Bond best fits your needs—Series E, F, or G. Your bank does the rest, automatically. You can set up the whole arrangement in two minutes, merely by filling in the form attached to the enclosed folder and mailing it to your bank."

ARE DOCTORS HUMAN?

". . . isn't it strange how seldom one gives a thought to who the doctor is, where he comes from, or what he is really like? Generally it is enough to know there is such a person to call on in case of need, like the fireman or policeman. Perhaps it is natural to think of him thus, but it would be nice for the doctor to be thought of as a person. After all, he is human, too.

"The practicing life of a physician is not great; his work is never done and his hours are long and irregular. The equipment he must buy, if he is to practice the best type of medicine, is expensive.

"Unlike the merchant, the doctor cannot go away and let someone else take over his business for a while. When he leaves town, his income stops. If one deducts the cost of his expensive education and prorates his total earnings over his years of study and training, the doctor is clearly not overpaid.

"Life's stream is flowing more swiftly nowadays and has caught both the patient and the doctor in its turbulent whirl. As a result, each of them has lost something in the way of human values. If everyone were to make a sincere attempt to become acquainted with his own medical adviser, he would find that doctors are people, too."—*Coronet Magazine,* February, 1952.

THE DOCTOR'S LIBRARY

Acknowledgment of all books received will be made in this column, and this will be deemed by us as full compensation to those sending them. A selection will be made for review, as expedient.

TREPHINE TECHNIQUE OF BONE MARROW INFUSIONS AND TISSUE BIOPSIES. By Henry Turkel, B.A., M.A., M.D. Detroit: Gale Printing Co. Price $1.00.

HUMAN STERILIZATION—TECHNIQUES OF PERMANENT CONCEPTION CONTROL. By Robert Latou Dickinson, M.D., and Clarence James Gamble, M.D. New York: Waverly Press, Inc.

SOME CONTEMPORARY THINKING ABOUT THE EXCEPTIONAL CHILD—Proceedings of a Special Conference on Education and the Exceptional Child of the Child Research Clinic. The Woods Schools—A Private School for Exceptional Children. Langhorne, Pa.: Woods Schools, 1949.

OCCUPATIONAL FACTORS IN THE AETIOLOGY OF GASTRIC AND DUODENAL ULCERS WITH AN ESTIMATE OF THEIR INCIDENCE IN THE GENERAL POPULATION. By Richard Doll and F. Avery Jones with the assistance of M. M. Buckatzsch. London: His Majesty's Stationery Office, 1951.

NEW AND NONOFFICIAL REMEDIES, Containing Descriptions of the Articles which Stand Accepted By the Council on Pharmacy and Chemistry of the American Medical Association on January 1, 1951. Issued Under the Direction and Supervision of The Council on Pharmacy and Chemistry, American Medical Association. Philadelphia: J. B. Lippincott Co., 1951.

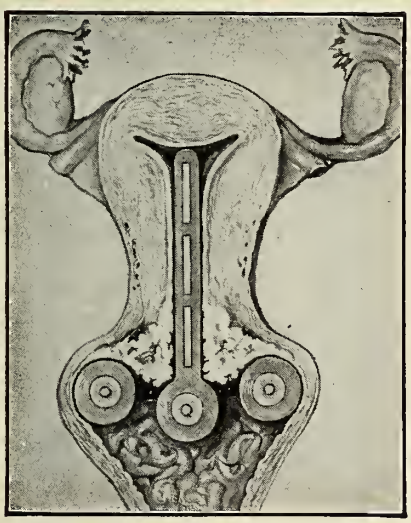
A STUDY OF EPILEPSY IN ITS CLINICAL, SOCIAL AND GENETIC ASPECTS. By Carl Henry Alstrom. Stockholm: 1950.

CLINICAL AND ROENTGENOLOGIC EVALUATION OF THE PELVIS IN OBSTETRICS. By Howard C. Moloy, M.D., M.Sc. Assistant Clinical Professor of Obstetrics and Gynecology, College of Physicians and Surgeons, Columbia University, and The Sloane Hospital for Women. Philadelphia: W. B. Saunders Co. Price $2.50.

PHYSICAL MEDICINE AND REHABILITATION FOR THE CLINICIAN. Edited by Frank H. Krusen, M.D., with articles by twenty-four doctors. Philadelphia: W. B. Saunders Co., 1951. Price $6.50.

The subject of physical medicine is growing in recognition and importance. This book is a text on the subject based largely on lectures on the subject given by twenty-four teachers in their instruction classes. The subject in general is divided into four groups: (1) therapeutic application of physical agents and procedures; (2) diagnostic applications of physical agents and procedures; (3) clinical aspects of physical medicine and rehabilitation; (4) fundamentals of anatomy, therapeutic exercise and physiology related to physical medicine and

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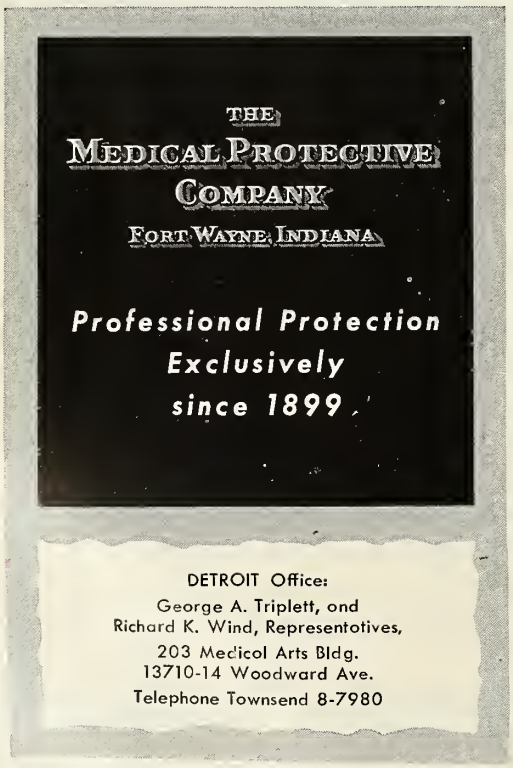
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rehabilitation. Throughout, the pressure is related to methods and means of rehabilitation. The course is comprehensive, and by different writers who use style and modes of expression to hold the student's attention.

DIABETES MELLITUS. Principles and Treatment. By Garfield G. Duncan, M.D., Clinical Professor of Medicine, Jefferson Medical College; Director of the Medical Divisions of the Pennsylvania Hospital and the Benjamin Franklin Clinic, Philadelphia. Illustrated. Philadelphia: W. B. Saunders Co., 1951. Price $5.75.

In a subject that is still as controversial as diabetes, a new book on diabetes mellitus is certainly most welcome. The author's objectives are twofold: first, to summarize and correlate latest principles in the understanding and treatment of the disease and, second, to present a practicable and simplified outline of therapy. That these objectives have been attained is evident upon even a cursory perusal of the text. Closer study reveals, that almost all fields of Medicine have been touched, illustrations have been used freely and detailed descriptions have been given to the many facets of therapy.

The format of the book is very good. Its size, type and form make for easy reading. There are nineteen chapters with headings from the history of the disease to the treatment of the diabetic child. Those sections on carbohydrate metabolism, pathology, insulin therapy, and the complications of diabetes, both acute and chronic, deserve special commendation. This text is of marked value to the physician and student and the author and his collaborators are to be congratulated.

G. W. S.

BULLETIN ON CURRENT LITERATURE. The monthly bibliography for workers with the handicapped. Chicago: The National Society for Crippled Children and Adults, Inc.

This is a twenty-two page mimeographed listing of every article published in the specified time covering the subject of crippled and afflicted children. There is a short abstract, so one may judge the article, and determine whether to seek it out for further study. This is a monthly publication, one dollar.

ELECTROENCEPHALOGRAPHY IN CLINICAL PRACTICE. By Robert S. Schwab, M.D., Director of the Brain Wave Laboratory, Massachusetts General Hospital, and Associate in Neurology, Harvard Medical School. 187 pages. Illustrated. Philadelphia: W. B. Saunders Co., 1951.

The author states that the purpose of this book is to discuss the uses and limitations of electroencephalography in the diagnosis and study of diseases of the nervous system. He states definitely that it is not a manual for the electroencephalographer or in any sense a textbook in this field.

For a small volume of 187 pages, there is a rather complete coverage of the subject. The author begins with a historical summary. The next chapter is on the relationship of neurophysiology to electroencephalography. Then there is a presentation of the normal and abnormal recordings. The normal includes adults, adolescents and the child. The fourth chapter pertains to technique, viz: recording apparatus, examination room, electrodes and



their placements, technique of localization, artifacts and special techniques. There are chapters on the electroencephalogram in epilepsy, neurological and neurosurgical problems, in psychiatry and in research. The last chapter deals with laboratory organization, training of staff and interpretation of records.

While this book is not an atlas, it nevertheless is profusely illustrated. It is not a reference book, yet the completeness of the coverage of subject matter is such that this small volume can be recommended to neuropsychiatric specialists or to anyone else interested in the subject.

G.K.S.

DYNAMIC PSYCHIATRY BASIC PRINCIPLES. Volume One. By Louis S. London, M.D. 95 pages. New York: Corinthian Publications, Inc. Price $2.00.

The author has written a small book, designated Volume I, which purports to be a series on the subject of dynamic psychiatry. It is an exposé of the theories of Freud. The first half of its ninety-five pages deals with the history of psychiatry. There is a short chapter on the meaning of dreams. Then the author discusses briefly the theories of the libido. He admits that he does not know the composition of the libido or its embryology or physiology. The last chapter is devoted to the development of the libido in the child and the libido in the adult.

The author is a Freudian psychoanalyst. The tenor of his writings is in conformity to his training and conditioning along those lines.

G.K.S.

A TEXTBOOK OF CLINICAL NEUROLOGY. With an Introduction to the History of Neurology. By Israel S. Wechsler, M.D., Clinical Professor of Neurology, Columbia University, New York; Consulting Neurologist, The Mount Sinai Hospital, Montefiore Hospital and Rockland State Hospital, New York. Seventh Edition, Illustrated. Philadelphia: W. B. Saunders Co., 1952. Price $9.50.

A review of a text and reference book that has been in print for twenty-five years, now in its seventh edition, and has been seen and read by everyone interested in neurology needs no comment. The author has again brought the text up to date. No changes have been made in the general arrangement. There are some minor textual transpositions, but the book greatly resembles the fifth edition to which it was compared. There are about forty-five fewer pages. The author states that he tried to incorporate what is new and valuable, to correct that which is no longer tenable in the light of present knowledge and to prune away all that appeared to be obsolete. In all of this, he again has succeeded.

G.K.S.

YOUR WEIGHT AND YOUR LIFE. A Scientific Guide to Weight Reduction and Control. By Alfred L. George, M.D. New York: W. W. Norton & Company, Inc. Price $2.95.

Overweight is a real danger to a great number of the American people. The recognition of the condition and the correction are a challenging problem to the physician, and to the victim who must reduce. This book teaches, and repeats frequently, the fact that overweight is the result only of having eaten too much. There is no

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such thing as inheriting it, or a glandular condition which increases weight. The only source of fat in the body is that which has been eaten.

Having accepted that fundamental fact the book describes the various foods and their values, the processes of metabolism, the digestion and utilization of foods, and the build-up of fat and protean tissue. A chapter is devoted to the cause of overweight. Another to glands, as a cause of overweight. Why do people overeat? The psychology of weight reduction, poor ways to reduce, and the fat are gullible. Under instructions given in this book it is easy to lose weight. A chapter tells of the nutritional aspects of weight reduction, giving the values in body building and in fat loss. A chapter tells how to eat and reduce, using the foods that satisfy in bulk but carry too few calories to add to one's weight. A chapter offers outline diets, with various alternates, telling how much, with the caloric values alongside. These lists are extensive, covering breakfast, lunch or supper, lunch substitute, and dinner. Then follows basic diets for each day of the week for 1200 calories, and 1500 calories, with instructions how to add or subtract.

Finally, there is an appendix giving the sizes of servings and the caloric values of practically all common foods. This book is valuable to the physician, who must direct his patient, but is also an invaluable guide to the patient, and is so intended.

TEXTBOOK OF REFRACTION. By Edwin Forbes Tait, M.D., Ph.D., Associate Professor of Ophthalmology, Temple University School of Medicine; Attending Surgeon (Ophthalmology), Temple University and Montgomery Hospitals; Fellow, Philadelphia College of Physicians, and American Academy of Opthalmology and Otolaryngology; Member, The Pan-American Association of Opthalmology, and The Association for Research in Ophthalmology. Illustrated. Philadelphia: W. B. Saunders Co., 1951. Price $8.00.

Dr. Tait has taught refraction, and practiced it for many years. With that experience he has recognized the need for a textbook on refraction. This book starts with the fundamentals, giving the physics of optics, lenses, binocular function. A space is devoted to refraction formulae, and their interpretation, ocular reflexes, accommodation, and the normal eye. Chapters are then devoted to hyperopia, myopia, astigmatism, presbyopia.

Considerable space is given to the recognition and treatment of progressive myopia. The reviewer could tell the professor of a means he has used for nearly forty years, with almost complete success. Use a drop of adrenaline in each eye night and morning. We have done it in hundreds of cases and can show records. Every instrument in use in refraction is pictured, described, and evaluated.

The book is very well done, and most acceptable. We have noted with interest certain tricks, especially the handling of amblyopic eyes.

HANDBOOK OF DISEASES OF THE BLOOD. By A. Piney, M.D., M.R.C.P. Physician, St. Mary's Hospital, Plaistow; late Director, Pathological Department, Cancer Hospital, and Charing Cross Hospital Institute of Pathology, London. Philadelphia: J. B. Lippincott Co. Price $5.00.

This little book of slightly more than 200 pages has the avowed purpose of attempting to separate the practical aspects of the many complicated diseases of the blood from the maze of material comprising the science of hematology which has grown up in the past twenty-five years.

The text stresses throughout the clinical side of the disorders of the blood and attempts at brevity and usefulness to the practising physician.

For those interested in furthering a working knowledge of diseases of the blood, without wading through a mass of detailed material, this text is to be recommended. It is in no sense a substitute for the standard working texts on hematology. R.W.B.

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PLASTIC SURGERY OF THE NOSE, including Reconstruction of War Injuries, and of Deformities from Neoplastic, Traumatic, Radiation, Congenital, and other causes. By James Barrett Brown, M.D., Professor of Clinical Surgery Washington University School of Medicine, St. Louis, Mo., Chief Consultant in Plastic Surgery, U.S.V.A. Washington, D.C. Formerly Chief Consultant in Plastic Surgery United States Army, and in E.T.O., and Chief of Plastic Surgery Valley Forge General Hospital, and Frank McDowell, M.D., Assistant Professor of Clinical Surgery Washington University School of Medicine, St. Louis, Mo. With 379 illustrations including 48 in color. St. Louis: The C. V. Mosby Company, 1951. Price $15.00.

The book begins with a historical evaluation of former plastic attempts and the ordinary work that has been done in remodeling the hump or depressed nose. This involves contour and anatomy. A small chapter is devoted to instruments and anesthesia. Section two is on the surgical reduction of the size of the nose—hump removal and lowering of the dorsal line, narrowing of the nose, shortening, reconstruction of the lower lateral cartillages, instruments used, suturing, splinting and care. In section three the authors build up and straighten the nose in several chapters. Cleft lip nasal deformities get a section, also repairs involving skin grafting. Section six treats of various other repairs, upper lip, chin, tumors, cancer, scars, burns, war injuries. This is the most explicit treatment of the field we have seen, profusely illustrated, with definite instructions and guides to maneuvers. We like it.

ANNUAL REPORT ON STRESS. By Hans Selye, M.D., Ph.D. (Prague), D.Sc. (McGill), F.R.S. (Canada), Professor and Director of the Institut de Medecine et de Chirurgie experimentales Universite de Montreal. Montreal: ACTA, INC., Medical Publishers, 1951. Price $10.34.

The author states that he has prepared a treatise. What he actually has done is to present his views on the General Adaptation Syndrome to Stress. He has not only collected all literature on the various serelogic, hormonal, cholinergic and histaminergic reactions to stress in order to go beyond the cellular and inflammatory changes, but also to show the stages in adaptation. This includes the alarm reaction, the stage of resistance and the stage of exhaustion. Certain illnesses he has called diseases of adaptation.

The table of contents lists physiology and pathology of stress, general, carbohydrate, nitrogen and salt, and water metabolism, enzymes, vitamins and the endocrine. There is a review of the effects of stress on the different systems and parts thereof, serologic reactions, wound healing and connective tissue.

The book is well edited and printed in large type. The only drawback in reading is the use of symbols such as ACTP, ACTH, DCA, DPA, FC, MC, which is confusing unless the meanings are mastered. Of course, much of the material is still theoretical and not fully established. For research workers and as a reference material for libraries, the subject matter is carefully brought up to date. G.K.S.



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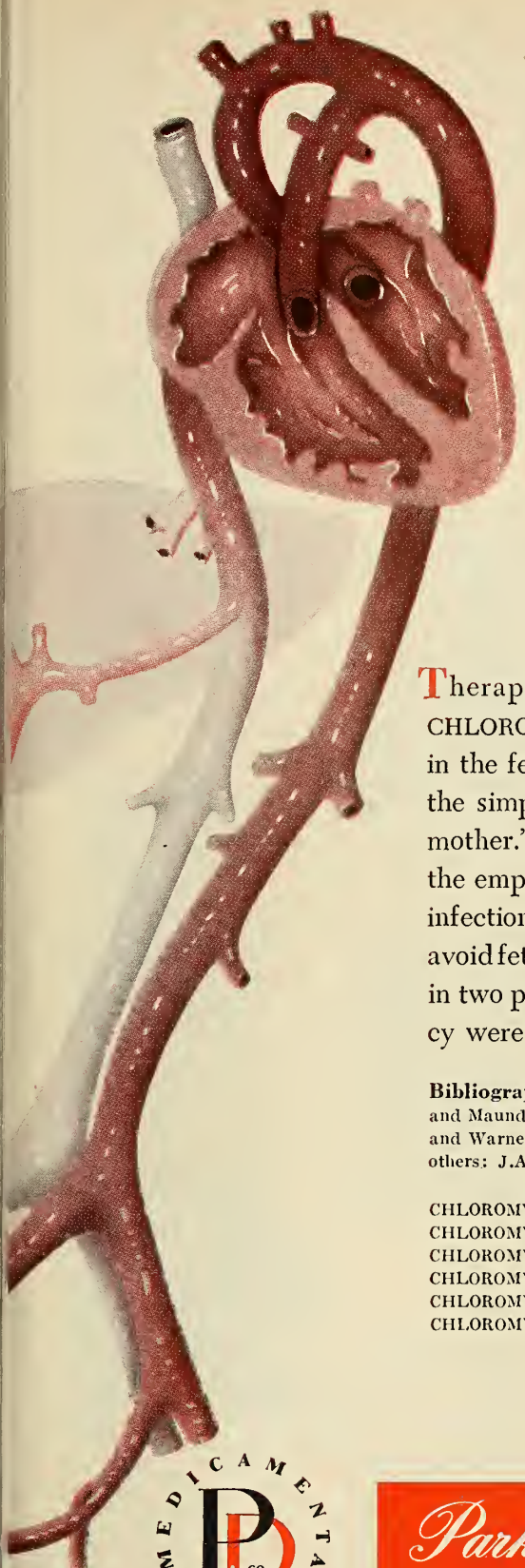
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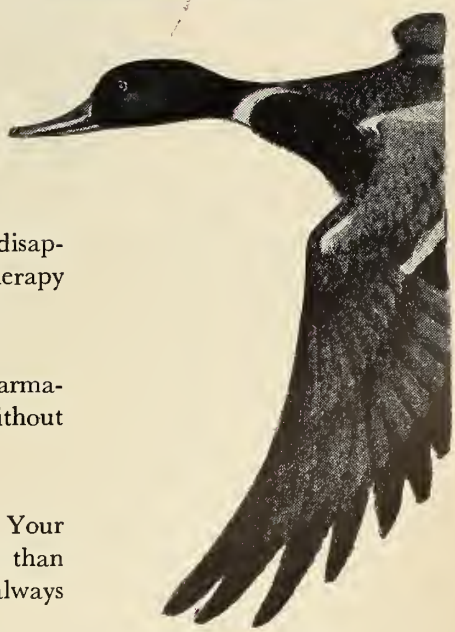
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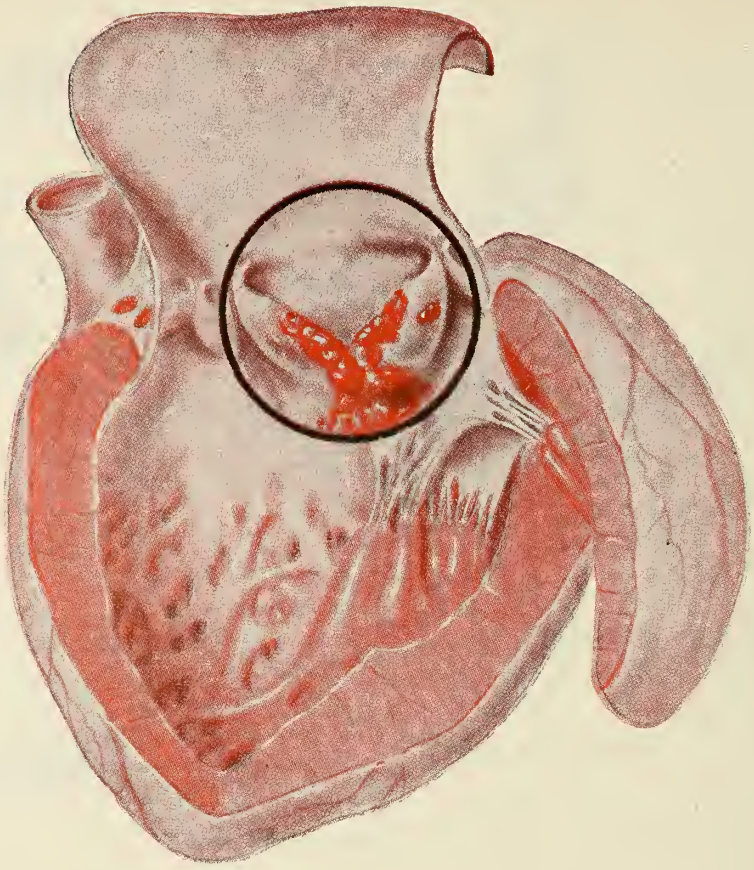
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Blake, F. G.; Friou, G. J., and Wagner, R.R.: Yale J. Biol. and Med. 22:495 (July) 1950.

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Gram-negative Bacterial Infections

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Bacteremia and septicemia
Friedländer's pneumonia
Mixed bacterial pneumonias
Pertussis • Diffuse bronchopneumonia
Post-partum endometritis • Granuloma inguinale
Dysentery • Urinary tract infections
Respiratory tract infections
Cellulitis • Peritonitis • Tularemia

Spirochetal Infections

Syphilis • Yaws • Vincent's infection

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Epidemic typhus • Murine typhus
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Cancer Comment

A BIT OF CANCER HISTORY

Far from being a new disease as many people think, because of the great interest now being shown in the subject, cancer is one of the oldest, if not the oldest disease known to medical science. Earliest medical writings describe it quite accurately as it is known today.

Ancient Egyptian papyri, especially the Smith papyrus of 3000 B.C., and the Ebers papyrus of 1500 B.C., contain descriptions of cancer. The Indian epic, Ramayama, ascribed to 2000 B.C., also refers to the disease. More ancient than these are evidences of cancer in the bodies of Egyptian mummies and in the fossil bones of animals that lived millions of years ago.

Hippocrates, in the fifth century, B.C., described some forms of cancer quite accurately, notably that of the skin, stomach, rectum and breast. He recognized the futility of cure of advanced cancer in these words: "It is better to give no treatment in case of 'hidden' cancer—to omit treatment is to prolong life." A century before Hippocrates it is recorded that Democedes cured Atossa, wife of Darius Hystapsis, of a breast cancer. Celsus, a contemporary of Christ, excised breast cancer and added a classical description of the disease. The crude surgery of the times included an even more crude attempt at diathermy in the use of hot irons for destroying the cancerous growth.

Galen, who lived about 200 A.D., attributed all disease to one of the four "humors": blood, phlegm, black bile and yellow bile. He theorized that cancer was due to a concentration of black bile in the patient's body.

The Galenic influence dominated medical thinking for a thousand years, although during this time individual physicians made noteworthy contributions to cancer knowledge. Among these, Paulus Ægina, about 650, separated chronic metritis from cancer of the uterus. Two Arabian physicians, Avicenna of 1000, and Avenzoar of 1100, recorded much factual information about cancer and its treatment. Avicenna was the first to use arsenic in the treatment of cancer, especially cancer of the skin. His methods were soon taken up by the Egyptians and remain today as one of the chief ingredients of the cancer pastes used by quacks and charlatans. Avenzoar employed the esophageal sound and nutrient enemata in his practice.

About the year 1300, Lanfranchi carried out radical operations for cancer and advised free bleeding of the operation wound.

Further impetus was given to the study of cancer when anatomical dissections were permitted publicly. Among the physicians of that day, Vesalius (1514), Fallopius (1523), and Fabricius (1537), made notable contributions to the knowledge of the human body and the relation of the various organs to one another. They also added materially to the knowledge of cancer.

Invention of the microscope in 1529 greatly extended scientific knowledge of human tissues. Construction of the acromatic lens in 1824 opened a new era in cancer research. Detailed study of the cell and its contents by Müller, Schleiden and Schwann in 1838 introduced the modern era of cancer research. Their work was greatly extended by Virchow who made the first study of tumors and published his findings in 1858.

The first clinical studies of carcinogenic agents was that of Percival Potts in England who, in 1777, published his classical studies on "mule spinners" and "chimney sweeps" cancer. He proved that the former was caused by exposure of the worker's skin to the oil used in lubricating the spindles in textile manufacture and the latter to the soot which impregnated the clothing of chimney sweeps. Since that time, especially since 1923, hundreds of carcinogenic chemical compounds have been identified.

The first hospital exclusively for cancer patients was opened in Rheims, France, in 1740. Its original twelve beds were soon increased in number but as cancer was then thought to be contagious, as some people still think it to be, it became necessary to remove the institution outside the city limits where it became known as the Hospital Saint Louis and where it continued to serve cancer patients exclusively until 1846.

Another famous cancer hospital with a long record of service is the Middlesex Hospital in Lon-

(Continued on Page 412)

To the Doctors and Hospitals of Michigan . . .

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STATEMENT OF CONDITION

Report of Condition as of the Close of Business, December 31, 1951

MICHIGAN HOSPITAL SERVICE

ASSETS

Cash in Banks and Office	$ 4,417,581.71
United States Treasury and Defense Bonds	11,981,579.27
Accrued Interest	60,105.47
Subscription Fees—Receivable	217,381.86
Other Assets	344,955.69
Total Assets	$17,021,604.00

LIABILITIES AND RESERVES

Reserves for Payment for Services Rendered Subscribers (Including Unreported)	$ 7,630,855.25
Reserve for Unearned Subscription Fees	3,198,450.02
Reserve for Contingencies	6,089,481.16
Other Liabilities	102,817.57
Total Liabilities and Reserves	$ 17,021,604.00
Total Benefits Paid Since Inception	$154,799,846.55

MICHIGAN MEDICAL SERVICE

ASSETS

Cash in Banks and Office	$2,839,154.07
Real Estate—Home Office Property	652,994.13
United States Government and Government Guaranteed Bonds	5,785,464.42
Interest and Rents—Due and Accrued	59,087.44
Subscription Fees—Receivable	85,395.03
Funds Advanced for Veterans Administration	124,601.51
Other Assets	1,030.18
Total Assets	$ 9,547,726.78

LIABILITIES AND RESERVES

Reserve for Payment for Services Rendered Subscribers (Including Unreported)	$ 3,848,538.38
Reserve for Unearned Subscription Fees	1,403,498.09
Reserve for Contingencies	4,264,829.62
Other Liabilities	30,860.69
Total Liabilities and Reserves	$ 9,547,726.78
Total Benefits Paid Since Inception	$67,267,310.23

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Say you saw it in the Journal of the Michigan State Medical Society

A BIT OF CANCER HISTORY

(Continued from Page 410)

don. This hospital was organized in 1791 and has functioned continuously since that date. Its clinical and research studies and reports have established it as one of the leading cancer institutions in the world today.

One hundred and fifty years ago, in 1802, an organization known as "The Medical Committee of the Society for Investigating the Nature and Cure of Cancer" was formed in England. Leading scientists of that day were among its members. Its chief activity consisted of sending to each physician in England a series of thirteen questions regarding the causes and treatment of cancer. Many of these questions were unanswerable with the knowledge then available and, indeed, are still unanswerable with the knowledge we have of this disease. This committee was short-lived, being dissolved in 1806. Its chief claim to fame rests on the vision and understanding of its members as reflected in the question they posed to the medical world of their time.

The history of cancer during the last 60 years has been highlighted by the discovery of x-rays and radium and their use in the diagnosis and treatment of cancer. Improvements in surgical and radiation therapy and extension of research to cover the scientific fields of biology, chemistry, physics, heredity, and related sciences are matters of current scientific interest and add emphasis to the elusive character of this ancient and still baffling condition.

THE HILLSDALE PLAN FOR TUMOR DETECTION PROVES ITS WORTH

Analysis of the four-year experience (1948-1951, inclusive) of the Hillsdale Plan for Tumor Detection brings out the following interesting facts among others:

The 2,365 individuals have been examined 4,733 times during this period, giving an average of one re-examination each. Many of these patients have been examined as many as five times, while others have had but one examination.

Women over forty years of age have comprised

HILLSDALE PLAN FOR TUMOR DETECTION

Four-Year Experience (1948-1951)

Sex	First Exams.	Re-exams.	Total Exams.	Cancers found	Per cent Cancer found: Individuals	Per cent Cancer found: Total Exams.
Fem—under 40	625	313	938	4	0.64	0.40
Fem—over 40	1,260	1,896	3,156	65	5.15	2.06
Males—all ages	480	159	639	37	7.70	5.70
Total	2,365	2,368	4,733	106		

Stage of Development

Stage	Number	Per cent
Early	40	37.76
Moderately advanced	26	24.50
Far advanced	30	28.30
Not stated	10	9.44

Per cent cancers found in *individuals* examined—4.58
Per cent cancers found in *total* examinations—2.24

more than 50 per cent of the individuals examined and more than 66 per cent of the total examinations made. Women under forty have provided 26 per cent of all individuals and 20 per cent of all re-examinations. Men of all ages account for the remainder of individuals examined and for 13 per cent of the total number of examinations.

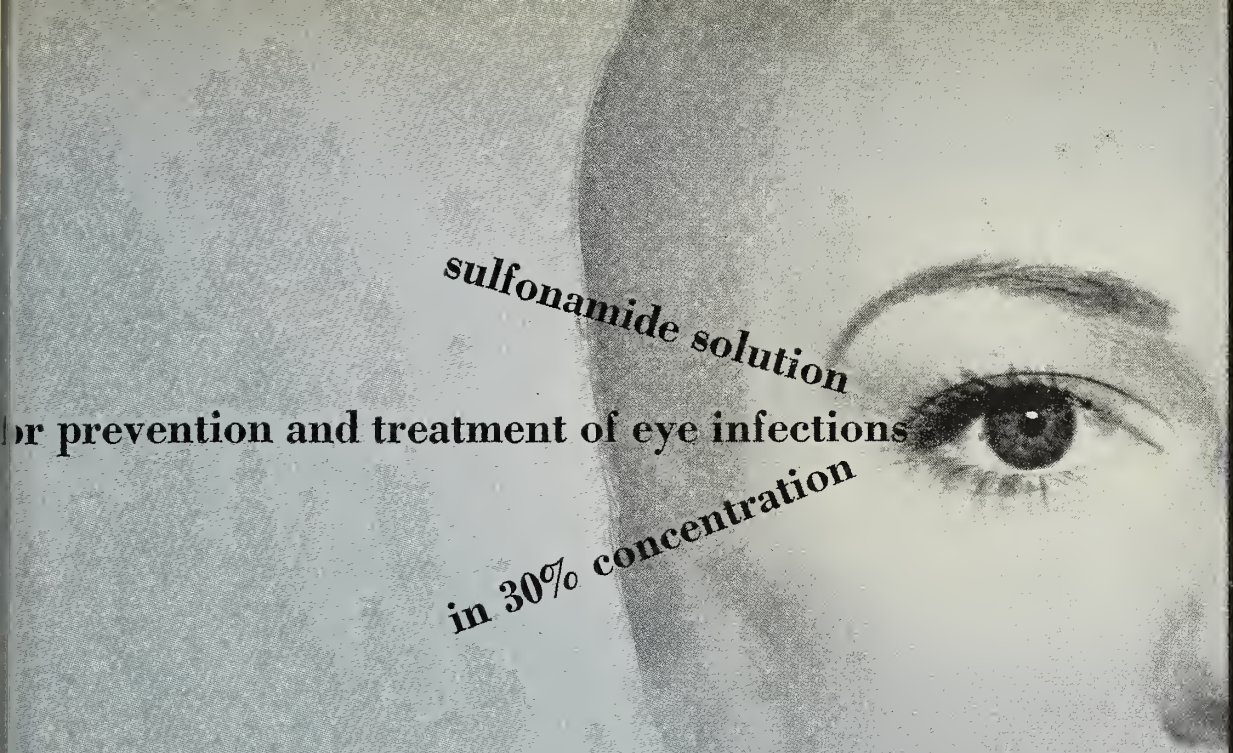
These 2,365 persons represent approximately 7 per cent of the population of Hillsdale County in 1950 and, of course, a much higher percentage of the adult population, the figures for which have not yet been announced by the Census Bureau.

Of the individuals examined, 4.58 per cent were found to have cancer. This percentage drops to 2.24 when applied to the total number of examinations which were almost exactly twice the former figure, viz: 2,365 individuals and 4,733 total examinations.

One hundred and six cancers have been found in this group of individuals. The real value of these examinations is seen in the fact that more than 62 per cent of these patients were found with cancer in a stage that gave every promise of cure with prompt treatment. But one-third were in a stage where treatment offered little hope for a cure. Without these examinations, many of these patients in early stages of their disease would have neglected themselves until they too were in advanced stages. No better evidence is needed of the life-prolonging value of the Hillsdale Plan for Tumor Detection. Through this Plan the

(Continued on Page 414)

EDITOR'S NOTE: At the Clinical Conference, March 13, 1952, the Michigan State Medical Society presented a Scroll of Honor to the Hillsdale County Medical Society for its pioneer work in formulating The Hillsdale Plan for Cancer Detection.



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THE HILLSDALE PLAN

(Continued from Page 412)

Hillsdale County Medical Society has brought honor not only to its own members but to the medical profession everywhere. The Plan has demonstrated that many cancers can be found before they give disabling signs or symptoms; also, that by careful planning interested physicians can find time for making these examinations in addition to caring for their busy office duties.

The Hillsdale County Health Department deserves praise for the co-operation it gave in acting as custodian of the examination records and for their analysis during the four years the Plan has been in operation. This overall program is an excellent example of co-operation in providing service to the community by the two organizations primarily responsible for the peoples' health.

A CANCER MANUAL FOR HIGH SCHOOLS

For the past two years, the Cancer Control Committee has had in preparation a short manual of cancer information for high school students. This manual was considered carefully by the Committee for scientific accuracy of its content in light of present knowledge about cancer, its causes and control. The manual was next given a trial in the classroom by high school teachers in Emmet, Genesee and Muskegon counties. Their suggestions and criticisms were then embodied in a second revision of the text.

The final text was submitted to the staff of the Michigan Department of Public Instruction whose approval was expressed in the following letter from Dr. Lee M. Thurston, Superintendent:

Dr. F. L. Rector, Secretary
Cancer Control Committee
Michigan State Medical Society
Lansing 15, Michigan

Dear Dr. Rector:

The constantly increasing cancer death rate clearly indicates the need for an educational program designed to acquaint high school students and adults with the facts pertinent to cancer control.

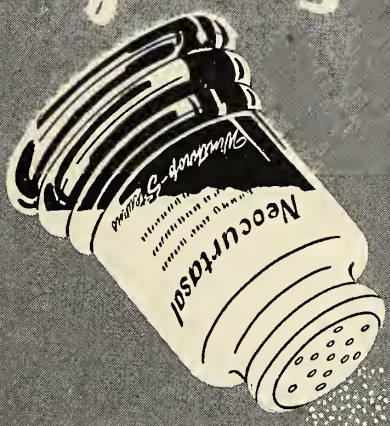
"The Story of Cancer for High Schools," prepared by the Cancer Control Committee of the Michigan State Medical Society, will prove to be a valuable source of information for students and teachers who are concerned about the problem of cancer. This bulletin contains a wealth of factual data which are discussed in an interesting and understandable manner.

The present limitation on the knowledge of cancer makes it essential that we become familiar with the research findings of the medical profession. The results of cancer research are presented in this manual in language devoid of technical terms.

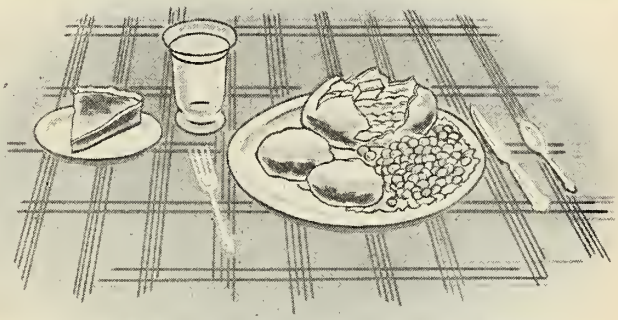
It is my hope that the students and teachers of Michigan will profit from the efforts of those in the

(Continued on Page 482)

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The MSMS Rheumatic Fever Program

Support of the Rheumatic Fever Control Program of the Michigan State Medical Society has been one of the major contributions of the Michigan Heart Association ever since the MHA's inception in 1949. The program had been in existence since 1945, starting as an activity of the Preventive Medicine Committee (later, of the Rheumatic Fever Control Committee) of the Michigan State Medical Society and financed by contributions from the Michigan Society for Crippled Children and Adults, Inc. (Easter Seals) and the Arthritis and Rheumatism Foundation, Michigan Chapter. From 1949 onward, the Michigan Heart Association has assumed the major share of support.

The aims of the Rheumatic Fever Control Program of the MSMS are fundamentally educational, based on the premise that rheumatic fever and its sequelae of rheumatic heart disease are basically a medical problem: a problem of recognition and a problem in management. The two are inseparably connected. From the solution of the problems of recognition there will naturally follow an endeavor for proper management, not exclusively medical, but also in the more or less related fields of social, educational, psychological and rehabilitation care. The conscientious Doctor of Medicine, having recognized and classified a case, will see to the total care of the total patient. In areas where he or she is unable to meet the patient's needs he will avail himself of the services of the many specialized agencies existing in almost every community to satisfy those needs.

Rheumatic Fever Diagnostic Centers

The feature project of the MSMS Rheumatic Fever Control Program are its Rheumatic Fever Diagnostic and Consultation Centers located in nearly all important medical centers of the State. Diagnostic and consultation service to the practicing M.D. is provided under the direction of a local Rheumatic Fever Committee consisting of interested physicians who are recognized authorities in their respective fields. This service is an adjuvant to private practice and not competitive with it. In addition the local committee carries on a program of lay education—through presentation of the subject of rheumatic fever to PTA, health groups, health study clubs and the like, as well as education of the allied professions of nursing, social service and teaching, by means of formal lectures, conferences and study groups.

Immediate benefit is afforded the family physician who refers a case to the Rheumatic Fever Diagnostic and Consultation Center. An opinion is rendered by a panel of qualified examiners and transmitted to the family doctor who follows through if treatment is indicated. *No treatment is tendered at the Rheumatic Fever Center.*

Rheumatic fever in the acute "classic" stage and acute carditis should be under treatment in the hospital, and in the less severe cases at home: these cases do not belong in the Rheumatic Fever Center at this time. What type of case may then be properly referred to the Rheumatic Fever Center?

Types of Cases for Rheumatic Fever Diagnostic Center

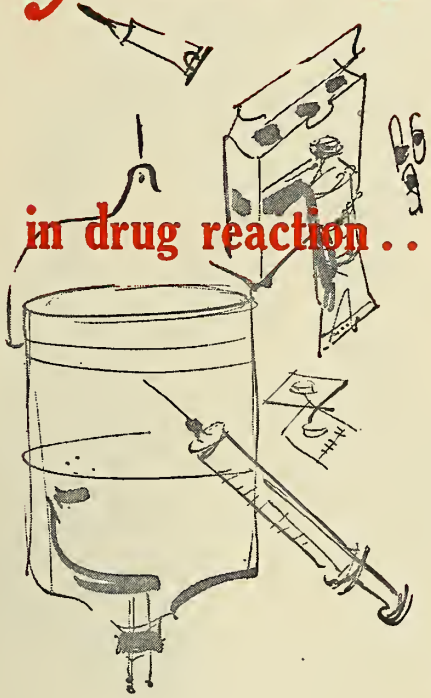
Suspected Rheumatic Fever.—For opinion regarding the presence or absence of the rheumatic state. This may include individuals with atypical joint pains, children with "growing pains," nosebleeds, persistent unexplained fever, persistent complaints of fatigue, suspicion of chorea, persistent tachycardia, cardiac murmurs, unexplained abdominal pain, pallor, elevated sedimentation rate, etc. Atypical rheumatic fever may be more common than the classical, hence a complete work-up in patients presenting these manifestations is desirable from the standpoint of early diagnosis. The current literature contains numerous case-reports indicating that rheumatic carditis was unrecognized at its inception only to declare itself when mitral stenosis was fully established. Recent reports of the presence—in a considerable number of cases—of Aschoff bodies in the sub-endocardium of biopsies of auricular appendage removed at operation in patients whose rheumatic fever was thought to be quiescent point to the difficulty of recognizing low-grade forms of car-

(Continued on Page 418)



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Therapy for Vascular Headache to Reverse the Physiologic Disturbance

Headache, a problem encountered in all kinds of medical practice, may occur in association with any of a variety of disorders, some organic, other purely functional.

Among the several types, functional headaches present the greatest problem because of their obscure etiology and recurrent nature.

Among these are:

Migraine (both classical and variant forms)
Tension headache
Psychogenic headache
Histaminic cephalgia

Wolff and his co-workers established that the pain of these headches is due to disturbance of the tonus of cranial blood vessels — hence the term *vascular headaches.*

The craniovascular changes associated with the several phases of the typical migraine attack are:

Vasoconstriction — to which the visual prodromata are attributable. It is possible to abort the attack during this phase in all but a few cases. (See treatment below.)

Vasodilatation — as the vessels lose their tone, exaggerated pulsations set in, resulting in the throbbing pain which characterizes vascular headache. Treatment for the attack is still effective during this phase. (See below.)

Vessel Edema — if the vasodilation continues for too long, vessel walls become edematous; this changes the character of the pain to a steady, intense aching. The attack can now no longer be checked, even with maximum dosage of specific drugs. *Moreover, sustained headache often induces reflex neck muscle tension, a source of residual pain.*

Therapy: 1. Reduce the frequency of attacks — psychotherapy and regulation of living habits to avoid fatigue and nervous tension.

2. Relieve the acute attack — of the numerous drugs which have been tried, ergotamine and its derivative preparations have proved most effective. The newest product is oral tablets of Cafergot®, N. N. R. (ergotamine with caffeine 'Sandoz'). When dosage is adjusted to the needs of the individual, Cafergot will give good relief in 85% of cases. It enables a greater number of patients to benefit from early administration since the oral route simplifies treatment as compared to parenteral therapy.

The dosage procedure is:

1. Take 2 tablets at first sign of the attack.
2. If attack continues, take one additional tablet every ½ hour until attack is terminated *(max. 6 tabs. per attack).*

Many migraine patients delay taking medication until the attack is at its height. Explicit dosage instructions may be forgotten unless the patient comes to realize their importance. Therefore, to encourage adherence to correct procedure, we have prepared pads outlining detailed dosage instructions. Supplies of these INSTRUCTION SLIPS will gladly be sent upon request.

GENERAL REFERENCES: DeJong, R.: Chicago M. Soc. Bull 54: 106, 1951. Friedman, A.: Modern Headache Therapy, St. Louis, C. V. Mosby Co., 1951. Wolff, H.: Headache and Other Head Pain, N. Y., Oxford Univ. Press, 1948.

Sandoz Pharmaceuticals
DIVISION OF SANDOZ CHEMICAL WORKS, INC.
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(Continued from Page 416)

ditis. Perhaps a more complete study of those individuals who present only one or two of the so-called minor manifestations of rheumatic fever would lead to an earlier discovery of these insidious carditides.

Established Rheumatic Heart Disease.—For opinion regarding the exact nature of the valvular involvement; for determination of the presence or absence of activity of the rheumatic process; for therapeutic classification; for advice on management: e.g., should physical activity be restricted, and if so how much, should the tonsils and adenoids be removed, may the child be permitted to go to school, what type of occupation is advisable, is sulfa or penicillin prophylaxis indicated, etc.; for study with regard to possible mitral surgery to relieve the valvular obstruction.

Differential Diagnosis with Congenital Heart Disease.—For opinion regarding the significance of certain types of murmurs—including functional murmurs—which are easily confused with those of rheumatic heart disease, especially in the presence of one or more of the minor manifestations of rheumatic fever.

The Rheumatic Fever Diagnostic and Consultation Center can also be very useful in "de-labeling" those patients whose activities have been unduly restricted and whose general outlook on life has been unduly darkened: many of these people can be saved from becoming psychologic cardiac cripples.

As an educational and public health undertaking by the medical profession, the Rheumatic Fever Control Program of the Michigan State Medical Society deserves the wholehearted co-operation of every practicing Doctor of Medicine.

For further information, write to the Chairman of the Rheumatic Fever Control Committee MSMS, 606 Townsend Street, Lansing 15, Michigan.

The future control of cancer rests on research, prevention through early diagnosis, and prompt, adequate treatment.

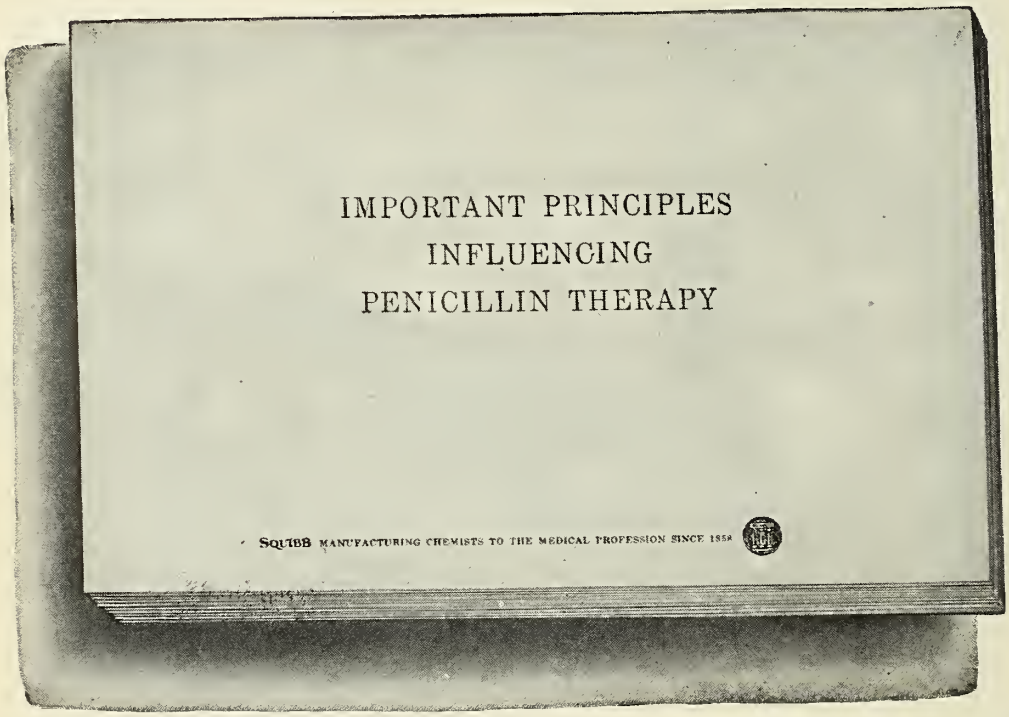
* * *

There is no easy way to solve the riddle of cancer control and early diagnosis; only by long, concentrated work and study can there be evolved the most practical way to attain this desired goal.

Say you saw it in the Journal of the Michigan State Medical Society


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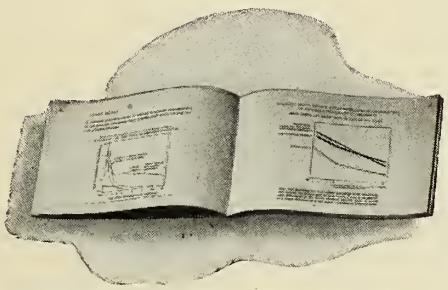
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MICHIGAN STATE MEDICAL SOCIETY ANNUAL SESSION
DETROIT—September 24-25-26, 1952

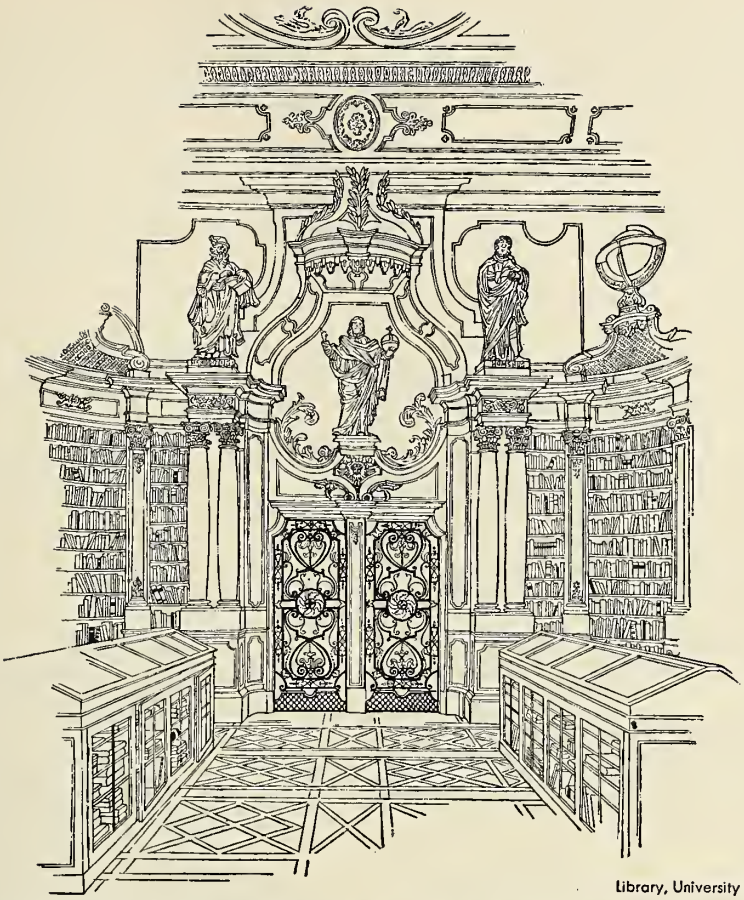
HIGHLIGHTS OF THE COUNCIL
February 20, 1952

Sixty-nine items were considered by the Executive Committee of The Council at its February 20 meeting in Detroit. Chief in importance were:

- Monthly financial reports were presented, studied, and approved. Bills payable were inspected and payment was authorized.
- Contributions to the Beaumont Memorial Restoration Fund, to February 20, included checks from Otto O. Beck, M.D., Birmingham; G. B. Saltonstall, M.D., Charlevoix; Woman's Auxiliary to the Allegan County Medical Society, six members of the Clinton County Medical Society, William Bromme, M.D., Detroit, and Wilfrid Haughey, M.D., Battle Creek. These represent contributions prior to the opening of the Beaumont Memorial Campaign.

 An exhibit on the Beaumont Memorial Restoration Campaign (during the Michigan Clinical Institute in Detroit) to be manned by members of the Woman's Auxiliary and the Michigan State Medical Assistants Society, will include a mock-up replica of the proposed Beaumont Memorial Building on Mackinac Island, authorized by the Executive Committee.
- A resolution to the memory of A. S. Brunk, M.D,. late Past-president and Treasurer of the Michigan State Medical Society, was approved for publication in The Journal MSMS.
- A loyalty pledge of allegiance was given by members of the Executive Committee of The Council, as enrolees in the Civil Defense effort.
- Appointments to the Arbitration Committee (to be used in matters concerned with the Uniform Fee Schedule for Governmental Agencies) were confirmed: T. H. Hunt, M.D., Chairman, Arch Walls, M.D., A. E. Catherwood, M.D., C. K. Hasley, M.D., I. S. Schembeck, M.D., and Mr. John W. Castellucci, Advisor, all of Detroit.
- Committee reports: (a) Public Relations Committee, meeting of January 26, (b) Beaumont Memorial Restoration Committee, January 26; (c) Committee on Development of Model Code for M.D. Announcements, January 26; (d) Hospital Relations Committee, January 27; (e) Tuberculosis Control Committee, January 28; (f) Geriatrics Committee, January 30; (g) Committee on Improvement of Nursing Services, January 30; (h) Legislative Committee, January 31; (i) Venereal Disease Control, February 10; (j) Mental Hygiene Committee, February 14; (k) Ethics Committee, February 13.
- A Committee to meet with Basic Science Board Chairman Dr. O. E. Madison was appointed and confirmed: Wilfrid Haughey, M.D., Battle Creek; E. D. Spalding, M.D., Detroit, and J. Joseph Herbert, LL.B., Manistique.
- John R. Rodger, M.D., Bellaire, was nominated to the Advisory Committee of the Health Information Foundation-Michigan State College Survey of Lenawee County's health facilities; also to the Board of Michigan Health Council in the place left vacant by the death of A. S. Brunk, M.D.
- George C. Thosteson, M.D., Detroit, was nominated as Advisor to the Michigan Nutrition Committee, representing MSMS.
- M. R. Weed, M.D., Detroit, was appointed to the MSMS Ethics Committee.
- The Executive Secretaries of Michigan's five county medical societies (Genesee, Muskegon, Saginaw, Washtenaw, Wayne), are to be invited to attend a one-day study-conference in the new MSMS "home" in Lansing, on April 16.
- 1953 Michigan Clinical Institute: one-half day program (Thursday morning, March 12, 1953) will be devoted to cancer subjects, including the Sykes Lecture; discussion conferences are to be held from 12:00 Noon to 1:00 p.m., with no subscription luncheons, during the 1953 Michigan Clinical Institute.
- William Bromme, M.D., Detroit, was nominated for the vacancy on the Board of Trustees of Michigan Hospital Service to fill the unexpired term of the late A. S. Brunk, M.D.

(Continued on Page 424)



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Ulcerative Colitis
Vascular Infection
Wound Infection

Throughout the world, as in the United States, aureomycin is recognized as a broad-spectrum antibiotic of established effectiveness.

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HIGHLIGHTS OF THE COUNCIL

(Continued from Page 422)

- Report of Delegate E. F. Sladek, M.D., Traverse City, on National Conference on Medical Service held in Chicago, February 3, was received with thanks.
- Congratulatory letters to L. H. Bartemeier, M.D., Detroit, as President of the American Psychiatric Association and to J. M. Robb, M.D., Detroit, as President of the American Academy of Ophthalmology & Otolaryngology were authorized.
- The monthly report of the Public Relations Counsel (H. W. Brenneman) included (a) the showings of the new MSMS color movie "To Save Your Life"; recommendation that a copy of this picture be presented to the Audio Visual Center of the University of Michigan which has a potential of 1700 high school showings; (b) 15 Formula for Freedom Nights have been scheduled, including presentations to 19 component county medical societies (from December 8 to April 22).
- J. S. DeTar, M.D., Milan, President of the Michigan Health Council, reported on the growth of the Council's activities and plans for the future.

MEDICAL EDUCATION FOUNDATION ANNOUNCES IMPORTANT CHANGE IN POLICY

The February 2, 1952, *Journal of the American Medical Association* announces on page 375 an important change in the policy of the American Medical Education Foundation which will be of special interest to Wayne University Medical Alumni who are planning to contribute to the Medical Library Fund.

The announcement, in part, states:

"At the suggestion of many leaders in the profession and in the medical schools, the Directors of the Foundation at their December meeting voted an important change in policy . . . "

"To eliminate possible competition with the fund raising campaigns of the individual schools, the Directors . . . voted that, effective January 1, 1952, the Foundation each year will give appropriate recognition in its annual report to those physicians whom the medical schools report to the Foundation as having supported medical education by making a gift directly to a medical school."

The Wayne University Medical Library Fund committee has worked out an agreement with the

(Continued on Page 436)

MEDICAL MEETINGS AND CLINIC DAYS

A list of known medical meetings and clinic days, sponsored by county medical societies and other physicians' groups in Michigan, follows:

1952

Spring	MSMS Postgraduate Extramural Courses State-wide
May 1	Ingham County Medical Society's Clinic Day Lansing
May 7	Third Michigan Industrial Health Day Flint
May 14	Wayne University Medical Alumni Clinic Day and Reunion.....Detroit
June 9-13	AMA Annual Session.....Chicago
June 27-28	Upper Peninsula Medical Society Annual Meeting.....Iron Mountain
June	St. Clair County Medical Society Clinic Day.....St. Clair
July 24-25	Annual Coller-Penberthy Medical Surgical Conference.....Traverse City
July 24-26	Conference on Housing and Living Arrangements for Older People....Ann Arbor
August	Third Annual Clinic, Central Michigan Committee, ACS Michigan Committee on Trauma, plus Michigan National Guard Medical Personnel, and Michigan Society of North Central Counties Grayling
Sept. 24-26	MICHIGAN STATE MEDICAL SOCIETY ANNUAL SESSION.....Detroit
Oct. 8	Clara Elizabeth Fund—Genesee County Medical Society—Lectures of 1952...Flint
Oct. 9	Fourth Michigan Cancer Conference Kellogg Center, East Lansing
October or November	American Academy of General Practice of Wayne County.....Detroit
Autumn	MSMS Postgraduate Extramural Courses State-wide

Additions to this list of meetings are invited by the Editor of JMSMS, in order to make this monthly announcement complete and accurate.

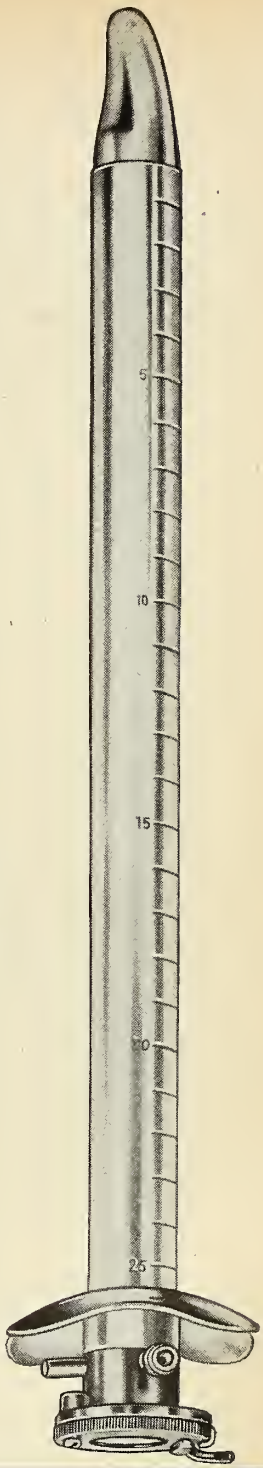
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No. 318 SET—Contains No. 308 sigmoidoscope, No. 300 proctoscope, No. 304 infant proctoscope, No. 342 biopsy punch, No. 280 medium anoscope, rectal probe and hook, No. 700 battery handle, No. 725 cord and inflating bulb, all in attractive case.....$169.50

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Federal Medicine

PROPOSED LEGISLATION

Universal Military Training.—Defense Department and National Security Training Commission are in agreement with *American Medical Association* that pre-medical and medical students, after six months of Universal Military Training, should be deferred from service in the reserves until completion of their schooling and internships. The two agencies presented their views before the House Armed Services Committee, which is holding hearings on bills to implement UMT. If Congress puts UMT into effect, it will be run by Defense Department but supervised by the Civilian Commission.

For the first year at least, deferments would not be an important factor, as Defense Department contemplates starting out with only 60,000 18-year-old volunteers. Eventually as many as 800,000 inductees could be trained annually.

Prior to opening of the hearings, AMA urged the Commission to support *deferment of reserve service through internships and in some cases residencies.* Thus men would serve their full seven and one-half years in the reserves *as physicians, not as students.* In subsequent testimony before the Committee, Karl T. Compton (Ph.D.), a Commission member, agreed with the AMA, saying ". . . recall to reserve duty could well be held in abeyance until schooling was completed." A Commission spokesman explained that this meant deferment through internship but not necessarily residency.

Assistant Secretary Anna Rosenberg testified that Defense Department was opposed to blanket deferment of college students from reserve service after completion of basic training. She said later, however, that the Department believed *medical students should be allowed to finish their education without interruption,* once they have completed the six months of training.

Commissions for Women.—*S. 2552* by Mr. Hunt, of Wyoming, on January 30, 1952 and *H.R. 6288* by Mr. Durham of North Carolina, January 29, 1952 authorize the appointment of qualified women as physicians and specialists in the medical services of the Army, Navy and Air Force.

Referred to the Committee on Armed Services.

These bills would authorize the commissioning of women as officers to perform medical, dental, or medical service duties in the armed forces. This bill is similar to H.R. 4384 of the last Congress which passed both the House and Senate. Since the Senate slightly amended the House-passed version last Congress it was necessary that conferees be appointed to agree on a compromise. The bill was sent to conferees in the closing days of the session and died when Congress adjourned. Last Congress the Army and Air Force favored the bill but the Navy had objections. Senator Hunt's office advises that the Navy has now withdrawn its objections and the bill will be supported by all branches of the military service.

Emergency Maternal and Infant Care.—H.R. 5871, which would provide maternity and infant care for wives and infants of servicemen up to the grade of warrant officer as well as providing hospital care for their dependents, was introduced the first day Congress convened. The bill would establish a federal-state program on a fifty-fifty matching basis to pay these costs. The bill was referred to the Committee on Armed Services. This bill would recreate the EMIC program which caused so much dissatisfaction during World War II.

Hospitalization for Persons Over Sixty-five.—Oscar Ewing's plan for free hospitalization for persons aged sixty-five or over has not yet been introduced in either the House or Senate, but its advent is expected momentarily. You will be kept informed on this cunning scheme in subsequent issues of the Legislative Bulletin.

Two-year Psychosis Presumption for All.—After more than a month's study of the situation, Veterans Administration has made its final ruling and issued regulations on P.L.239, this Congress. It has decided that all World War II veterans and men in service since start of Korean war developing psychosis within two years after separation *will be considered service-connected* for purposes of hospitalization and outpatient care. Because law made no mention of cause of psychosis, VA ruled all men, even those whose disability was obviously not due to service, will be considered service-connected. This means that at least 9,000 patients awaiting VA hospitalization are service-connected cases and VA is faced with an acute bed problem. Some patients will be sent to private and state institutions and a few will require only outpatient care but VA will have to give these NP cases priority as its own beds empty.

Social Security.—H.R. 6078 by Mr. Ford of Michigan introduced January 16, 1952, proposes *to amend the Social Security Act to permit Federal participation in public assistance for patients in private institutions for tuberculous and for patients in private institutions for mental diseases.* Referred to the Committee on Ways and Means.

Comment: At present the several states conducting public assistance programs (old-age, blind, totally and permanently disabled) partially supported by the federal government, may not use federal funds to make money payments to, or for medical care in behalf of, recipients of such public assistance programs who are patients in private or public institutions. This bill would remove the prohibition in the case of recipients who are inmates of *non-public* institutions while retaining the prohibition for such payments to or in behalf of such recipients in *public* institutions.

(Continued on Page 428)

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$	300	Monthly Benefits thereafter for Life.
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$	5,000	Cash, & $400 monthly first 2 years, $300 monthly thereafter. Adjusted benefits for disabilities occurring after age 60.

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PROPOSED LEGISLATION

(Continued from Page 426)

Several bills have been introduced into the Congress which were approved by the Committee on Legislation at its Los Angeles meeting:

Senate Joint Resolution 110 on Air Pollution, by Senator Murray.

House of Representatives Bill 4405, by Mr. Clemente permitting deductions from gross income for medical expenses.

House of Representatives Bill No. 5426, by Mr. Brooks, Armed Forces Reserve Bill.

House of Representatives Bills 4549, by Mr. Clemente; 4569 Mr. Dollinger; 4577 Mr. Fine; and 4579 Mr. Klein, all to establish hospitals for juvenile drug addicts. The following statement was agreed to: "That the AMA fully appreciates the problem that the juvenile addict presents; that this is a problem of a few of the very large metropolitan areas and that wherever possible it should be taken care of on a local basis; where this cannot be done, the present existing facilities should be used (Fort Worth, Texas, and Lexington, Kentucky); when this can no longer be done, then the AMA would advise expansion of the present facilities."

Senate Bill 1140 by Mr. McClellan and others to create a Department of Health. The Committee reconsidered and restated its opposition to the bill as it is now written because the AMA does not approve the inclusion of the medical functions of the VA and the military organizations under a single department of health.

Senate Bill No. 1875, by Mr. Humphrey, Federal Aid to Co-operative and non-profit health insurance plans, and Senate Bill 2171 by Mr. Hill and Mr. Aikin on voluntary health insurance was opposed upon the recommendation of the Council on Medical Services. The bill is incompatible with the sound philosophies concerning the rendition, distribution, and financing of medical care enunciated by the AMA.

Social Security Amendments.—S.2705 by Messrs. Lehman of New York, Murray of Montana, Magnuson of Washington and Humphrey of Minnesota, February 21, proposes *to extend and improve the old-age and survivors insurance system, to provide permanent and total disability insurance and rehabilition benefits.* Referred to the Committee on Finance.

Comment: Bill would (a) extend social security benefits to an additional eleven million persons, (b) increase benefits approximately 35 per cent, (c) raise the taxable base from $3,600 to $6,000 on which is predicated the contributions of employes and employers, (d) increase both the employe's and the employer's contribution to four per cent (each) by the year 1961—the self-employed would contribute 5.25 per cent by 1961, (e) add a compulsory program of permanent and total disability benefits and a cash sickness benefit program (temporary disability), and (f) finance a broad rehabilitation program for disabled persons covered by social security.

According to testimony given on the 1953 FSA Appropriation Bill, approximately 75 per cent of the population (workers and their dependents) are now covered by social security. Under the terms of this bill, adding eleven million persons to the rolls, approximately 83 per cent of the population would be covered. The main additions are farm owners and workers, additional household domestics, members of the armed forces, and certain groups of government employes. Self-employed physicians, lawyers, and certain other professional persons are not included.

At least six identical bills have been introduced.

Transfer of Hospitals Between the VA and Department of Defense.—H.R.6724 by Mr. Rankin, of Mississippi, February 20, proposes *to authorize the transfer of hospitals and related facilities between the Veterans' Administration and the Department of Defense.* Referred to the Committee on Veterans' Affairs.

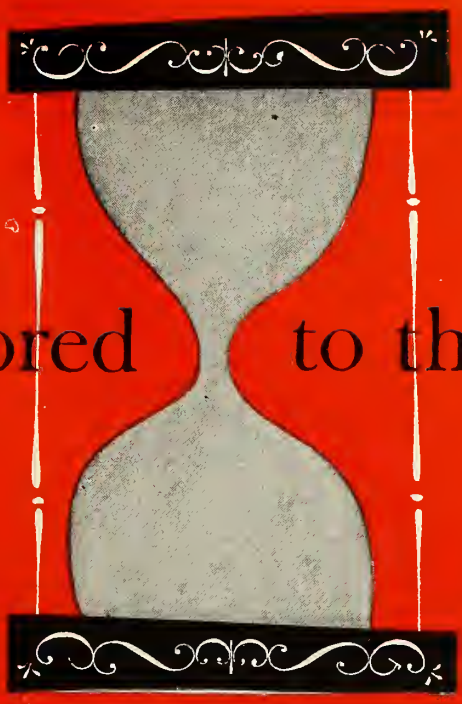
Comment: This bill was introduced at the request of the Department of Defense. It would permit transfer of hospitals and other facilities without reimbursement between the VA and the Army, Navy, and Air Force. VA officials advise that under existing law VA can acquire hospital facilities from the Department of Defense without transfer of funds. However, Defense may not acquire from VA without transfer of funds.

Defense Community Facilities and Services.—The President, February 14, requested supplemental appropriations for several government agencies. The requests included $25,750,000 for the Federal Security Agency to carry out the recently authorized program of federal assistance to critical defense areas for hospitals, health centers, water purification plants, sewage treatment plants, refuse disposal facilities and recreational facilities. Further, $535,000 was requested for administrative expenses of the Federal Security Agency in connection with these responsibilities. The President also requested $18,750,000 additional for the Housing and Home Finance Agency, which agency shares with the FSA responsibility for carrying out these programs. It will be recalled that last year Congress authorized $60,000,000 for community facilities and services but only appropriated $15.5 million to initiate the program. The legislation runs until June 30, 1953, and the new amounts requested would be available for expenditure until that date. The total of earlier appropriated funds plus these funds requested, equals the $60,000,000 authorized by Congress.

Indians.—S.2780 by Mr. Thye, of Minnesota, March 4, is *a bill to transfer administration of health services for Indians and operation of Indian hospitals to the U. S. Public Health Service.* Referred to the Committee on Interior and Insular Affairs.

Comment: Introduced at the request of Association of State and Territorial Health Officers. In addition

(Continued on Page 430)



tailored to the moment



Whenever capillary bleeding becomes a hazard in surgery

Gelfoam*

BRAND OF ABSORBABLE GELATIN SPONGE

is tailored to fit the situation.

Gelfoam may be speedily cut to shape and pressed against oozing capillary surfaces, where it rapidly *absorbs* up to 45 times its own weight in blood. Left *in situ*, Gelfoam is completely *absorbed* in 20 to 45 days with virtually no cellular reaction.

Gelfoam is supplied in a variety of convenient sizes, including a sterile surgical sponge, dental pack, prostatectomy cone, and biopsy sponge.

*Trademark Reg. U. S. Pat. Off.

a product of **Upjohn Research**

for medicine . . . produced with care . . . designed for health

THE UPJOHN COMPANY KALAMAZOO MICHIGAN

PROPOSED LEGISLATION

(Continued from Page 428)

the bill is supported by American Public Health Association, Governors Interstate Conference on Indian Affairs and the Inter-Tribal Council of the Sioux Nations. Senator Thye pointed out that none of the sixty-two hospitals now operated by the Bureau of Indian Affairs is recognized by the AMA for the training of interns or otherwise as teaching hospitals. He indicated that Representative Judd would introduce a companion bill in the House.

MAGNUSON COMMISSION HEARS REPORTS ON FEDERAL HEALTH PROGRAMS

The Presidential Commission on the Health Needs of the Nation, under chairmanship of Dr. Paul Magnuson, met for two days in Washington and received reports on health programs conducted by the federal government. Appearing before the Commission were Fred A. McNamara, chief of the Hospital Branch, Bureau of the Budget; and Dr. Leonard Scheele, the Surgeon General and head of U. S. Public Health Service; and Dr. Howard Rusk, Chairman of the committee which serves in an advisory capacity to Selective Service, Defense Department and Office of Defense Mobilization. A spokesman said the three officials were able to give the Commission "a pretty broad picture" of the present activities of the government in medical and health fields.

BRIEFS

Under a new directive, the Department of Labor's Bureau of Employes' Compensation is added to the list of government agencies which may, under certain conditions, obtain partial transcripts of pertinent information from medical records of military personnel. Other agencies and departments exercising the same authority are Army, Navy, Air Force, Treasury Department, Department of Commerce, Federal Security Agency, Veterans Administration, Selective Service and Post Office Department. Details of the amended regulations appear in Federal Register, Vol. 17, No. 7, January 10, 1952.

Senator Murray's survey of state governors, started last summer to determine the supply and distribution of physicians, probably will be dropped. According to a spokesman for the Labor and Public Welfare Committee, "answers were not such as to lead to anything."

Veterans Administration medical research conference at Chamblee, Georgia, in January reviewed all major research projects conducted at VA hospitals. . . . Statistical summary for end of November shows about 1,500 veterans with military service since start of Korean War are hospitalized; in all, 32,000 service-connected cases and 64,000 non-service-connected cases (including NP, TB and other chronically ill) are in VA hospitals.

National Research Council received 2,800 applications for the 400 graduate fellowships offered by National Science Foundation—the largest number ever received. NRC says it will be weeks before the applications are sorted according to field—medical, physical, mathematical, biological and engineering research. Then grants will be distributed in proportion to the number of applications in each.

President Truman advocates "far greater" quantities of medical supplies in reserve for civil defense and has promised state civil defense directors he will seek more funds from Congress for such purpose. Directors discussed plans for recruiting 17.5 million civil defense volunteers at three-day meeting.

A survey of the first year's operations of the new U.S. program for aid to *totally and permanently disabled needy adults* shows $27.5 million distributed to 28 states, the District of Columbia, Hawaii, Puerto Rico and the Virgin Islands. The program was designed to extend federal assistance to permanently and totally disabled persons between the ages of eighteen and sixty-five. *Under eighteen* they would be eligible for aid as children, *over sixty-five* as old-age assistance cases. The formula provides for federal payment of three-fourths of the first $20 monthly, and one-half the balance up to a maximum of $50. Social Security Administration said the new program was "an important factor in reducing the cost of state and locally financed general assistance programs." Emphasis on medical check-ups in the new program, the agency added, "has resulted in many persons learning for the first time that treatment which would remedy or alleviate their condition was available. Some eventual savings in federal and state funds may result from the rehabilitation of these people."

EWING DIFFERENTIATES

The University of Illinois College of Medicine faculty met in January and invited Federal Security Administrator Oscar Ewing to address the meeting.

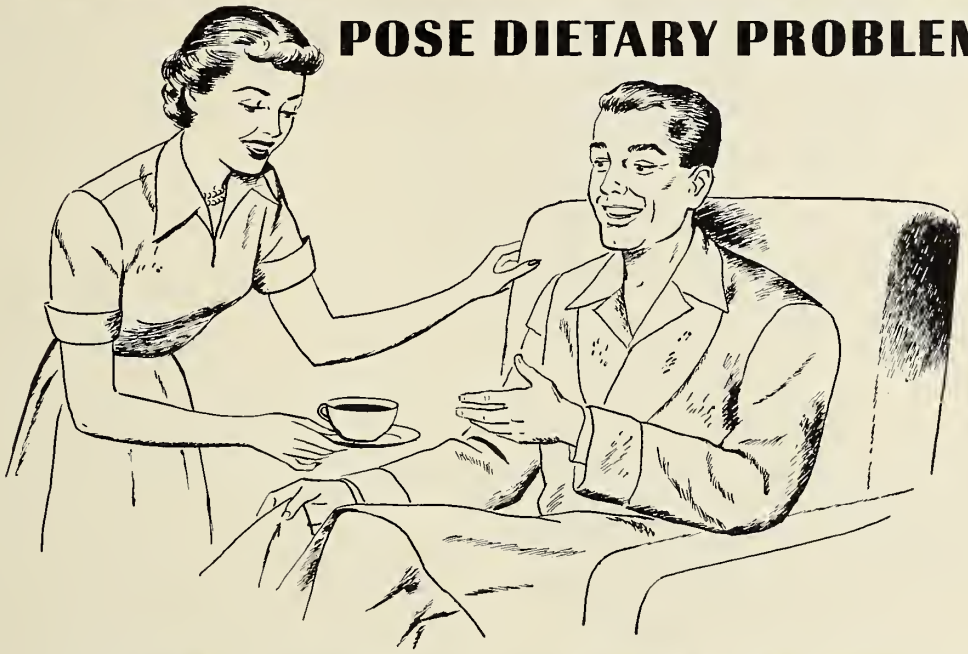
Mr. Ewing emphasized the difference between the proposals for national compulsory health insurance and socialized medicine. "I don't know anyone who is in favor of socialized medicine—neither the President, I, nor anyone else," he declared. He defined socialized medicine as a system under which the medical profession works for the government, hospitals are owned by the government, and the entire system is paid for out of the general tax fund. "This is not the kind of medicine that would fit the American way of doing business, and it is entirely different in concept and practice from what the President has proposed," Mr. Ewing stated.

"The nation does have a serious problem involving the cost of medical care," Mr. Ewing asserted. "Three out of five American families have an annual income of less than $3,500 and cannot pay the costs of the medical care they require," he said. "Four out of five families have less than $5,000 income and cannot meet the costs of so-called catastrophic illness," he added . . . "This is no reflection on the medical profession," the speaker said. "The problem is to bring doctors and patients together. It is the dollar bill which prevents families from getting needed care." It is also the dollar bill which prevents medical schools from producing a sufficient number of doctors and causes doctors to settle in larger cities rather than in low income communities, he added, and it is the dollar bill which

(Continued on Page 432)

When Functional Derangements

POSE DIETARY PROBLEMS



In the interest of maintaining good nutrition in the patient, many functional derangements of the gastrointestinal tract make the use of a well rounded dietary supplement, such as Ovaltine in milk, highly advantageous. Among such functional derangements more commonly encountered are nausea, anorexia, gastritis, diarrhea, dysentery, enteritis, and colitis.

In these conditions, Ovaltine in milk is particularly useful, not only because of its easy digestibility but also because of its blandness and its high nutrient content. It offers the opportunity of providing a balanced fare of essential nutrients without mechanical irritation or excessive digestive demands. Hence it qualifies especially when customarily eaten foods are contraindicated and a nutritious bland diet is required.

The wealth of nutrients supplied by three glassfuls of Ovaltine in milk is outlined in the table below.

THE WANDER COMPANY, 360 N. MICHIGAN AVE., CHICAGO 1, ILL.



Ovaltine

Three servings of Ovaltine, each made of ½ oz. of Ovaltine and 8 fl. oz. of whole milk, provide:

PROTEIN	32 Gm.	VITAMIN A	3200 I.U.
CARBOHYDRATE	65 Gm.	VITAMIN D	420 I.U.
FAT	30 Gm.	ASCORBIC ACID	30 mg.
CALCIUM	1.12 Gm.	NIACIN	6.7 mg.
COPPER	0.7 mg.	PANTOTHENIC ACID	3.1 mg.
IODINE	0.7 mg.	PYRIDOXINE	0.6 mg.
IRON	12 mg.	RIBOFLAVIN	2.0 mg.
PHOSPHORUS	940 mg.	THIAMINE	1.2 mg.
CALORIES	658		

Two kinds, Plain and Chocolate Flavored. Serving for serving, they are virtually identical in nutritional content.

EWING DIFFERENTIATES

(Continued from Page 430)

causes people to stint in medical care they need—or to go broke paying for it.

Explaining the proposed national compulsory health insurance system, Mr. Ewing said it was simply an arrangement to change the method of payment for medical and hospital services; it would not in any way affect the services themselves, he insisted. He explained that insurance costs would be paid out of a health fund to be collected by a 3 per cent payroll tax, 1.5 per cent to be paid by employes and 1.5 per cent by employers, and that doctors would receive payment for services rendered on either a fee for service, capitation, or salary basis—according to their own choice. The program would be administered locally rather than by a federal agency, Mr. Ewing said. The federal government would pass the law, establish standards, collect the health insurance fund and distribute it to stages for local disbursements, he said . . .

Asked to explain the "health crisis" which he said made a national health insurance plan necessary, Mr. Ewing acknowledged there was no crisis in the sense that a sudden, overwhelming emergency existed. He insisted, however, that the economic circumstance which left many American families unable to pay for the medical services they required was sufficient reason for the introduction of the President's program. Voluntary health insurance plans were paying only 12 per cent of the nation's health bill, Mr. Ewing said, and were thus an inadequate solution to the problem.—*Modern Hospital,* February, 1952.

MEDICAL BUDGET PROPOSAL

President Truman's budget message, given to Congress with his budget, again urges passage of legislation for federal aid to *medical education* and to *local public health departments.* The President also asked for extension of Social Security benefits to the armed forces, to public employes and to farmers and irregularly-waged farm and household help. While making no mention of National Compulsory Health Insurance, Mr. Truman did cite his new Commission on the Health Needs of the Nation, to which he has referred health problems.

Appropriation Requests of Interest to Medical Profession

(Budget requests shown below are subject to increase or decrease by committees or on floor of House and Senate. They will provide funds for the period July 1952 through June 1953, identified as "fiscal 1953." Figures shown below are in millions.)

	Provided by Congress For Fiscal 1952	*President's Requests For Fiscal 1953*
Civil Defense, medical stockpiling*	$ 50.0	$193.0
National Science Foundation	5.0	15.0
Public Health Service	334.5	292.4
Hill-Burton Hospital Construction	82.5	75.0
National Institutes of Health	16.8	15.5
Cancer Institute	20.6	16.7
Heart Institute	13.0	9.7
Children's Bureau, grants	31.5	30.0

*Civil Defense appropriations carry no new money for state-matching grants for medical stockpiling. The 1952 grants, according to the budget, are sufficient to assist all critical target areas to provide first-aid supplies and equipment for the first four hours after an attack. The $193 million listed above is for wholly federal procurement of medical supplies, based on CDA estimates that 2,700,000 casualties could be cared for with this amount of supplies.

No request was made at this time for funds for school and hospital construction in crowded defense areas, but $15 million may be asked later. Enough money was asked for Veterans Administration hospital construction to pay for construction already approved by Congress. Military Departments' budgets are not complete; Congress will be asked to consider them in supplemental appropriations bills. Health, welfare and education requests from all departments and agencies for fiscal 1953 are placed at $2,662 million, as against $2,680 million actually appropriated for fiscal 1952.

EWING DEFENDS COMPULSORY HEALTH INSURANCE

According to Federal Security Administrator Oscar Ewing, "No group in this country have a greater need for national health insurance than the Negroes." Mr. Ewing made the statement before a meeting of the Manhattan Central Medical Society, a New York City Negro medical association. It was the most spirited defense of the Truman-Ewing compulsory health insurance plan that the Administrator has delivered in many months. Mr. Ewing started his argument for the plan by stating that, "The plain truth is that the average Negro has less than a fair chance for health because he is not a lucrative patient." He added: "We are not going to change the mind of the individual physician and persuade him to set aside his financial concerns in order to go out and help the sick who need him most . . . and I do not think it would be right." Then Mr. Ewing denounced AMA for its opposition to compulsory health insurance, and explained how the plan would be expected to work.

On Sunday, January 27, 1952, Mr. Ewing visited Detroit and spoke to a group there. He told of the Administration's compulsory health insurance plan as the only practical method of giving the people the health security they demand. He also advocated the plan for hospitalization and care for the sixty-five-year-olds who are beneficiaries of social security. He said they could just as well as not be given this care, and the cost would not exceed $360 million per year. This is a step up. Not long ago he said there would be no extra cost, because there was money enough in the Social Security fund. Mr. Ewing also said his department had been criticized by the doctors who were not willing to cooperate with his plan, as spending a lot of money on propaganda. He admitted that considerable money has been spent but far less than the millions the AMA has spent through its $25.00 assessment on its members. Incidentally, the AMA raised about $3,000,000, and gave $500,000 to the Medical Colleges. But Mr. Ewing's departments have from 30,000 to 40,000 propagandists in their employ and spend over $75,000,000 of our money each year on socialized medicine, other socializing programs, schools, agriculture, et cetera.

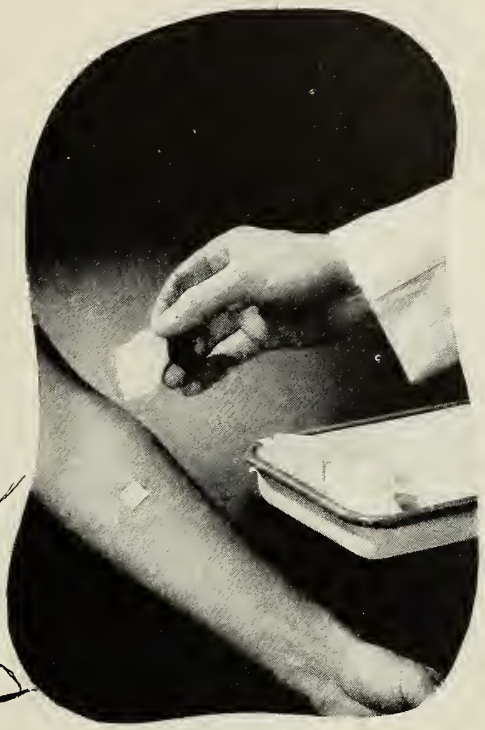
Said Mr. Ewing: "We in the administration feel that this plan will stir up much less opposition than any of the other health proposals now under consideration. In fact, we anticipate its quick adoption."

(Continued on Page 434)

citrus is virtually

NON-ALLERGENIC





TYPICAL PATCH TEST

Over 400 infants and children from 2 weeks to 6 years of age acted as test subjects to check the incidence of sensitivity to orange juice. After 2 to 12 months' observation,* "no disturbance of bowel function (diarrhea or constipation) that could be attributed to the orange juice" was found. Also, the occurrence of regurgitation and rashes was "minimal". In the rare instances of sensitivity, care exercised by gentle reaming of juice (or the use of frozen concentrate) to avoid contamination with peel oil usually obviates the difficulty.

**J. Pediat. 39:325, 1951*

FLORIDA CITRUS COMMISSION • LAKELAND, FLORIDA

FLORIDA *Citrus*

ORANGES • GRAPEFRUIT • TANGERINES

EWING DEFENDS COMPULSORY HEALTH INSURANCE

(Continued from Page 432)

Speaking at University of North Carolina, *FSA Administrator Oscar Ewing* made these observations: ". . . . we could add this benefit (hospitalization-at-65) to social security by next year, and do it without any increase in the present wage deductions (and) . . . the plain truth is they (voluntary health plans) do not go far enough—and they very probably can never go far enough." National compulsory health insurance, Mr. Ewing said, was arrived at as a solution "with inexplorable logic," but "if anyone can come forward with a better way . . . we will . . . be happy to welcome him and his ideas."

FREE HOSPITALIZATION URGED

Federal Security Administrator Oscar R. Ewing said Saturday he hopes to send to Congress soon his plan for free hospitalization for 7,000,000 persons.

The program would cost $230,000,000 annually. Beneficiaries would be those participants in social security who are aged 65 or over, their widows or widowers, and dependents of deceased participants.

Since Ewing first proposed the plan, which would be financed by social security funds, he has made one major change. He would provide for administration in some cases through non-profit voluntary health insurance programs such as the Blue Cross.

Those eligible for the free hospitalization would be entitled to 60 days' hospital care a year. But the care would not be available to those with chronic afflictions nor to the mental and tubercular cases.

"I can't help believing that this is a plan which will be accepted by everyone when they understand it," Ewing said in an interview.

Says Funds Available

"Actually the money is there and it gives hospitalization insurance to a group of our society which has less money to pay for it than any other group."

Here is how the plan would be administered:

1. By the states through their health departments.
2. If not through the health departments, by the states through the voluntary health insurance groups.
3. If not by the states, by the federal security agency through the voluntary groups.
4. All other methods being unavailable, by the federal security agency itself by dealing directly with the hospitals.

Ewing said he prefers to have the administration completely decentralized and handled entirely by the states.

He figured the average daily cost per patient would be $15 and that is what the total annual cost is based upon.

Persons receiving the benefits would be allowed semi-private accommodations—two to a room. If they wanted better accommodations, they could pay the difference from their own pockets as is the case in the usual group hospitalization plan.

Services included would be those usually provided by a hospital to bed patients, such as drugs and appliances.

Physicians would decide who should be hospitalized and would make the necessary arrangements. The government would pay the bill.—*The Enquirer and News,* Battle Creek, January 20, 1952.

CNH ATTACKS AMA

As in the past, so now, the Committee for the Nation's Health, Inc., is promoting the Truman-Falk-Becker line. CNH is now publishing a 4-page monthly bulletin. At the top is a quotation from Truman's Budget Message: . . . "we need to fill important gaps in our social security system by providing protection on a prepaid basis against the costs of medical care." This is another way of saying "we need compulsory Social Security medicine."

The CNH release is devoted primarily to jibes at the AMA. However, this should be recognized: The medical profession has not initiated any subversive activities; it has not attempted to overthrow our form of Government either by violence or stealth; it has not attempted to set up a Socialist Government. The medical profession acted only after it was attacked. Seeking to defend itself and those who are ill, it has spent its own money, instead of squandering tax funds as Ewing, Altmeyer, Cohen, and Falk have done.

In this connection we may note the rising cost of the Welfare State and of its publicity programs. Since Ewing took over the Federal Security Agency its budget has been trebled:

1946	$ 743 million	1950	$1,511 million
1947	928 „	1951	1,750 „
1948	1,028 „	1952	1,619 „
1949	1,370 „	1953	2,179 „

Ewing still has over $1 million a year for his personal entourage of some 235 persons. He still spends about $100,000 a year on publicity. His speeches and those of his top brass pour out of FSA by the ton.

It is impossible to measure indirect publicity expenditures in the FSA—time spent on speeches, travel, regional office activities, et cetera.—Margaret Shearon, Challenge to Socialism, February 28, 1952.

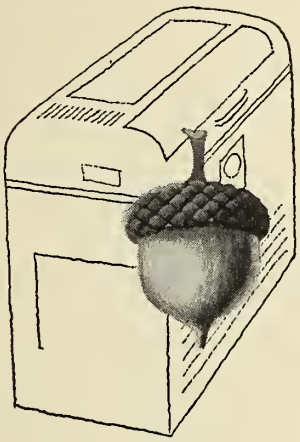
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Paul Hawley, M.D., in a speech at the American College of Surgeons thirty-sixth clinical congress at Boston, October, 1951, said: "I cannot share the optimism of some of the leaders in organized medicine that the peak of this danger (compulsory health insurance) has been passed. This is a battle that medicine can never win . . . it can only lose."

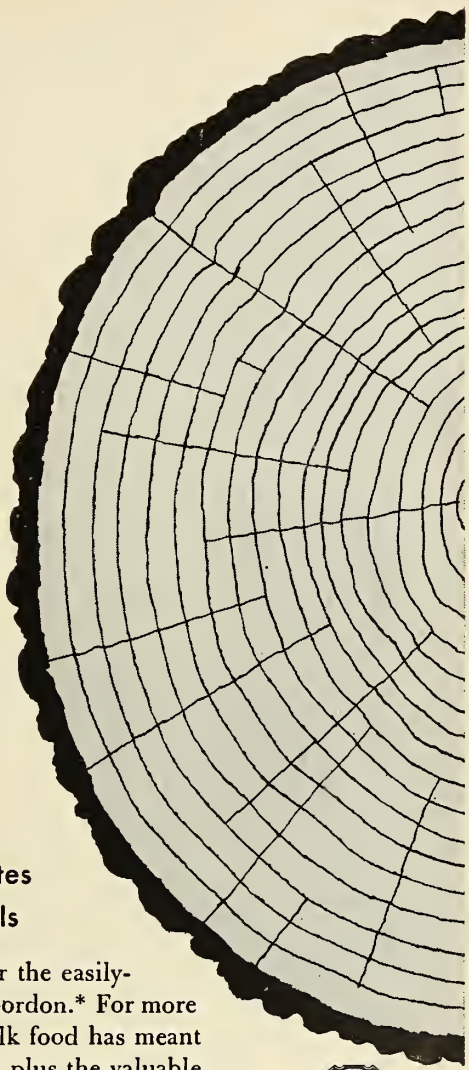
SOCIALIZED MEDICINE OPPOSED BY 91 PER CENT VOTE IN IOWA CONGRESSIONAL DISTRICT

Basing his findings on a mail public opinion sampling, Rep. Thomas E. Martin (R., Iowa) reports that over *91 per cent of the residents of his district are opposed to socialized medicine.* Questionnaires were sent to 39,800 persons, 3,870 of whom had replied at the time Mr. Martin inserted the results in the Congressional Record. That rate of return, according to Mr. Martin,

(Continued on Page 436)



for
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maturing
of the
premature



DRYCO

A dehydrated milk-food
LOW in fat and carbohydrates
HIGH in protein and minerals

Confirmation of the need of prematures for the easily-digested Dryco formula is found in the study by Gordon.* For more than three decades, this low-fat, high-protein milk food has meant minimum digestive derangement from fat... plus the valuable tissue-building benefits of protein. For the premature, these are important food considerations. Dryco's easy digestibility, due to its soft flocculent curd of small particle size, further enhances its choice for premature feeding. Dryco is a spray-dried half whole, half skim-milk mixture, vitamin fortified with vitamins A and D. Only supplementary vitamin C need be added. Dryco is readily reconstituted in cold or warm water and permits a wide range of formula flexibility to meet the varying nutritional requirements of the premature.

Additional data and samples will be mailed on request.

*Gordon, Harry H.: Feeding of Premature Infants, American Journal of Diseases of Children 73:715 (June) 1947.

DRYCO® *Each tablespoonful supplies 31½ calories.*
Frequently used for supplemental feedings.
Available at pharmacies in 1 and 2½ lb. cans.

Prescription Products Division

The **BORDEN** Company • 350 Madison Avenue • New York 17, N.Y.

SOCIALIZED MEDICINE OPPOSED

(Continued from Page 434)

is approximately equal to Gallup's estimate of total expected returns from such a mailing. This particular question, one of twenty, reads: *"Do you favor socialized medicine?"* Of the 3,669 who replied, 3,365 (91.7 per cent) said no, 304 (8.3 per cent) said yes. Every occupational group included in the survey was overwhelmingly opposed to socialized medicine. Opposition to the idea was voiced by 96.6 per cent of the businessmen, 86 per cent of the laborers, 93 per cent of the white collar workers, 91 per cent of the professionals, 94.8 per cent of the farmers and 90.2 per cent of the remainder. Another question asked those replying to indicate the most important issues facing the country. Government spending was singled out as the most important issue, with "the threat of socialism in this country" as No. 2 issue. Mr. Martin's district, the first, is mostly rural, but contains several cities, including Burlington, Keokuk and Muscatine.

NEW BILL IMPOSES CHARGES FOR HEALTH SERVICE

A new bill imposing charges for national health service in Great Britain has been introduced by the Conservative government. The proposed charges include a basic fee for prescriptions, a maximum fee for dental treatment, and a maximum daily fee for private rooms in hospitals. It also stipulates that persons receiving certain services should pay for half their cost. The items apply to wigs, hearing aids, surgical boots and shoes, surgical corsets and elastic hosiery. Charges for the use of day nurseries would be left to the discretion of local authorities. An unusual feature of the proposed bill is its authorization of fines of £100 ($280) or imprisonment for three months, or both, for attempting to obtain free benefits under false pretenses. The penalty provisions are a new feature in connection with National Health Service in Great Britain. Bill passed.

HEALTH INSURANCE

The Insurance Economics Society of America commented on a press release from Commissioner Altmeyer of the Federal Security Agency's Social Security Administration in which he said that, in the aggregate, "private insurance against sickness met about 10 per cent of the costs of sickness in 1950."

While the press release did not say so, as the memo pointed out, the figures seem clearly to suggest that the voluntary health insurance movement is of trivial worth in aiding the public to meet the costs of ill health.

The percentages compare health insurance benefits with the total cost of sickness rather than with the fraction of such costs which can and should be met by insurance.

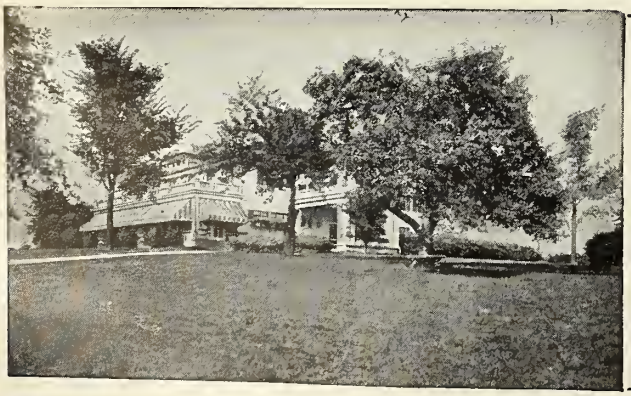
In spite of the above statement of FSA Altmeyer, the *Council News* of the National Research Council for March reports:

Voluntary insurance has met almost one-third of the cost of the nation's hospital bill and one-eighth of the estimated cost of physicians' care. These percentages for 1950 represent a gain of almost 8 per cent and 5.5 per cent, respectively, as compared with 1948 figures. In its report, "Voluntary Insurance against Sickness: 1950 Estimates," the Social Security Administration reveals that the amount of the nation's hospital bill paid through private resources came to approximately $2¼ billion. About $680 million of this total bill were paid from insurance funds. Blue Cross Plan payments accounted for $378 million; commercial insurance company payments came to about $254 million. The nation's medical care expenditures were estimated to be somewhat over $2½ billion, of which voluntary insurance funds paid about $312 million.

MEDICAL EDUCATION FOUNDATION ANNOUNCES IMPORTANT CHANGE IN POLICY

(Continued from Page 424)

Wayne University College of Medicine to report to the American Medical Association all gifts made to the Library Fund by alumni and other doctors. In this way, contributors will receive appropriate recognition from the American Medical Education Foundation for their gifts under the new policy.



The Mary Pogue School

Complete facilities for training Retarded and Epileptic children educationally and socially. Pupils per teacher strictly limited. Excellent educational, physical and occupational therapy programs.

Recreational facilities include riding, group games, selected movies under competent supervision of skilled personnel.

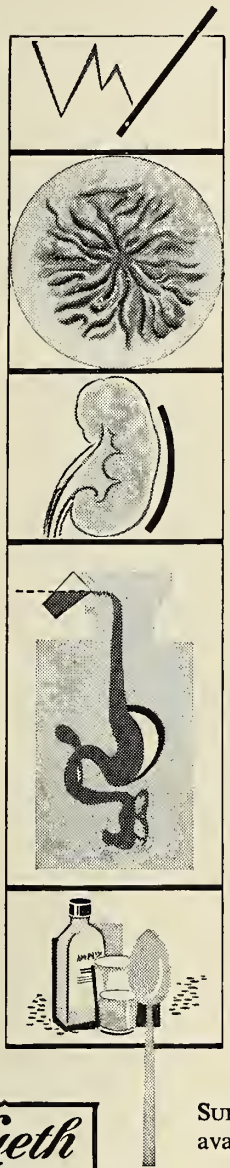
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relieves pain promptly	stops gastric corrosion
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never causes alkalosis	buffers gastric contents moderately; permits normal neutralization of alkaline secretions of upper intestine
no acid rebound	even in excessive doses. Does not cause unphysiologic alkalinity and consequent acid secretory response
pleasant to take	smooth, creamy, pleasing taste and texture

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SUPPLIED: Liquid, bottles of 12 fl. oz. Also available: Tablets of 5 grains and 10 grains

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ARMY TEAM ON EPIDEMIC HEMORRHAGIC FEVER LEAVES SOON FOR KOREA

In anticipation of a resurgence this spring of epidemic hemorrhagic fever among U. S. troops in Korea, an Army team headed by Dr. Joseph Smadel leaves in March for the Far East. Maj. Gen. George E. Armstrong, Army Surgeon General, who made the announcement, said *the service anticipates a return of the disease beginning in April.* He listed hemorrhagic fever, frostbite, Japanese B encephalitis and acute hepatitis as the major problems of the medical services in Korea.

Dr. Smadel is chief of the department of virus and rickettsial diseases of the Army Medical Service Graduate School, Walter Reed Army Medical Center. Dr. Smadel was in charge of a team that visited Malaya, Burma and Layte in 1947 and found chloramphenicol was effective against scrub typhus.

Gen. Armstrong, who returned recently from a tour of Korea, reported the death rate from hemorrhagic fever among U.N. troops last year was 6.5 per cent of some 1,000 cases. Most of the deaths were attributed to massive hemorrhages of the kidneys.

On the other hand, Gen. Armstrong said *the situation regarding cold injuries, principally from frostbite, was "most encouraging."* So far this winter there have been 700 frostbite cases among U. S. personnel compared with 4,400 cases last winter and reports indicate only a small number now are due to negligence, he said. Because of administration of the drug primaquine to returning military personnel, Gen. Armstrong anticipates a low incidence of vivax malaria cases this year in the U. S.

DEFENSE DEPARTMENT CONSIDERS INVOKING DOCTOR DRAFT LAW

Because the pool of Priority I reserves is about exhausted, Defense Department is preparing to call on Selective Service to start inducting *physicians* under the doctor-dentist draft law (P.L.779, Eighty First Congress), possibly as early as April.

Explaining the situation, one Defense Department official said that only a large influx of Priority I men into the reserves in the next few weeks would postpone use of the draft.

To date less than half a dozen physicians actually have been drafted. If the draft is resorted to now, it will be aimed at a group of about 1,000 Priority I physicians *who are physically fit, are not in essential civilian service but who have neither joined the reserves nor indicated they intend to.* Of the others in Priority I, about 1,500 have been deferred because of the essential nature of their civilian practice or status, and 2,000 have been found physically unfit for military service. The remainder are in the reserves, and either on active duty or awaiting orders.

Defense Department already has put in its first call with Selective Service for induction of dentists. It has asked for 335 during April, with 200 to be assigned to the Navy, 85 to the Army and 50 to the Air Force. As with M.D.s, if enough Priority I dentists join the reserves, the draft will not be used.

ONLY FOUR "CRITICAL TARGET" STATES NOT ACTIVE IN CD MEDICAL STOCKPILING

Federal Civil Defense Administration's medical supply stockpiling program now is moving ahead after a year of delays, mostly due to reluctance of some states to appropriate matching money. As late as December 1, CDA reported that 15 states containing critical target areas had not yet entered the program. Within the last two months, however, *all but four of these either submitted acceptable plans to Washington or are busy working out plans.* The funds, matched by states, will be spent for emergency medical supplies, to be stockpiled locally for use immediately after an attack.

CDA disclosed that the situation was changing for the good in announcing allocation of more than $8 million to 14 states for local medical stockpiles, including such items as burn dressings, litters, blood plasma, antibiotics and surgical instruments.

States participating in the program, February 19, 1952, with total budgets for each, are:

California	$3,984,638	Michigan	$ 793,707
Colorado	39,632	New Jersey	552,360
Connecticut	303,903	New York	9,486,896
Delaware	50,275	Oregon	15,504
Kansas	97,549	Rhode Island	3,766
Maryland	398,231	Tennessee	197,430
Massachusetts	298,674	Washington	498,666

Although states are paying half the costs, most of the funds will be expended through CDA, to take advantage of bulk purchasing while at the same time not exceeding the capacity of manufacturers. Federal Civil Defense Administration also has about $33 million available for setting up and maintaining regional warehouses for medical supplies. These stocks, *paid for entirely by U. S.,* will be held in reserve, to be rushed into an attacked area to supplement local supplies after the first few hours.

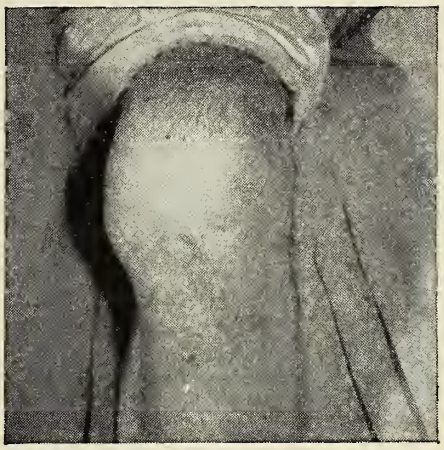
ARMY MEDICAL SERVICE REPORTS 500 CERTIFIED SPECIALISTS ON DUTY

Five hundred officers now on active duty with the Army Medical Service have been certified as professional specialists, Major General George E. Armstrong, Army Surgeon General, announced. This number includes 466 physicians qualified in nineteen medical specialties

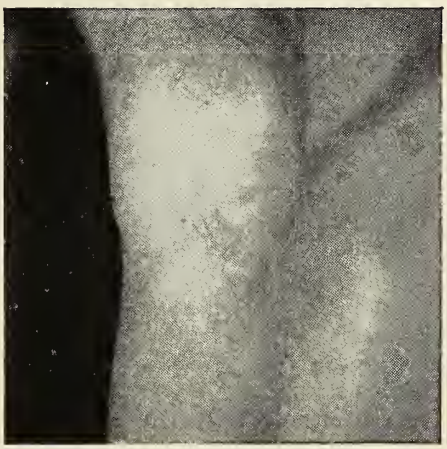
(Continued on Page 440)

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Ward, L. E., Slocumb, C. H., Polley, H. F., Lowman, E. W., and Hench, P. S.: *Proc. Staff Mtgs., Mayo Clinic* 26: 361, September 26, 1951.

Literature on Request

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CATASTROPHIC HOSPITAL BILLS

Every eighty minutes on the average, each working day of the week, your Blue Cross Plan during 1951 paid a hospital bill for one of its members that amounted to $1,000 or more. A great many of the bills ran as high as $3,000. A substantial number amounted to $4,000.

Blue Cross has paid bigger bills, much bigger bills, than the ones above. However, we are not concerned here with the unusual peaks but with the big bills that happen every little while. Blue Cross now covers 40 per cent of the people of Michigan. If the Blue Cross experience holds for all of the people—and we have no reason for thinking otherwise—the hospital bill above $1,000 must happen on the average every 32 minutes of the day, each working day of the week, in Michigan alone.

In addition, however, each of you who is a member of Blue Cross-Blue Shield can enjoy this deep satisfaction, that your participation has helped bring increasing opportunity for healthy living as well as security to millions in this state.

Since the day it opened for business, 13 years ago, your Blue Cross Plan has paid for 1,800,000 hospital admissions, amounting to 13,699,258 days of hospital care.

Your Blue Shield Plan paid for 1,849,045 surgical and medical services for its members during the period between February, 1940, and December, 1951.

HOSPITAL FEES PUSH UP MEDICAL CARE COSTS

Bureau of Labor Statistics in Labor Department reports a 3 per cent increase in the national average cost of medical care and drugs for the fourth quarter of 1951, in contrast to a 1 per cent rise during the third quarter. Of the various items and services surveyed by the government, hospital rates showed an increase of 6.8 per cent. Close behind were premiums for group hospitalization (Blue Cross) programs, up 5.8 per cent.

BLS gave these figures on other fees: physicians generally, up 2.3 per cent; general practitioners, up 2.5 per cent; surgeons and specialists, up 1 per cent; dentists, up 1.2 per cent; prescription drugs, down 0.1 per cent.

ARMY MEDICAL SERVICE REPORTS 500 CERTIFIED SPECIALISTS ON DUTY

(Continued from Page 438)

and subspecialties, twenty-three board-certified dentists, seven specialists in psychology and four in nutrition.

General Armstrong pointed out that the current situation contrasts sharply with that in 1945 when there were only 75 medical board specialists on duty with the Army. He attributed the increase to inauguration of the Army Medical Service's Graduate Professional Training Program in 1947 and to the recall of Reserve medical officers to active duty since the outbreak of the Korean conflict.

Of the total number of medical specialists, 311 are Regular Army Medical Corps officers, 148 are Reserve or National Guard physicians on extended active duty and seven are retired Regular Army officers remaining on active duty. When the Army began its residency training program five years ago there were only 99 Regular Army and 44 non-Regular physicians with board certification on active duty.

CLINICAL LABORATORY CHEST FOR IMPROVISED HOSPITALS

Federal Civil Defense Administration has developed a clinical laboratory chest for improvised hospitals; it weighs about 75 pounds when fully equipped with necessary supplies for blood and urine tests and other examinations that may be necessary immediately after an attack. Chests, costing about $125 complete, will be included in CDA medical stockpiles when funds permit.

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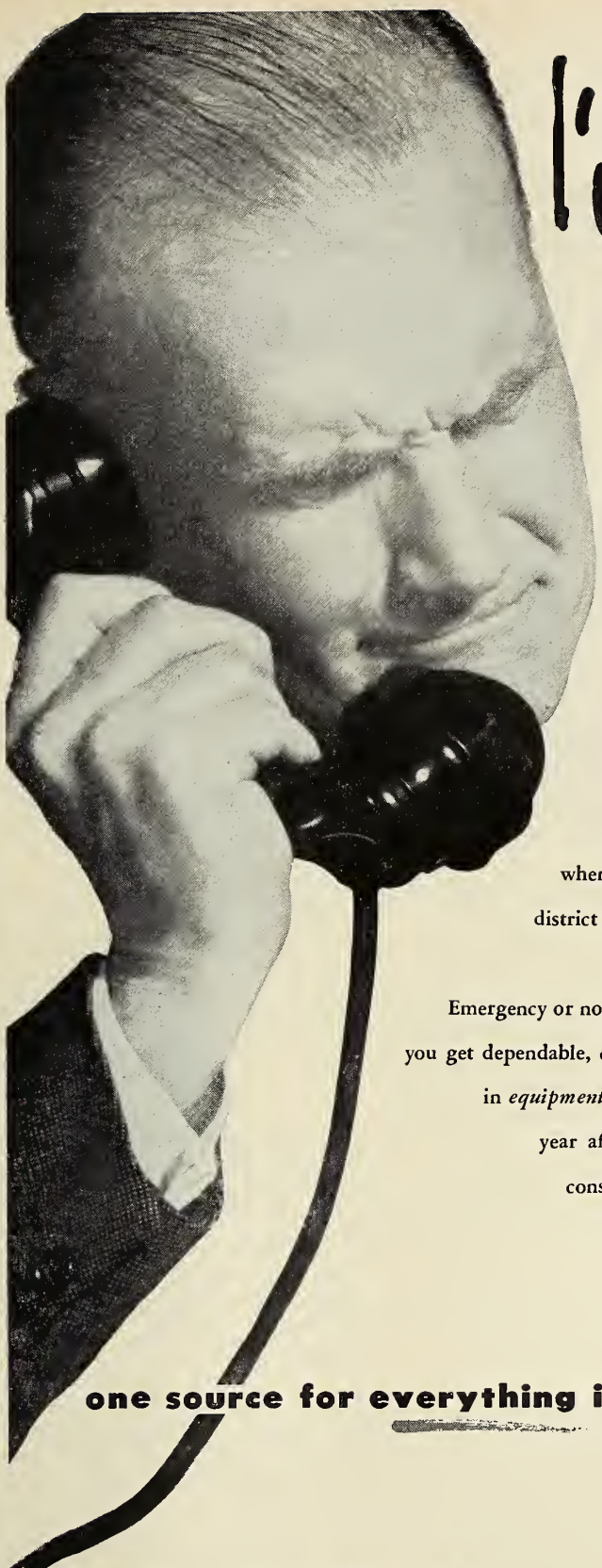
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WAYNE COUNTY COLLEGE OF MEDICINE ALUMNI ASSOCIATION

Annual Clinic Day and Reunion

May 14, 1952

The Annual Clinic Day and Reunion of the Wayne University College of Medicine Alumni Association will be held on Wednesday, May 14, at the Fort Shelby Hotel.

The professional program will include five guest speakers and a panel of four Michigan doctors. Dean Gordon Scott will speak to the alumni at the noon luncheon and Dr. LaMoyne Snyder will give the banquet address in the evening.

SPEAKERS

Angus McLachlin, M.D., M.Sc., D. Phil., F.R.C.S., M.S., F.A.C.S.
Professor and Head of Department of Surgery, University of Western Ontario.
Subject: "Surgery of the Diabetic Foot."

Joseph W. Gale, A.M., M.D., F.A.C.S.
Professor of Surgery, University of Wisconsin—Surgeons General Hospital, State of Wisconsin.
Subject: "Thoracic Surgery."

Sidney S. Gillis, M.D.
Chief of Pediatrics, Childrens Hospital, Boston, Massachusetts.
Subject: "Infants of Diabetic Mothers."

William Harrington, M.D.
Instructor in Medicine, Washington University, St. Louis, Missouri.
Subject: To be announced.

Hugo Rony, M.D., F.A.C.P.
Associate Professor of Clinical Medicine, Chicago Medical School.
Subject: "Newer Trends in Clinical Endocrinology."

PANEL—Subject: "Management of Upper Gastrointestinal Hemorrhage.

Moderator: Rudolph J. Noer, M.D.—Professor of Surgery, Wayne University.
Composed of members of the Faculty of Wayne University
Charles G. Johnston, M.D.—Professor and Head of the Department of Surgery.
Alfred M. Large, M.D.—Clinical Assistant Professor of Surgery.
Elmer B. Jennings, M.D.—Associate Professor of Pathology.
Sol. G. Meyers, M.D.—Clinical Associate Professor of Medicine.
Duncan A. Cameron, M.D.—Clinical Assistant Professor of Surgery.

Michigan doctors of medicine who are not Wayne University alumni are cordially invited to the professional sessions. Members of the Class of 1902 will be presented with Golden Anniversary Certificates and inducted into membership of the Emeritus Club of the Alumni Association.

Class Reunions will be held for all classes having graduated in classes ending in two or seven.

Detailed information can be secured from the Alumni Office, Wayne University, Detroit 1, Michigan.

BON SECOURS HOSPITAL

Annual Clinic Day Program

June 3, 1952

Morning Session

Moderator: Lyle E. Heavner, M.D. Discussion fifteen minute period: J. F. Wenzel, M.D.; C. R. Defever, M.D., N. M. Taylor, M.D., C. J. France, M.D.; E. J. Hill, M.D. and R. G. Swanson, M.D.

Afternoon Session

Moderator: E. Gordon Aldrich, M.D. *Participants*: L. E. Heavner, M.D.; E. F. Lang, M.D., D. N. Sweeny, Jr., M.D., and Bruce Proctor, M.D.

Luncheon

Courtesy of the Sisters of Bon Secours Hospital.

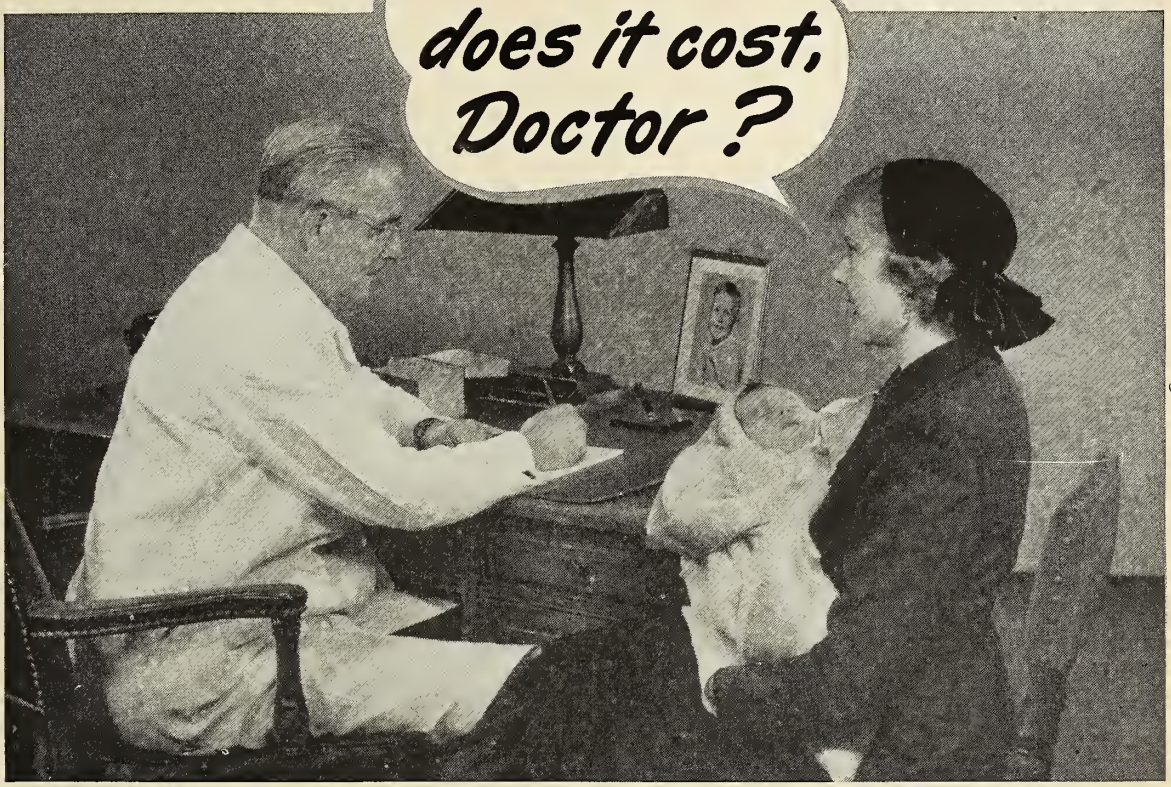
Evening Session

Moderator: Donald N. Sweeny, Jr., M.D. Participants: W. R. Flora, M.D.; W. J. Yott, M.D.; I. G. Downer, M.D.; Hugh Stalker, M.D.; J. E. Coyle, M.D.; C. S. Stevenson, M.D.; N. M. Diebel, M.D. and G. R. Granger, M.D.

Buffet Supper

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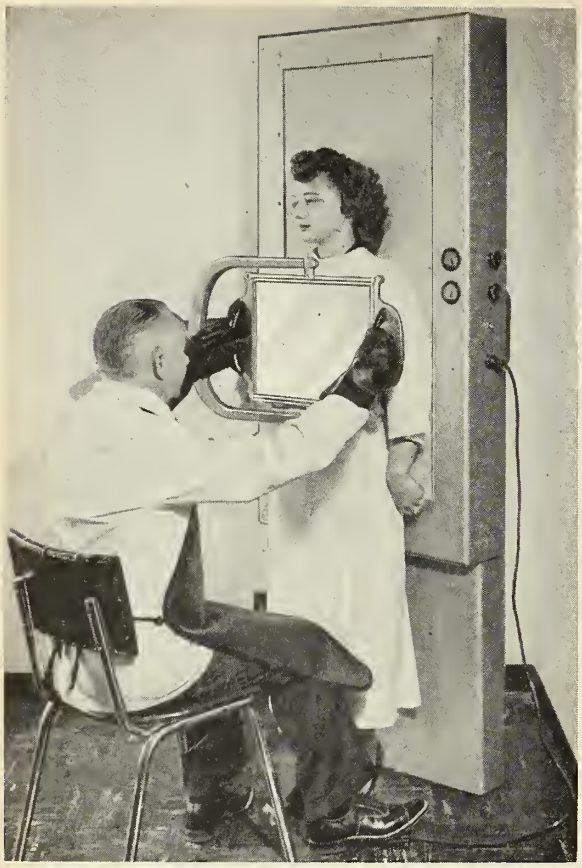
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1. Perloff, Wm. H., (1951) Treatment of the Menopause. II. Amer. J. Obst. & Gynec., 61:670, March. 2. Reich, W. J., et al. (1951), A Recent Advance in Estrogenic Therapy. I. American J. Obst. & Gynec., 62:427, August.

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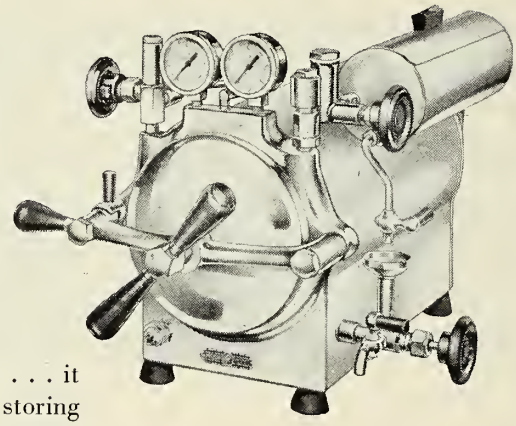
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Cancer of the Head and Neck

Surgical Excision and Reconstructive Surgery

By Herbert Conway, M.D.
New York, New York

THE TREATMENT of a tumor by surgical excision implies the removal of the lesion together with a varying amount of adjacent normal tissue. The latter may be negligible in amount in the handling of benign tumors. In malignancy, the situation commonly demands the sacrifice of important regional structures. Malignant tumors fall into the scope of surgical excision only if their location allows for the preservation or reconstruction of essential physiologic mechanisms. In recent years, a greater number of cancers of the pancreas, of the cardia of the stomach and of the esophagus have become surgically accessible because of significant advances in the techniques of reconstruction of those physiologic systems, the essential parts of which are sacrificed at the time of radical surgery.

In the management of tumors of the head and neck, surgery was decried for years because of the fact that the inevitable result was a crippling deformity of the face. It is my objective to demonstrate that advances in reconstructive surgery of the head and neck have widened the scope of surgery in the treatment of tumors in this region. Case reports will be given which argue that a waiting period of one to five years, in order to demonstrate that a given tumor actually is cured, is an unjustified assignment of the individual to incapacitation or institutionalization during that long period. In these cases reconstructive surgery has been initiated promptly after surgical excision of the tumor, often at the same operative procedure and in many cases with completion of the excision and the reconstruction in one operation. This plan presupposes the close evaluation of a given tumor in regard to its relative malignancy. This may be judged by the duration of symptoms and signs, the location of the lesion and microscopic study of the cytology of the tumor. It has not been applied in cases of highly malignant and rapidly growing neoplasms.

Review of the records of patients at The New York Hospital has shown that in recent years a higher percentage of patients with carcinoma of the head and neck are coming for treatment when their disease is early. This has been reflected in the significant increase in the percentage of five-year cures. Because of this factor, Martin has reported recently from the Memorial Center, New York City, that percentages of five-year cures have doubled following surgical excision of carcinoma of the lip, tongue, floor of the mouth and cheek. The combination of radical surgical excision and prompt reconstruction of the regional anatomy results in the early return to useful life of a high percentage of patients with cancer of the head and neck.

The earnest interest of the public in the solution of the cancer problem and in the improvement in the management of this disease is evidenced by the generous financial contributions to the American Cancer Society. Therefore, a redoubling of surgeons' efforts to cure cancer is a logical demand of the public. In cancer of the

From the Department of Surgery (Plastic) of The New York Hospital and Cornell University Medical College.
Read before the Detroit Academy of Surgery, Detroit, Michigan, January 10, 1952.

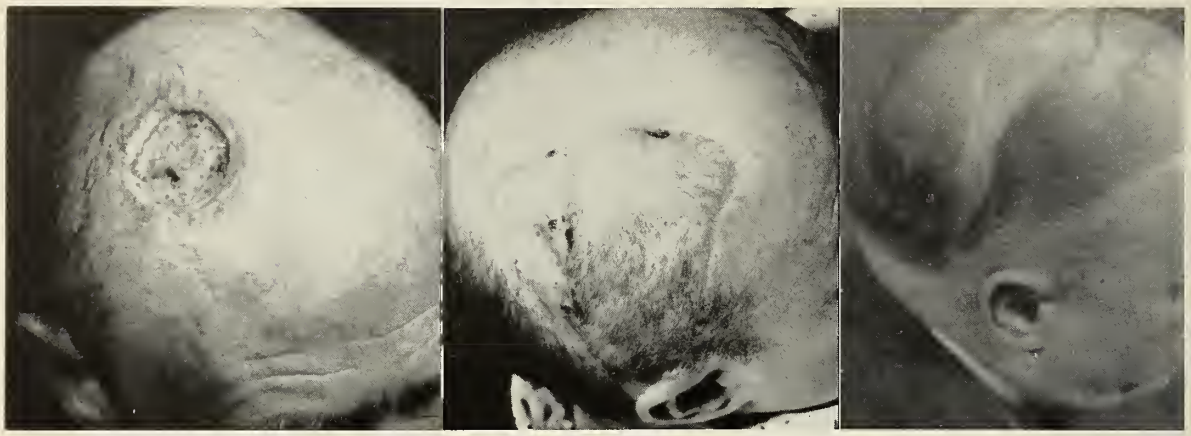


Fig. 1. M. C., New York Hospital Case No. 455977. (a) Basal cell carcinoma of the scalp (invading parietal bone) of three years' duration and recurrent following x-ray therapy and previous surgical excision. (b) Appearance after excision of the scalp and underlying skull followed immediately by rotation forward of a scalp flap and closure of its defect with free graft of skin. (c) Appearance six years later when follow-up examination showed no evidence of disease.

head and neck, it has been possible to demonstrate that intensified surgical attack has produced significantly higher percentages of cure. The combination of excision and reconstruction, no different in broad principle from the steps of the Whipple operation for cancer of the pancreas, or the various methods of reconstruction of the esophagus and colon, widens the scope of surgery for tumors of the head and neck, reduces the period of morbidity and disability, and brings more patients to the goal of clinical cure with acceptable appearance and function.

The primary principle in the treatment of cancer by surgery is the complete removal of the tumor with its regional lymphatics. Of nearly equal importance is the social and economic rehabilitation of the patient. In consideration of cancer of the oral cavity there are many reasons why these principles are not fulfilled. These reasons fall into three general categories: one relates to the changing status of the various specialties interested in the treatment of these cases; another relates to the anatomy of the area; and the third to the fear of mutilation with its physical, economic and social implications.

Regarding the first point, surgery has been extended in the treatment of cancer of the oral cavity as new techniques for exposure, better control of infection and more effective means of supportive therapy have been developed. Surgery has already made certain lesions, not curable by radiation therapy, potentially curable; e.g. carcinoma invading the mandible. Radiation therapy still plays a role in intra-oral cancer because some lesions are definitely curable by radiation therapy while some are inaccessible to surgery. Among these are the cancers of the nasopharynx, some of the tumors of the palate, of the tonsil and of the base of the tongue. There is some common ground between radiation therapy and surgery, for some tumors are potentially curable by either surgery or radiation. In this group of cases, the location of the cancer, its size, its histology, and the presence or absence of involvement of lymph nodes determine the better mode of therapy.

The second reason for failure of cure of tumors of this area is the regional anatomy of the head and neck which makes it difficult for the application of standard surgical practice for the removal of cancer by wide excision together with the lymph nodes in continuity if they are involved. Among the obstacles to clean cut cancer surgery are the position of the mandible, preventing either wide excision of the local lesion or maintenance of the continuity of the specimen or both, the presence of the lingual and hypoglossal nerves, the probability of infection from mouth organisms and the ever-present possibility of serious postoperative hemorrhage. All of these hurdles are surmountable by well planned surgical management. If the necessary details of pre and postoperative care and of surgical technique are not known to the surgeon, a potential cure may be lost. For example, we have records of cases which clearly were curable but in which the lesion was deemed incurable for fear of hemorrhage, infection or



Fig. 2. I. M., New York Hospital Case No. 237954. (a) Epidermoid carcinoma of the eyelids in a woman of sixty-four. The lesion had recurred following therapy by electro-desiccation three years and again one year earlier. In 1939 the lesion was excised together with the eye, the orbital contents and the eyelids. (b) Appearance after healing by thick-split graft of skin. (c) Facial reconstruction by latex prosthesis which incorporated an artificial eye. There was no recurrence twelve years later. (Reproduced from S.G. & O. 74:449, 1942, by permission of author and publishers.)

because the lesion was erroneously classified as inaccessible due to its location. Such cases have been passed by the surgeon to the radiation therapist for palliative treatment. Postoperative hemorrhage should not influence the decision as to mode of therapy, for hemostasis may be secured by clamp and ligature just as effectively in the head and neck as in other portions of the anatomy. There is, in our opinion, no need for preliminary ligation of the external carotid artery, a step which has the disadvantage that it requires incision into the ipsi-lateral neck at a critical area. The scarring of such procedure makes subsequent neck dissection, if and when indicated, technically more difficult and potentially less effective. We do not use cautery excision because of the tissue necrosis with subsequent impairment of healing which attends that technique.

The third deterrent to adequate surgical treatment in intra-oral cancer is the fear of making the patient a "facial cripple," that is, an individual who will require continuous care in a hospital or nursing home for the rest of his life. Grave postoperative sequelae such as salivary fistulae, large facial defects requiring external prosthetic restoration and loss of the function of mastication can be avoided by the careful pre-operative planning of the steps of excision and reconstruction.

The principles involved in radical surgery for malignant tumors of the oral cavity are as follows:

1. Adequate margin of tissue to be removed with the primary tumor.

2. Resection of regional lymph nodes if involved or if the neck must be entered to remove primary tumor.

3. Unhesitant sacrifice of important anatomic structures in the neighborhood of the tumor.

4. Placement of incisions parallel to the lines of elasticity of the skin when possible.

With a view to final reconstruction, the surgeon should:

1. Close all wounds by a two layer suture of mucous membrane and by suture of skin when possible or by the deliberate creation of a temporary oral fistula by suture of mucous membrane to skin when necessary. If primary suture does not apply, wounds may be closed by the temporary use of a free skin graft.

2. Pay attention to the fixation of remaining jaw fragments by intermaxillary dental wiring, by external splint or by intramedullary splint, so that contracture of muscles of mastication does not develop.

3. Utilize primary flaps of regional tissue for



Fig. 3. F. L., New York Hospital Case No. 30066. (a) Basal cell carcinoma of nose and lip which first appeared four years earlier and persisted despite several courses of x-ray therapy and treatment by electro-desiccation. (b) Appearance after radical excision of the lesion and immediate reconstruction by temporal flap. Three weeks later the pedicle was divided. (c) Appearance at time of discharge from the hospital seven weeks after primary operation. The patient has shown no recurrence but has been followed only one and one-half years. This patient was operated upon by the author's associate, Dr. Richard B. Stark.

closure or outline flaps for reconstruction at the time of the radical excision. This step demands the employ of fresh surgical drapes, gowns, gloves and instruments once the specimen has been excised and sent to the pathologist. This precaution protects against the inadvertent transplant of cells of malignancy to the donor site.

In the final reconstruction, the surgeon may utilize the following:

1. Free grafts of skin, derma, fascia, cartilage or bone.

2. Pedicled flaps from neighboring tissues or from a distant site.

Recent additions to these methods include the use of diced cartilage for filling out a concavity and the use of composite free grafts of skin and cartilage from the ear. Attention to color match of the permanent skin transplants is important to the rehabilitation of the patient. This can be accomplished successfully by the intradermal injection of insoluble, flesh colored pigments (tattooing).

Our aims are threefold in treating cancer of the head and neck by surgery.

First and foremost is the removal of the local lesion with a wide margin of adjacent normal tissue together with the regional neck nodes in continuity, thus following the principles of cancer surgery as applied to other areas of the body.

Second, we aim at the correction of the defect by reconstructive surgery at the same operation if there is reasonable probability of cure of the tumor and if the condition of the patient permits. One-stage excision and reconstruction when possible is an answer to those who object to surgery for oral cancer because it produces mutilation or requires long term hospitalization for reconstruction. As stated earlier, this plan of combined excision and reconstruction applies only to the management of cancers which are selected as curable by surgery. It is not good surgical judgment to undertake extensive reconstruction in cases in which there is possibility of persistence or probability of early recurrence of the tumor. In none of our cases of intra-oral carcinoma have we experienced any difficulty in obtaining adequate lining for the mucosal suture line and, therefore, see no need for preliminary operation such as skin graft or pedicle flap in order to develop such lining. When closure by flap is required for carcinoma involving the maxilla, the flap may be lined by free graft at the time of its construction and migration. In the management of intra-oral carcinoma we use an old technique described at least as early as 1930 by Bloodgood but refined and adapted by Martin and his staff



Figure 4. V. A., New York Hospital Case No. 449293. (a) Epidermoid carcinoma of the right alveolar ridge in man of sixty-nine. (b) At operation on February 21, 1951, a radical neck dissection and excision of the mandible in continuity with neck nodes and primary lesion was done. (c) The sutured wound with tracheotomy tube in place. It was possible to preserve the upper 2 cm. of mandible and the continuity was re-established immediately by the wiring in place of a cancellous bone graft taken from the iliac crest. The mucosal suture line closed easily by mobilizing floor of mouth to tongue and suturing it to buccal mucosa. (d) X-ray showing cancellous bone graft wired to the two fragments of mandible. This patient was operated upon by Dr. Joseph Murray of Boston, Massachusetts, formerly plastic surgery resident at the New York Hospital.

at Memorial Center, New York City. The technique for the neck dissection and mandibular resection with removal of the lesion in continuity have been accomplished successfully by this group for several years. By using the mobilized tongue, the floor of the mouth, or the buccal mucosa, the greater number of defects of the mucosa have been closed by primary suture. Reconstruction of mandibular continuity is advisable if it can be done without limiting the margin of wide surgical excision and without undue prolongation of the time required for operation. The methods used for such mandibular reconstruction are not original. The use of bone grafts and of intramedullary wire re-establishment of mandibular continuity have been described by others. Mandibular function is maintained in normal degree if it is possible to preserve one or two centimeters of mandible below the sigmoid notch. It is our contention that the combined use of radical resection and reconstruction at one operative treatment solves many of the distressing problems which are encountered in the surgical management of cancer of the head and neck. In addition, this plan gives wider limits to the use of surgical resection of cancers of the head and neck. By this plan more patients with cancer of the head and neck may be looked upon as operable without undue concern for the fear of creation of permanent facial cripples.

Our third aim is to get the patient home in order to assume his position in his family circle or business life as soon as possible. This implies the completion of the reconstruction at the earliest possible date following radical surgical excision. Usually these patients are elderly males and, regardless of the subsequent course of the disease, i.e. whether or not they are to become five-year survivals, everyday at home or at business is of great economic and emotional value. In those cases in which clinical judgment as to the curability of the tumor has been wrong, the use of grafts and flaps in the reconstruction has not prevented the early detection of recurrence. Therefore, we take issue with the argument which says that an operative bed from which a cancer has been excised should be covered with a thin graft in order to allow for careful observation.

In an effort to show what can be accomplished surgically in certain types of cancer of the head and neck, the following cases are reported to illustrate variations of excision and reconstruction. In all of these cases consultation was held preoperatively between radiotherapists and surgeons and there was agreement that surgery

offered the better chance for cure. The period of follow-up is not long in all cases; this paper does not attempt to show long term results. These cases are presented to show what sound surgical

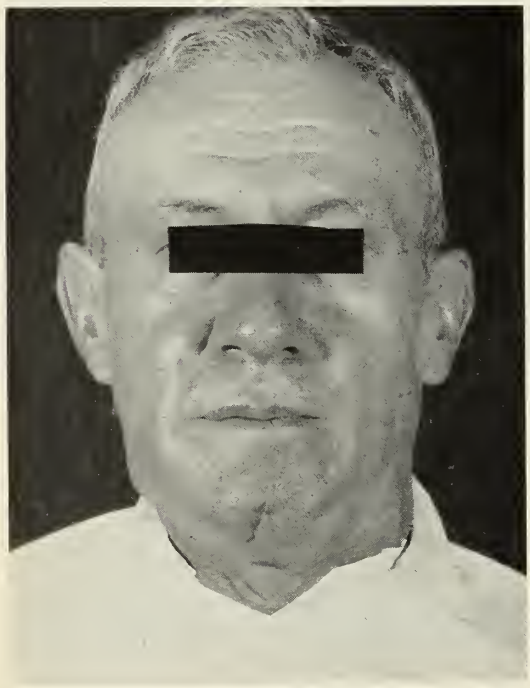


Fig. 5. Appearance of the patient (V. A.) one year after discharge from the hospital. He is free from disease and has normal jaw function.

principles have to offer patients who have cancer in the more inaccessible portions of the head and neck. These case reports are presented in summary under their illustrations. Examples are presented of carcinoma of the scalp invading the skull, of the forehead and frontal bones, of the nose with invasion of auricular cartilage, of the eyelid, orbit, cheek, lips, of the mandible with invasion of skin, bone and mucous membrane, of the buccal mucosa, and of the alveolar ridge with invasion of the mandible. The details of surgical excision and reconstruction are explained best by study of the illustrations.

Summary

The premise that advances in techniques of plastic and reconstructive surgery have widened the application of surgical excision in the management of cancer of the head and neck is supported by the presentation of case reports in which massive defects of the scalp, face and intra-oral cavity have been corrected successfully by reconstructive surgery. The opinion is advanced that the older policy of delaying reconstruction one to five years after excision of cancer is not justified unless there is concern because of the high degree of malignancy or rapid growth of the tumor, as to whether or not it has been cured. In many of the case reports which are presented reconstructive surgery was initiated promptly after surgical excision of the tumor, often at the same operative procedure, with completion of excision and reconstruction in one operation. An example is the resection in continuity of cancer of the alveolus together with the mandible and cervical nodes and the re-establishment of mandibular form and function by the insertion of a cancellous bone graft at the primary operation. This procedure presupposes accurate evaluation of the relative malignancy of the tumor by consideration of the duration of symptoms and signs, the location of the lesion and microscopic grading of the tumor. The combination of excision and reconstruction in one operation reduces the period of morbidity and disability and brings more patients to the goal of clinical cure with acceptable appearance and function. Intensified surgical attack on cancer of the head and neck is reflected in a significant increase in the percentage of clinical cures. Deterrents to the surgical management of cancer of the head and neck relate to the changing status of the various specialties interested in the treatment of these cases, the problems associated with the removal of important anatomical structures, e.g. eye, nose and jaw bones, and the fear of converting the patient into a "facial cripple." The developments in plastic and reconstructive surgery which answer these three objections are presented. The aims in treatment of head and neck cancer are, in order of their importance, the cure of the tumor, the correction of the defect resultant from radical surgical excision and the return of the patient to useful economic and social life at the earliest possible date. Combined excision and reconstruction, feasible and practical in a high percentage of cancers of the head and neck, brings these patients to the goal of clinical tumor cure and rehabilitation.

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Cancer Education in Schools

By Frank L. Rector, M.D.

Lansing, Michigan

THE CONCEPTION of cancer education of high school students is of recent development. It began about seventeen years ago, the first efforts along that line being made in the high schools of Westchester County, New York. The subject was introduced into the high schools of the Midwest at about the same time, where it found ready acceptance by most schools.

At first blush, it might seem that the subject has no place in the high school curriculum, and it has been so considered by some "educators" both within and without the high school field. In spite of all objections, there are seven unanswerable arguments for including the subject in high school health education programs:

1. The high school student of today is the potential cancer patient of the next generation.
2. High school students are in the midst of acquiring knowledge that will help them to lead healthier and more useful lives. Therefore, a knowledge of cancer and how it may be controlled should be a part of every high school health program.
3. Some adolescents develop cancer and others will inevitably develop it in their later years. If they have no better knowledge of the disease and its control than many of their parents, they will delay in having diagnosis and treatment until too late.
4. High school students accept teaching about cancer as general helpful information without the emotional stimulation that surrounds the thinking of most adults on this question.
5. When informed about cancer and why and how it should be treated, these students often influence parents to seek medical attention for neglected conditions that are suspicious and which often prove to be cancer.
6. It is believed that cancer may start years before it is recognized and be caused in a measure by the habits and mode of life of the patient. By proper educational effort, high school students can avoid development of habits that may be conducive to cancer.
7. No one can look to the community for protection against cancer. Each must provide his own. The community can help by the support of cancer educational activities in the same manner as it assists the child to become an informed and useful citizen by providing general educational opportunities for him during the formative years of his life. That is why education is the key to cancer control. The individual must recognize the fact that he must initiate measures for his own protection. The extent to which he will apply these protective measures will depend on how effective has been his early education in the problem.

In spite of the adult education program of the last fifteen years, the constantly increasing cancer death rate indicates that something more is needed to bring about a downward trend. Some say that adult cancer education has failed to accomplish its purpose for the masses although many individuals have profited from it.

It is realized that the thinking habits of those of middle age and over are pretty definite and difficult to change. It is far easier to implant cancer knowledge in younger minds who have no preconceived erroneous ideas on the subject. Since past educational efforts directed toward the age groups most directly affected have apparently been of less value in arousing them to action than the slight efforts directed toward younger groups, a change in emphasis on cancer education seems desirable. To effect a change eventually in the public attitude toward cancer, what would be more logical than to direct major educational efforts to that segment of the population, the school group, which will comprise the adults of the next generation? The acquisition of such knowledge will enable the student to shape his life not so much on habit as on understanding. Out of the writer's experience in lay cancer education he has no hesitancy in saying that if facilities and funds for this purpose were limited, they should be used exclusively in the high school field.

High school students accept cancer information enthusiastically provided it is placed before them in simple fashion devoid of technical language and in a manner that convinces them the speaker is qualified in his subject. They are in-

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telligent and able critics and above all resent—and rightly so—being addressed in a condescending manner. The successful speaker soon learns not to "talk down" to high school audiences.

In discussion, the average high school student phrases his questions well and directs them toward cancer as an objective problem in health education; while adults by their questions more often seek answers to personal or family experiences.

In many schools, biology is an elective study while many subjects of a cultural or historical character, but of doubtful practical use in the future life of the student, are on the required list. It seems rather odd that the one subject that will best prepare the student for living because of the knowledge it gives him about himself and others should have such casual consideration in the high school curriculum. Greater emphasis is given to this criticism when it is realized that formal education for many people ends with graduation from high school.

High school cancer education should be objective in character and built around the biological problem of growth. The nature of cancer as an abnormal growth of the patient's tissues can be emphasized by contrasting it with normal growth and its controlling biological influences. The disease aspects of the subject should be limited to a discussion of early signs. Factors involved with advanced cancer should be ignored. Approved treatment methods may well be discussed and the dangers of quackery emphatically pointed out. Some notice of preventive measures should be taken, especially the dangers of chronic irritation and the need for avoidance of habits entailing some irritation factor such as prolonged sunbathing with its well-recognized danger of producing skin cancer.

High school students should understand that with the present limitations on knowledge of cancer, the periodic medical examination of the apparently well individual by the family physician is the best protection against development of cancer from precancerous conditions discovered by the examination or the extension of an early cancer to an advanced and incurable stage. Such examinations often bring to the patient's attention diseases other than cancer which are, or in time will be, undermining his general health.

The above sketchy outline of the content of a cancer education program in high schools will indicate the extent of such an undertaking. Beyond this the matter may be pursued only as the qualifications of the teacher and the interest of the students indicate.

Cancer education should not be taught as a specialized or overemphasized subject but should be a part of the general health program of the school. Its effectiveness will depend in large measure on the qualifications and interest of the teacher concerned. Until very recently little or no attention has been given to cancer in teacher training institutions and schools of public health with the result that many teachers today have no more factual knowledge of the subject than other adults. Indeed, many of them harbor the misconceptions and fallacies of other adults and because of these inhibitions are unable to render any constructive teaching service in this field. One of the greatest needs in school cancer education today is for teachers who know enough about the subject to instruct their students intelligently. The remedy for this situation lies in proper emphasis being given the subject by teacher training schools and schools for training professional public health workers.

Some basic training in the nature, causes, methods of diagnosis and treatment and prevention of cancer has been offered to teachers in the public schools of a few local areas. A seminar of ten hours can give a rather complete review of what is known today about the subject, and can provide time for discussion of ways and means of applying this knowledge to class room instruction. Extension of such helpful programs will depend upon capable seminar leaders and teachers interested enough to take advantage of the opportunity for instruction. Michigan has been the pioneer in this seminar method of teaching, several such meetings, county-wide in character, having been conducted in recent years.

A successful high school cancer educational program is possible in any county by co-operation of the county school commissioner, public and parochial high school authorities, the county medical society, health department and cancer society. Time does not permit detailed discussion of the part each organization plays in such a co-operative venture but experience has shown that an excellent school educational program under such cooperation is possible.

The first step in such a program would be a meeting of representatives of the interested groups at which the reasons for and value of the pro-

gram, as well as methods for carrying it into effect, would be thoroughly discussed and understood. Each participating organization would become acquainted with the program and the part it would play in its operation.

As its next step, the program might well include an assembly talk in each high school, given by a physician familiar with cancer and with speaking to high school groups, to introduce the subject to students and teachers. This talk should be *only* the means to an end; *never* the end in itself. A source book containing cancer information and some suggested class projects should be available for classroom use. Other teaching aids, as films, charts, posters, etc., are desirable. These could well be supplied by the local cancer society as its contribution to the project. From the same source might be provided books and pamphlets to be kept as a reference unit in the school library.

To stimulate interest in cancer education in schools, the Cancer Control Committee, Michigan State Medical Society, has prepared a manual for use in high school teaching. This manual, in preliminary form, has been used during the past school year in the counties of Emmet, Genesee and Muskegon in Michigan and in one California city to test its suitability for the purpose intended. Criticisms and suggestions for improvement made by these teachers are being incorporated in the revised edition to be offered to high schools of Michigan wishing to incorporate the subject in their health education programs.

Students often gain added knowledge and interest through visits to hospitals to be shown methods of diagnosis by the microscope and x-ray. Seeing normal and cancerous tissues under the microscope and having their characteristics pointed out by the pathologist, with similar demonstrations of the x-ray by the radiologist, produce lasting impressions and help students to better understand these aspects of the cancer control problem. Finally, the cancer seminar, which should include the hospital demonstration just described, would give the health teachers some training in the fundamental knowledge of cancer that should enable them to present this subject to their pupils in a helpful manner. The seminar might well precede the classroom instruction. A desirable side effect of these seminars has been the fact that in a few instances participating teachers have had examinations that have uncovered early cancer. At least three such instances are known to your essayist.

As additional activities for extending the student's knowledge of these problems, interested students could be encouraged to develop posters, illustrated slogans, scrap books, essays and similar projects. These might be on a competitive basis with community organizations, as Parent-Teacher Associations, civic, fraternal, or religious clubs, offering prizes or other community recognition for excellence of effort and product.

Cancer education in high schools should never be undertaken as a part of or in connection with money raising activities. To do so places the program in the special propaganda class with a distinct lessening of its educational value. It would be as reasonable to distribute the entire school health educational program among the host of community fund-raising efforts. If the subject does not warrant inclusion in the regular health education program, it should be omitted. Any connection of students with fund-raising activities should be on the same basis as other individuals of the community interested in the subject of cancer control.

An abbreviated plan of cancer education for junior high school pupils has been successfully carried out in some schools where the students have had introductory courses in biology. Any pupil, regardless of grade, can understand the basic facts about cancer as soon as he has studied biology and knows what a cell is and the part it plays in the organization and functioning of living tissue.

In a few elementary schools, interested and qualified teachers have introduced cancer education into the health teaching of fifth and higher grades with excellent results. Some fifth and sixth grade teachers in the Genesee County, Michigan, public schools have introduced cancer education into their health courses with most astonishing and successful results. In at least one state, Idaho, such teaching is begun in the third grade.

In all this school cancer education, care must be taken to stress the optimistic, hopeful phases, rather than to discuss the more tragic and pessimistic side. Pupils will see enough of the unfavorable side as they grow older, but will not be influenced by it as they would be had the brighter side not been presented to them earlier in life. As an example of the wrong approach, may the instance of a high school principal be cited who, in introducing the speaker to his student assembly said: "One in seven of you students here this morning will die of cancer." A true statement

from the standpoint of general statistics but most unfortunate in its psychological impact on those young minds.

Due to the vision and the initiative of the local cancer unit and school authorities, Genesee County, Michigan, has been the principal testing ground for the high school cancer education program as outlined in this paper. For the past ten or more years the high schools of Flint have been offering cancer education programs and almost every student during that time has had the opportunity to learn something about the cancer problem. During this time many of the high schools throughout the county also have had speakers at assemblies on one or more occasions. Recently all public and parochial high and junior high schools in the county were reached with an assembly program and a cancer seminar was held for teachers, nurses and others interested.

During the past school year, a teaching program has been under way in high, junior high and some grade schools throughout the county. The outcome is being watched with interest as it will set the stage and pattern for similar projects elsewhere. The County Superintendent of Schools, public and parochial school authorities, county medical society members, county health department personnel and officers of the local cancer unit are all contributing to the program and deserve generous praise for their fine co-operation in making this pilot educational program possible.

The educational plan outlined in this paper is not the only one possible and probably not the best. However, it has been tried in the crucible of experience, has been approved by use in the classroom and has done some good. For these reasons it is offered to this assembly.

Up to this point, this discussion has kept away from statistics, partly because we wanted to avoid the undesirable connotations that the word describing those who work with statistics sometimes suggests, and partly to emphasize anew the educational opportunities abounding in the high school field. In 1948, there were in round numbers 5,675,000 pupils enrolled in the public high schools and 629,000 in the nonpublic high schools; a total of 6,305,000 pupils in the 28,800 high schools in the United States.

In 1950, there were 650 public high schools in Michigan with an enrollment of 225,000. There are about 170 nonpublic high schools with an enrollment of 38,300; a total enrollment of approximately 270,000 young people who are already organized into teaching units. Where, in Michigan or elsewhere, can be found more than 800 more promising audiences for a constructive health education program?

In this country there are more than one million high school graduates each year. With proper emphasis on high school cancer education, a large majority of these graduates can take with them enough information about cancer control to enable them in large measure to protect themselves against cancer if and when they meet it, as many of them will, later in life.

It has been said that "ours is a civilization in which we strive for the protection and survival of the unfit." It is comforting to know that in cancer education in schools we strive to prevent the development of some unfit members of society.

The key to the ultimate reduction of the cancer death rate is intensified and continuous education of the school population; you and I have a duty to help bring this about. Possibly a story will impress this duty more firmly on your minds.

An amateur golfer placed his ball on an anthill and took a healthy swing. Half of the anthill and many of its inhabitants disappeared while the ball rolled a few feet away in the grass. Replacing the ball on what was left of the anthill, he swung again with the same result as before. After the second swing, two surviving ants found themselves in the vicinity of the ball and, after shaking the dust out of his eyes, one ant was heard to say to the other: "Buddy, if we don't want to get hell knocked out of us, we'd better get on the ball."

No matter how effective we have been or tried to be in cancer education, it behooves each of us interested in this problem to think seriously on the philosophy of the ant. Let us all "get on the ball" of cancer education, especially education of the future citizens of this state and nation, and do a really worthwhile job of reducing deaths from cancer.

MSMS

The application of routine block dissection of pelvic nodes for Stage I and Stage II lesions, clinically controlled by irradiation, is of doubtful theoretic, and no evident practical value.

* * *

Primary carcinoma of the thyroid gland should be considered in the presence of tumors of the side of the neck even in the absence of palpable nodes in the gland itself.

Rural Organizations and the Cancer Problem

By Marjorie Karker

Lansing, Michigan

LIKE MANY other people interested in the volunteer field of cancer control, I had my introduction to this dread disease in a tragic and personal way, having lost a younger brother from cancer of the lungs. I helped take care of him the last two weeks of his life and saw the terriffic suffering he endured. I saw the fright in his eyes when he thought the oxygen tanks might be running low, and all the while I saw this happen I said to myself: "How awful! Why can't something be done about it?"

After it was all over, I talked with his wife about how long he had known there was something wrong and she told me a sad story. She said that he had known for some time that there was something wrong but that he thought it was a routine thing which could be taken care of later. Their family doctor had gone to war and there was no doctor left in this rural community so that made putting the matter off easier. I knew a little about cancer, about early diagnosis being necessary and after our talk I came to the conclusion that here at least was one death that probably could have been prevented had the victim been more alert to the possibilities of his seemingly routine symptoms.

I have told you this story for two reasons. First, I wanted you to know that I had a big stake in this problem because I had seen first-hand the results of ignorance on the part of one I loved regarding cancer.

Shortly before this time I was starting work in the organizational field with rural women and the rest of my talk will be confined to what I have actually seen done in the rural areas by rural people through their rural organizations. In order to make the story mean much to you, I feel I must deviate a little and tell you something about the organizational structure of the Michigan Farm Bureau, the farm organization for which I work.

The Farm Bureau is a voluntary membership organization of the farm family. In Michigan we have nearly 48,000 farm families as members. They pay dues to carry on the work of the organization. It is set up on a county basis and the county units are affiliated into a state organization. In the 61 County Farm Bureaus we have 1077 community groups which are purely voluntary, and which meet monthly.

The job of selling the idea of an education program on cancer to a group of people who know nothing about it except as they have seen people die is not an easy one. I found the best approach to be that of mentioning rather casually the seven danger signals, leaving a question in their minds as to what they might be. Timidly, some woman might ask what they were. If you can get that far, I believe you are in. Before you have completed talking about them some person has an idea that maybe that lump in her breast should be checked, or that she had been having some indigestion lately. When these signals have been discussed by the planning committee someone probably will mention that all people ought to have this information. At that time it can be suggested that there is an organization within the county that is willing to talk to groups about this matter, that has pictures that can be shown and that is set up to serve those people who are ill, with loan closets, bandages, et cetera. No group I have worked with has ever turned down the idea of bringing someone from the county cancer society to talk with them. After the county women's committee has heard the talk, many local groups ask for a similar talk in their community Farm Bureaus. I have personally had the experience of calling on women in the hospitals shortly after they have heard the county commander of the cancer society talk to them about the seven signals and the necessity of early diagnosis. They are all most grateful that they had the opportunity to get this information. I think it only fair to say, however, that I have also seen women, not many but some, get up and leave the meeting when the talk is begun. Also some of the women, particularly the older ones, have been rather perturbed with the picture "Breast Self-Examination."

We have found out in following this procedure, however, that many times it is impossible to find

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out who the County Commander is, particularly in those counties where there is no County Health Unit. I have had fine co-operation with the State Cancer Society and have been able to furnish those names in cases of this kind. Another snag we have run into is that in some cases the county commanders, not knowing what the Farm Bureau is and how it is set up and the number of people in rural areas who can be reached through it, have not been too anxious to come to the meetings. I would not like to blame the commander entirely in a situation of this kind; undoubtedly the person who approached her did not explain her problem too well and it probably is a case of misunderstanding from beginning to end. Of course, situations of this kind are unfortunate.

After the county women's committee has heard the talk, they report back to their community groups (on a family basis) and many local groups have asked for a similar talk in their own Community Farm Bureaus. Not only do they report to their own Farm Bureau, they take the information to other groups to which they belong. Because I have seen it happen, I believe thoroughly in the joke that is often made about the three means of communication: telephone, telegraph and tell-a-woman, and it is with a thought to compliment them that I say this. In two counties, I know the Farm Bureau organization has sponsored a series of special meetings on the educational phase of the cancer work.

After the county women's committee has heard the talk, many things may happen which indicate that the average layman is anxious for information and, once he has it, will be willing to help. Following are some of the projects which have been carried out by the cancer society and the farm organization working together.

Because women like to do something with their hands and in many cases understand this language best of all, the bandage making program of the cancer society appeals to many groups. In Macomb and Bay counties the Farm Bureau women have made hundreds of bandages for the cancer society. If they do not have time to do it in their regular meetings they call special meetings to make bandages. There is a tremendous amount of energy in rural women if you can get them interested and at work. Another way that rural organizations can be used, and which has been demonstrated, is in the financial and educational projects which are needed if there is to be a detection center or if there is one already established. I'll tell you about one I know about.

After the Saginaw County Farm Bureau Women's Committee had heard the county cancer commander talk they asked if there was something they could do. They were told that there were hopes of having a detection center in Saginaw but at that time there were not funds enough. The rural women asked if they could help in this matter and, of course, they were told that their help was welcome and needed. Each member of the women's committee went back to her own group with the suggestion that they carry on some money-raising project for the cancer detection center. The first group held a dance and raised $405. The second group held a fair and earned $410. A gentleman from Saginaw County was telling me about the fair and how much money they had raised and I remarked: "Wasn't it coincidental that the first group raised $405 and the second group $410?" He grinned and fidgeted and said, "Well, we weren't going to let those other women get ahead of our wives so some of us reached into our own pockets." If I remember correctly, the amount raised by the Saginaw County Farm Bureau group for the detection center was in the neighborhood of $2,500.

That isn't all of the story, however, and while we are always interested in money, I don't think some of the other results should be minimized. This one project brought the rural and city people closer together than they had been for a long time, particularly that segment of the city people who were active in the work of the cancer society. The rural people of Saginaw County were proud of that detection center, they showed it off with pride, they urged people to use it, it was partly theirs. The last I knew about this, people from miles around were using it.

Several other county Farm Bureaus have worked hard with their medical societies and their cancer societies in getting the Hillsdale Plan of Cancer Detection started in their counties.

After the rural people know something of the organization of the cancer society and the work they do, they think of many ways they can assist. I'm thinking now of the number of rural groups, both Grange and Farm Bureau, who have built loan closets. In fact, the Bay County Farm Bureau Women have done so much along this line that sometimes I think they secretly wish

they had more cases so they could do some more; of course, I'm only kidding. I believe they have given five hospital beds in addition to the other regular articles usually found in the loan closet. In Clinton County, the loan closet is stored in the County Farm Bureau office, or was.

Of course, the work of the cancer society in the local communities cannot go on without money and the rural organizations can be of immeasurable aid in the field of fund raising. I believe I should state here, however, that most county Farm Bureau organizations do not sponsor fund raising of this type as a usual thing but in getting to know personally and in working closely with individuals on other phases of the cancer problem they know whom they can ask to do the soliciting in the rural areas. Clinton County won a national citation on their participation in the fund raising in their county. Also most of the county and community Farm Bureaus contribute to the cancer society.

Probably another point should be made. People are suspicious of those things they do not understand. Many people do not contribute to charities and public service organizations because they do not know how and where the money is spent. Could I make the suggestion that this information be offered by the cancer people in their regular talks, not just when they are asking for money? I believe it would help. I feel people would be more liable to help if they knew that half the money is being spent for their own folks in their own county.

Another suggestion I would like to make is that the rural people be asked to sit on the county boards of the cancer societies, in those places particularly where they have been actively working with the society. It is only fair, I think, to give those people who help do the work an opportunity to help in planning the work and making the policies. If this suggestion has any merit, another should follow. In those counties where the farm organizations are not too active, it might be helpful in getting them more active if one of their leaders were asked to be on the County Board of Directors, to whose meetings they could bring the thinking of the rural people.

Farm Bureau is not active in all counties of our state. There are other farm organizations, however, believe it or not. I refer specifically to the Grange. The Grange has a health committee in each of its subordinate Granges, as well as a state and Pomona Grange health committee. I feel sure that these health committees would welcome the co-operation of the cancer society in bringing their educational program to the Grange members and I know they would give all kinds of help. Perhaps this is already being done but if it isn't I would like to suggest that here is a source for getting vitally needed cancer education to the rural people. If the farm organizations do not make the first approach, why doesn't the cancer society seek them out? So far, I believe, at least as far as Farm Bureau is concerned, it has been a one-way proposition as far as the original contacts are concerned.

In summing up, I would like to say that on the whole the ignorance regarding the cancer problem, the seven danger signals and what to do about them, is great in the rural areas. Undoubtedly this is true because the cancer people have not known how to contact rural people. The most logical way to contact them is through their rural organizations. In the cases of the Grange and Farm Bureau they are set up organization-wise so that many people could be given information on the cancer problem with relatively few contacts. The foremost problem at this time appears to be that the cancer societies and the farm organizations do not know each other well enough to work together. One will have to make the first approach. Once they start working together there is nothing much they can't do. The work of the farm organizations in this field of cancer educational work alone has hardly been started, the surface has not been scratched.

I hope you will pardon the number of times I have told you of personal experiences, and of the work done by the Farm Bureau. That's where I live, that's what I know about. What I have said would have no weight if I were telling you about things which could happen; I have seen these things happen, and just as I saw my brother die needlessly because he did not know what was happening to him, I know that by working together, much can be done so that others will not have to die from ignorance of the cancer problem.

MSMS

The appearance of a lower abdominal or pelvic mass, especially after the menopause, the presence of ascites with omental or cul-de-sac nodules should make one suspicious of ovarian carcinoma.

* * *

Vulval carcinoma responds poorly to irradiation.

Cancer of the Scrotum

By Hazen L. Miller, M.D.
Royal Oak, Michigan

SIR PERCIVAL POTTS, in 1775, associated cancer of the scrotum with the occupation of the victim. There this disease, except for advances in surgical skill, remains today.

Almost without exception this cancer is found in those who are exposed to tar, pitch, lubricating oils, crude wool, et cetera. Workers in oil refineries are the most susceptible group. Other occasional cases, as in the series reported by Dean,[2] gave a history of prolonged administration of Fowler's solution or exposure to x-ray. Otherwise, it is not seen in the white collar class.

Due to the restriction to one class of industrial workers, the total number of cases appears to be relatively small. Those reported in the literature point up the need for doing something about this group which in spite of its low numbers is important inasmuch as so much is yet to be done for it.

Death records, "those ashes of vital statistics" when sifted, show that in the period of 1911 to 1935 there were 1,487 fatal cases in England and Wales. A subsequent study by E. L. Kennaway and N. M. Kennaway[4] showed a total of 1,752 deaths from scrotal carcinoma from 1911 to 1940 in the same countries. Deaths in the United States are relatively rare; thirty-five being reported in 1948.

These English authors concluded that cancer of the scrotum is almost wholly dependent on environmental factors, indicating that it is *preventable.*

Not only is it preventable, but if recognized early it is curable. Usually, the lesion is a squamous cell carcinoma, grade 2, which may be diagnosed early and effectively excised removing a margin of one centimeter or more of skin. Orchiectomy is clearly indicated if there is deep infiltration.

Unfortunately, as pointed out by Coleman, Joyce and Graves[1] recently in their paper read before the North Central Section of the American Urological Association, early diagnosis is seldom made. The warty growth appearing characteristically on the most dependent portion of the scrotum is "treated" by the patient himself who though exposed daily to carcinogenic agents is almost never exposed to cancer education. Periodic examinations at three-month to six-month intervals discover these lesions. Instead, the victim applies local remedies of his own choosing and in some cases meets with further delay after finally going to a physician. On the average, this first medical visit is one year or more after the lesion appears.

Prompt biopsy should be the rule on all suspicious cases. While wide excision may be adequate, all cases with palpable inguinal nodes should have bilateral radical dissection of these glands. When in doubt as to metastases, a close watch is necessary. Coleman, Joyce and Graves cite Warren's enumeration of the factors encouraging lymphatic dissemination. They are: (1) a rich lymphatic supply in the scrotum, (2) the scrotum by location being subject to trauma and movement, (3) absence of substratum which prevents the usual tissue reaction and walling off of the lesion.

The prognosis in late lesions is poor. The average duration of life is twenty-one months from the onset of symptoms.

It would seem that this small group of cases presents an ideal proving ground for joint efforts on the part of leaders in the oil industry, public health officials, cancer educators, and the medical profession. By such means a death from cancer of the scrotum could be made a genuine rarity.

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MSMS

The treatment of cancer of the prostate gland by attacking the endocrine balance of the patient rests on firmer physiological grounds, is better understood and yields more predictable results than the hormonal treatment of mammary carcinoma.

* * *

As investigation continues, it becomes increasingly evident that endocrine therapy singularly affects only certain types of tumors.

Heredity in Cancer and Its Role in Cancer Prevention

By Madge T. Macklin, M.D.

Columbus, Ohio

THREE very essential parts of the cancer control program concern matters upon which the public and medical profession alike do not agree. They are, (1) the role of heredity in causing cancer; (2) should cancer be made a reportable disease? It is not so in many states. At its last session, the Ohio legislature refused to make it so in that state. (3) Should the physician tell the cancer patient that he has cancer? That is the most controversial of the three subjects, and I hope that sometime you will ask me to talk to you on that very important topic.

I have been asked to talk on inheritance of cancer and how such knowledge can be used in preventing or diagnosing cancer. I think it will be well at the outset to have a clear understanding of what we mean by heredity in cancer so that we may have a common basis of communication. I shall enumerate a few of the misconceptions and factors which stand in the way of believing that heredity plays a role in causing at least some cancers if not all.

First, in order for a trait to be hereditary, it is not necessary that every child in the family should exhibit it even if one does. We know that one parent may have brown eyes, the other blue and the children's eyes may be either brown or blue. Similarly, with cancer; if one parent has it, not all of the children need have it before we accept it as hereditary.

Second, a trait may be hereditary, one parent may show it, but none of the children may exhibit it. Thus, our brown and blue eyed parents may not have a child with blue eyes, they all may have brown eyes. So with cancer; one parent may have cancer; it may be inherited, yet none of the children show it.

Third, a hereditary trait may show up in one or more children in the family, yet neither parent may have it. Using our eye color as the example again, two brown eyed parents may carry latent genes for blue eyes, and so have blue eyed offspring although neither parent had blue eyes. Thus, while several children may have cancer, and neither parent have it, yet it is still an inherited cancer.

Fourth, in the case of cancer (and here our analogy with eye color breaks down) it may occur in an organ found only in one sex, so that the line of descent may be broken. For example, cancer of the breast is seldom found in men, cancer of the uterus never. If a mother with breast or uterine cancer has only sons, it is impossible for her children to show her disease, even though these cancers may have a strong hereditary basis. These sons, in turn, may transmit the hereditary determiners to their daughters who may then show the cancers, or to their sons, who, in turn, must pass it on to their daughters before it can become evident. Hence, it is possible for such cancers to be hereditary, to pass through several generations of males who cannot show them, and come to light in later generations when the original female ancestor who had them has long been forgotten.

Fifth, cancer occurs for the most part late in life. Hence a mother who would have developed breast cancer at fifty-five, died of typhoid or of puerperal fever at thirty-three. She had passed on to her daughter the factors for breast cancer, and the latter, living in a generation when puerperal fever and typhoid have been largely eliminated as a cause of death, lives to be fifty-five and so develops her inherited breast cancer. Or a man who would have died of gastric cancer at sixty-two is killed in an accident at forty-seven. No one knows that he had the genes for gastric cancer, or that he had passed them on to his son who lives to the age at which the cancer develops in him. In both cases, it would appear that the cancer was not inherited but it was in both instances.

Sixth, many persons will deny that cancer is inherited but admit that they believe that a "tendency" to cancer is inherited. They are usually not at all clear as to what they mean by a "tendency." If pressed for an explanation, they will usually say that cancer takes so long to develop, that it cannot be inherited, only the tendency to develop it. I will agree with them if they will, in turn, agree with me, that nothing as such is inherited, not eye color, or hair color or resemblance to parents, or special abilities, or in-

From the Department of Medicine, Ohio State University Medical School, Columbus, Ohio. Presented at Third Michigan Cancer Conference, East Lansing, October 12, 1951.

telligence, or any of the host of other traits which we usually call inherited. All that we inherit from our parents is a tiny blob of protoplasm which has neither eyes or nose or mind or musical talents or cancer. All that it possesses is a marvelous ability to develop all these characteristics given the right environment. We inherit no traits or characters but merely a bundle of potentialities. In that sense, I will agree that cancer is not inherited, only a potentiality to develop cancer, provided that we live long enough.

Seventh, one often hears a pseudo-scientist state that although cancer in mice is undoubtedly inherited, this is because mice are inbred; but cancer in man is not inherited because he is a mongrel. This is a stupid fallacy which shows that the speaker does not know what is meant by an inbred strain or by heredity. Inbreeding does not create cancer, it does not create heredity; it merely enables the observer to separate out more adequately what effects are due to heredity, what to environment.

Let us, for example, divide 100 mice into two groups. They come from an inbred strain in which every mouse is genetically indentical with every other mouse. We now subject one-half of them to smoke, and determine whether the incidence of lung cancer is higher in them than in the control group of mice which had not been subjected to smoke. If there is a difference we say that the difference must be caused by the treatment since, hereditarily considered, the mice are identical.

If we try a similar experiment in man and divide 100 men into two groups and have one group smoke and the other not, and if there is a difference in the incidence of lung cancer after the experiment, we cannot say that this difference was definitely caused by the treatment. We do not know how many of the men who smoked and developed lung cancer would have done so anyway without the smoking, and we do not know how many of the men who did not smoke and did not develop lung cancer would not have developed it even if they had smoked. We are not much further ahead in finding what part the smoking played, and how much of a role the differing hereditary makeup of the men played in determining who did and who did not develop lung cancer. Just because your heredity differs from mine, does not preclude your having inherited your facial and bodily characteristics from your parents, or me from having inherited mine from my parents. Man's mongrel inheritance makes it more difficult to assess the relative roles of heredity and environment; inbreeding makes it easy; its chief role is in allowing you to have your cake and eat it too.

Finally, an inherited trait may be profoundly influenced by external factors. For years, a popular subject for high school debates was the old topic: Is heredity or environment the more important? Both are indispensible; one cannot exist without the other. In some instances one plays a more pronounced role than the other but both are present. So the fact that some cancers may be produced experimentally does not prove that other cancers are not hereditary.

With this preliminary explanation of some of the interpretations to be placed upon the term hereditary, we may ask: "How can a knowledge that at least some types of cancer are inherited serve either to prevent cancer or to assist in early treatment?" Let me tell you of some of the cases I have come across in my work, and you will see how a knowledge that certain forms of cancer are prevalent in your family may assist you either in preventing it in yourself, or in having it diagnosed at the earliest opportunity once it has developed.

A nurse told me that her mother and three of her mother's sisters had died of ovarian carcinoma. She was thirty-eight and afraid that she, too, would succumb. She was not married, she had no intention or perhaps no prospect of being married, and even if she had, would hardly have started a family at that late age. I proposed that she have both ovaries removed and take hormones. She might develop some other type of cancer, but unless it had already started, she would be guaranteed not to die of ovarian cancer.

Another woman asked her surgeon to do a complete hysterectomy on her, as eight of her immediate female relatives had developed cervical cancer. Can you blame her? But it is not in the field of such radical prevention that most of the benefit will be obtained. One can hardly say that because one's father died of lung cancer, one is ready to undergo removal of both lungs; or that because your mother died of primary cancer of the liver, you want to dispense with your liver. It depends on the organ in which the cancer arises as to how much prevention can be accomplished, either because that cancer is inherited, or merely because we have diagnosed it early. When the

organ is one that is indispensible, it is better to risk the chance of dying of cancer in the future than accept the certainty of dying without that organ in the immediate present. Rather it is in the field of early diagnosis (which we may have to admit may still be too late) that a knowledge of heredity in certain forms of cancer may play its greatest beneficial role.

An attractive woman of forty-eight agreed to give me her family history to assist in my research program. She knew that she had breast cancer, that she had gone for treatment too late, and she wanted to do something to help others. This shows that she was intelligent, and would have acted more quickly than she did had she not been handicapped by lack of two pieces of knowledge; (1) that breast cancer tends to be found more often in the female relatives of women who themselves have breast cancer than it is in the general population; and (2) that three of her close relatives had died of breast cancer. She discovered a lump in her breast just before the rent restrictions were lifted in July, 1947. Her family had to move, and she said, "There are no cases of breast cancer in my family, so this is probably a benign affair, and I simply have to find them a place to live. I will attend to this lump later on." Later on, in her case, meant after she had packed and moved and unpacked and got her family settled in her new home: "later on" meant "too late." I took her family history with the names of all her close relatives, the dates and places that they died, and then verified all the causes of death by obtaining the original death certificates. I found that a paternal aunt, a maternal aunt, and an older sister had died of breast cancer. But because some members of the medical profession believe that it alarms the members of the family to be told that a relative has died of cancer, each one of these deaths had been reported to the family as caused by something not cancer. The sister who had died just three years before, had an inoperable breast cancer, and had been reported to the family as having died of heart trouble. Had the woman I interviewed known that her two aunts and sister had died of breast cancer she would have not delayed finding out about that lump until her family was settled.

Another woman wrote to me that four of her mother's sisters had died of breast cancer, a fact which I verified. She asked what she should do. I pointed out that all women should have yearly examination at least for the most obvious types of cancer to which women are prone, namely uterus and breast. With a family history of that sort I urged her to have her examinations at least every six months.

A third woman whom I contacted had her breast removed for cancer. The surgical report stated that no evidence of metastasis had been found. The woman reported that a sister had died ten years before with breast cancer, and that she had been very careful ever since to have not only examinations by the physician every six months but to examine her own breasts at frequent intervals. She had thus discovered the lump when it was very small, and had it removed immediately. I could duplicate this story, as well as the one in which the woman did not know of her family having cases of breast cancer, many times.

But let us turn to some other types of cancer. In a small town a man died of rectal cancer at the age of thirty-four. He left a wife and four small daughters ranging in age from ten to three. About seven or eight years later, the oldest daughter, then about eighteen, and her next oldest sister started having rectal distress, which their physician diagnosed as mucous colitis. They were treated for this for about five or six years. In the meantime, the third sister developed mucous colitis, and the family also moved to another town. Here they went to a surgeon who fortunately appreciated the significance of the family history. All three daughters were examined and all three were found to have rectal cancer. The oldest girl, who was now twenty-six, was too far advanced in the disease to live long after her operation; the second girl survived her operation for about six months. The third daughter was apparently diagnosed in time, and when I was last in contact with the family had returned to her duty as a graduate nurse. The fourth daughter, at that time nineteen, told me that she intended to have semiannual examinations for rectal cancer.

In my work, I frequently desire to correspond with the relatives of the patients whom I have contacted. If I do not have their address, I write to the Chamber of Commerce of the city in which they live for their street address. A few days ago I received an answer with the wanted addresses and also a personal letter, in which the secretary of the Chamber of Commerce gave me his own history. Twelve years ago his sister had died of rectal cancer. Eight years ago his mother had

died of the same thing. This is a little unusual in that the parent died of the cancer after the child had shown it first. For the past five years this man had been treated for various ailments of the gastrointestinal tract, but not once did the physician examine him to see if he had rectal cancer. After five years, he had an operation for the removal of a benign tumor from his colon, but again the doctor did not tumble to the obvious diagnosis and look for a possible malignancy. The man continued to go down hill, and finally got into the hands of a specialist who had sense enough to examine him for the presence of cancer of the bowel. The cancer was found, the segment of bowel removed, and today the man is feeling very well. But think of what might have been saved had the first physician had even a faint appreciation of the hereditary nature of that type of rectal cancer. Polyps of the bowel are almost inevitably followed by cancer if the patient lives long enough.

Another very interesting family history was one in which there was a marked concentration of stomach and rectal cancer. In a family of seven children, five died of cancer of the stomach. One of the brothers so affected had six children, two of whom died of cancer of the stomach and rectum respectively. One of the sisters so dying had ten children. Three of these had died of stomach cancer, one of cancer of the colon. A fifth sister had a polyp removed from the rectum at a supposedly reputable hospital. I wrote for the pathological report, and was told that the surgeon had not considered any possibility of malignancy, and so no microscopic examination was made of the tissue removed at operation. You can imagine what the prognosis is for that woman; if she does nature of polyposis of the bowel and the ensuing her rectal cancer which undoubtedly will develop on polyps that were left in the intestine. The polyps removed might have been benign but any surgeon, even remotely aware of the hereditary nature of polyposis of the bowel and the ensuing malignancy, would have felt obliged to have a microscopic examination made and in the face of a history of twelve close relatives dying of cancer of the stomach or rectum, would certainly have examined that woman more carefully and probably would have removed the affected segment of the bowel rather than just one polyp.

A man in New York was operated upon for gastric cancer at the age of fifty-four. His fifty-two-year-old brother called to see him, and was distressed deeply that cancer had appeared in their family. He confessed to the surgeon his obsession that he too might have cancer. The surgeon advised him to forget about it, but he could not. The surgeon then said he would relieve his mind on the matter and give him an examination to prove that he did not have cancer. The examination revealed, however, that this brother also had gastric cancer and he was operated upon within a few days of his brother's operation. The surgeon found that there was a third brother, aged fifty, and sent for him to give him a thorough examination. Fortunately, in this man there was as yet no gastric cancer, and it may be that he never will develop it, but as the surgeon remarked to me, "I am having him in for examination every six months, and if he does develop it, I will discover it before he ever has had symptoms from it." Here is a chance for really early diagnosis.

If one member of a family has had gastric cancer, it should make both the patient with vague symptoms of indigestion and his physician more alert to the possibility of cancer. If one member of the family has already had rectal cancer, the first evidence of chronic constipation or bleeding from the rectum should send the next member at once to the physician for an examination instead of to the medicine cabinet for a laxative.

Some of the rarer types of cancer show marked heredity, such as cancer of the eye, known as retinoblastoma. The first evidence of that in the eyes of a second child in a family in which a former one has already developed the disease, should send the parents to the physician in haste.

Not all cancers, however, show such definite evidence of heredity. At present, lung cancer in man does not show any tendency to develop in several members of a family. This may be caused by lack of diagnosis in many instances or it may be that lung cancer is one in which the environmental role is predominantly strong.

As will readily be recognized, this role of heredity in cancer control means that someone in the family must be the first to have the disease, and he will have had no close relative whose cancer makes him aware of the significance of his symptoms. He will be no worse off, however, than those who do not believe in heredity in cancer. They do not accept the tips they have from other members who may have had it. Moreover, life is like that; there always has to be a tragedy of some sort before

we take preventive measures. We know the danger of fire in a hotel, but there has to be a series of disastrous hotel fires with great loss of life before the public becomes aroused enough to demand adequate fire escapes and fire protection. There always have to be a number of deaths at a bad railroad crossing, before the overhead pass is built. So there will always have to be a first death from cancer in a family before the other members are made aware of an increased liability on their part to develop it.

Finally, many people ask me if I do not consider this outlook very depressing. Not at all. When we consider that one in every seven of us will develop some sort of cancer before we make our final exit, a belief that cancer is inherited does not deepen the gloom. It merely points out what types of cancer we are more likely to develop should we be the one in seven. My father died of rectal cancer at age seventy-four. My great fear is that I am not going to be allowed to live to develop my rectal cancer at seventy-four, but will be killed by some reckless fool behind the wheel of an automobile years before that time.

Cancer is often a painful and always an expensive way to die. Anything we can do to prevent it or to save the patient who has already developed it from suffering pain and dying of it will be infinitely worth while. But let us not forget that a person saved from one type of cancer is a person saved to die of some other disease or some other type of cancer at a later date. We can battle Death on many fronts; we may have many temporary victories, but in the end Death always wins. About a year ago, I read an article in a lay magazine stating that if we put as much money into a study of cancer and all chronic diseases as we did into armaments, we could eliminate all of them as we are now eliminating acute infectious diseases; that the time might even come when we could eliminate all the effects of old age itself. Now I hold these truths to be self-evident.

1. Man cannot live forever; therefore, Man must die.
2. If Man must die, he must die of some cause, accident, acute infection, chronic disease or old age.
3. If we eliminate all causes of death, Man will ultimately have to die of old age.

(Continued on Page 476)

Carcinoid of the Colon and Rectum

A Representative Group of Three Cases

By James A. Ferguson, M.D.

Grand Rapids, Michigan

CARCINOID TUMORS may occur any place in the gastrointestinal tract and have been a matter of record for many years. For an extensive review of the literature regarding carcinoids in general, the reader is referred to the excellent paper of Pearson and Fitzgerald[2] and its thorough bibliography.

Carcinoid tumors of the colon and rectum, alone and exclusive of the appendix, are relatively uncommon though not rare. Horn,[1] including his own cases in a critical résumé of the literature on this subject, reports the following occurrence and distribution:

	No. of Cases
Cecum and ascending colon	15
Transverse colon	2
Sigmoid colon	2
Rectum	59*
Total	78

*Including three cases mentioned by Dr. Robert Horn in personal communication.

It is the purpose of this paper to promote awareness of carcinoid tumors in the large bowel, to emphasize the fact that diagnosis may not be easy and may depend upon a consensus among pathologists and to stress the prognostic importance of accurate diagnosis. A group of three cases is illustrative.

Carcinoid of the Rectum

Case 1.—C. A., a twenty-five-year-old white man, was examined July 13, 1949. The patient's only complaint was pruritus ani, but proctosigmoidoscopic revealed a clinically benign, sessile polpy at 15 cm. The polyp was entirely removed with biopsy forceps for pathologic study. Barium enema with double contrast was entirely negative.

Pathologic Diagnosis.—A startling report of "adenocarcinoma" was made on the tissue removed. Because of the obvious implications of this diagnosis, pathologist A recommended consultation with pathologist B, who

made a diagnosis of "carcinoid," and the tissue was therefore submitted to pathologist C, who made a diagnosis of "carcinoid."

Periodic examinations to include proctosigmoidoscopy and double contrast barium enema were recommended, and the patient, last seen December 12, 1951 (two years later), is entirely asymptomatic with no evidence of disease.

Carcinoid of Transverse Colon

Case 2.—B. L., a fifty-three-year-old white man, was admitted to the hospital December 28, 1950, with complaints of rectal pain and soreness, mild intermittent abdominal cramping, and weight loss of 35 pounds, all of approximately one year's duration.

Barium enema studies revealed a "large annular intrinsic neoplasm of the right transverse colon."

Operation revealed a massive neoplasm of the right transverse colon with heavy involvement of the mesocolon but curiously absent signs of any distant spread whatever. The ascending colon and right half of the transverse colon were resected on December 30, 1950, and ileocolostomy was performed.

Pathologic Diagnosis.—Carcinoid of the transverse colon.

Comment.—There are only two cases of carcinoid of the transverse colon on record[1] and because of its great rarity, pathologist A submitted the tissue to pathologist B, who made a diagnosis of "adenocarcinoma." The tissue was therefore submitted to pathologist C (actually a reviewing board) who diagnosed the tumor as "malignant carcinoid." Argentaffine granules in the tissue were demonstrated in support of the diagnosis.

Progress of Patient.—The patient recovered uneventfully and now, one year later, has gained 10 pounds, is asymptomatic and shows no general, proctosigmoidoscopic or roentgenologic evidence of disease.

Carcinoid of Cecum

Case 3.—H. L., a fifty-four-year-old white man, was admitted to the hospital November 28, 1949, for resection of a cecal lesion which had been found on a routine barium examination prior to proposed hemorrhoidectomy. The patient had had no gastrointestinal symptoms.

Operation revealed a firm tumor in the cecum with local mesocolic extension and no distant spread. Right colectomy with ileo-transverse colostomy was done three days later. The patient's recovery was uneventful.

Pathologic Diagnosis.—Carcinoid of the cecum.

Comment.—For the sake of consistency only this tissue was submitted to pathologist B, whose opinion was also "carcinoid."

Progress of Patient.—The patient was last seen December 11, 1951, two years after his operation, was entirely asymptomatic and showed no clinical, proctosigmoidoscopic, or roentgenological evidence of disease.

Discussion

It is rightly pointed out by Pearson and Fitzgerald that all carcinoids must be considered malignant. The peculiarly phlegmatic nature of these neoplasms is tremendously different from adenocarcinoma and prognosis is infinitely better. Had the diagnosis of adenocarcinoma been accepted in Case 1, a radical, mutilating, operation would have been the procedure of choice and the patient may have lost his rectum to eradicate a lesion which is generally thought to be of local significance only. On the other hand, if the diagnosis of adenocarcinoma had been held in Case 2, the physician's critical evaluation of the patient's prognosis for morbidity and mortality would have been profoundly inaccurate. Case 3 is added to point out the diversity of location of these tumors in the large bowel.

The argentophilic properties of these tumors is well known by pathologists, but the absence of silver granules in the specially prepared stains does not obviate the diagnosis and oddly enough is rarely if ever seen in the group of rectal carcinoids.[3]

Though many carcinoids of the large bowel have undoubtedly been recognized and not reported, it is also probable that the existence of some has escaped attention under the diagnosis of carcinoma. Erroneous diagnosis may also explain why some "carcinoma" patients mysteriously exceed by many years an estimated poor prognosis.

Summary

Attention is recalled to carcinoid tumors of the large bowel by a group of three cases. Carcinoid may be difficult to diagnose and should be suspected when atypical neoplasms are seen. One case of carcinoid of the transverse colon is added to the records of this rare entity.

Accurate pathologic diagnosis is vital to the selection of proper management and to prognosis.

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Home Care of Cancer Patients: Psychiatric Problems

By Harrison Sadler, M.D.
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IN ORDER to prepare myself for this talk I began (psychologically) some weeks ago to immerse myself in cancer. I decided to review the medical journals of the past year and so searched carefully through the Quarterly Cumulative Index Medicus, briefly noting 350 articles per month and, cumulatively, 1,200 articles. There was none at that time on the problem which we are considering today. Since then there has appeared in the August, 1951, issue of *The Journal of the American Medical Association,* an article which I commend to your attention.[2]

In order, further, to immerse myself I spoke to doctors, nurses and medical students who constantly were seeing cancer patients. To my query: "Tell me a little bit about some of the problems that you noticed," all began with: "Well, it is according to the patient"—or —"I remember one case that stands out in my memory"—or—"I use such and such a drug or technique." I then visited patients and noted all varieties of reactions.

Here is a man with carcinoma of the spine, crying out constantly in pain, "How can you let me suffer this way?" Here is another with similar pain, "What did I do to bring this on?" And here is another tolerating his pain with seeming equanimity, revealing to me that this was his punishment for an act committed long ago.

Here is a patient contemplating suicide and here another who found at last religion, and another "the cure." There was a lady with carcinoma of her face. So disturbed was she by this that she would not let anyone see her but her daughter. "It is so horrible," she said, moved by an old vanity and feeling of shame.

I thought: Certainly nothing happens to an individual without being drawn into his mental conflict. Disease (cancer here) seems to represent something which disturbs the mental equilibrium. Thus, our patients manifested old, neurotic conflicts which rose to the surface in this present situation. Then, old personality problems are given full display.

Here was a patient with a cancer diagnosis who secluded himself in his room, depressed and saying, "What is the use, I'm all done." Here was another with a similar diagnosis who worked all the harder, "Sure it is bad, but no use letting it get me down."

I saw that illness demands a new investment of emotional energy if mental balance is to be restored. Former interests were often impoverished (friends, work, hobby, et cetera.) I noted that often the nurses called this increased self interest and reflection a psychological problem. I was consulted often about these problems.

I observed that, generally speaking, patients and their medical attendants (i.e., their family, friends, nurses, doctors) seemed to display greater concern if the organic system involved was one which was greatly charged with emotional energy, such as the brain, the eye, the sexual organs.

I came away from this general experience with a few observations which may be helpful to share.

1. There is a variety of techniques for dealing with special problems, such as morphine for pain, electroshock for depression, occupational therapy for reinvesting emotional energies.

2. That illness serves to disintegrate the personality and allow previously renounced conflicts to emerge in full flower, such as guilt, rage, hate, self condemnation.

3. These attributes (or attitudes) which emerge are often referred to as problems by the medical attendant, and the patient is cajoled, blamed, accused or threatened to give them up.

4. I could not help observing that all of us have characteristic ways of reacting to threats (such as illness), that our individuality is as characteristic of us as are the qualities of things in our object world: stones, trees, leaves. We acquire these characteristics as necessities in our growing up, just as the young sapling which was scarred by a knife bears the marks when it becomes a tree. I was forced to accept this truth in my patients and myself.

The psychological problem seemed, in all instances above, to consist of two parts:

1. The mental dis-equilibrium in the patient brought on seemingly by the knowledge of having cancer.

2. The patient's attempt to stabilize this dis-

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equilibrium by mental means, regressing to depressive state, assuming passivity, blaming others, turning to religion.

I must caution you that we should continue to pay attention here to the broadest principles. In the short time allowed, we must not delude ourselves and turn our gaze to special problems. If we do, we shall end up examining bits and particles of the problem such as: If this is so, then you do this. For example, the question is asked: "Should the patient be told if he has cancer, and if she should be told, when?" You know how complicated the answer to this problem can be, and each time I have asked it or have been answered I always hear that one must first examine the patient, make sure that he has cancer, then pay attention to the kind of individual he is.

Then will you allow yourself for the moment to consider with me that the common denominator in our present concern is that there are present two human beings (the patient and his medical attendant) concerned with what is called a problem? This psychological problem concerns not the illness itself, that is, the cellular growth or the discontinuity of the bowel, but these human beings and their disturbed mental balance: Their mutual fears, anxieties, doubts, guilts. It has previously been noted that the doctor's trust or mistrust of his patient, his fears or his dislike of his patient, as well as his positive feelings toward him, are factors which often determine how well or how poorly the patient responds to the medicine he prescribes, the treatments he administers, or the operations which he performs. In the mind of his patient, these are often his medicines, his treatments, his operating procedures.[1]

I remember one situation in which I visited a patient. The patient had cerebral manifestations with loss of memory, cloudy consciousness and a depressed reaction, because, as she stated so many times, "I am not all here." The physician was forced to tell her, because of his own anxiety, "You will be all right, this will pass away, you'll be grand again." This disturbed her more than her progressive illness. She said, "He really doesn't understand me at all."

If you have followed the presentation closely, I am afraid that you, too, will have arrived at the conclusion which I was forced to accept; not because I wanted to, but because it was so apparent from what I saw. The patient and his medical attendant each have a characteristic personality. The medical attendant, however, is the therapist and he is charged to represent health. He has as his first responsibility, to be aware constantly of his personality manifestations and to represent in his attitude only healthly manifestations. Generally, this can be summed up by stating that he must respect his patient's individuality, that is, his illness, his symptoms, his gripes, his hostility—all of his personality. Often, unknowingly, he takes the side of the illness against the patient.

I use the word respect a great deal (too often, I am sure), assuming that it is completely understood. I refreshed my memory in Webster before I came here this morning. It means to have a deferential regard for, to hold sacred, inviolable, to pay attention to. Now, see how difficult it is to respect. That is, to hold sacred a patient accusing you of allowing such a thing to happen to her, or that you are a poor nurse, or a poor doctor. Respecting that she spends day after day in a depressed mood, wondering what she did in her life to bring this on, or that she secludes herself from sight and refuses to have anyone see her. It is difficult for us to see this as necessary for our patient. I am afraid that these demands on the medical attendant often arouse feelings of counter hostility, accusation, condemnation, or simply a denial, such as the physician who said, "Oh, you will be fine." If we respect them, we see them as necessary for this particular individual. Only then can we endure, tolerate and represent cheerful attention. We then begin to give the same amount of respect to the psychological problems as we give to the cell growth. Neither is removed by our wishing it.

You may take it from me that one's attitude can be therapeutic in itself. It has been said that in many instances, the attitude of the medical attendant is as potent a factor in the medical therapy as the prescribed medical medications or surgical procedures. In other instances it is a most powerful instrument in the armamentarium of the physician.[1] Please do not take it for granted. Strive consciously to be aware continuously of it and to improve it to the best of

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Home Care of Cancer Patients: Nursing Problems

By Hulda Edman, R.N.

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TO GIVE ADEQUATE nursing care to the cancer patient in his home is a daily challenge to our skills, resourcefulness and patient persistance. It is a good opportunity to bring comfort to the patient and family alike. The nurse finds in this service rich rewards and lasting satisfactions.

To be successful, she needs a variety of simple and complex nursing skills as well as an adequate knowledge of general human biology in order to understand the physiological and psychological factors which affect the cancer patient. She needs to have a sound philosophy of life, information of community agencies and how each can contribute to the patient's welfare. She needs to know how to participate as a member in the working team; namely, patient, family, physician, public and private agencies and nurse. Likewise, she needs a hopeful attitude toward the disease if she is to be an effective nurse. Accurate up-to-date knowledge regarding the prevention, the diagnostic procedures and the treatment of cancer helps to generate such an attitude. Finally, a long-term view of chronic disease should be a part of her working equipment.

Nursing care of the cancer patient is much the same wherever he is—hospital or elsewhere. However, some nursing problems may be brought more clearly into focus because he is in his home. A desirable aspect of home care is that it is possible to achieve individualization of the patient's care. Can it be said without much fear of contradiction that the patient is better off in his home when the necessary care can be given there? What is it that makes the home the most desirable place for care of the patient with a long-term illness?

A good nurse today knows the important part food plays in health and disease. Anyone who faces the problems of long-term illness, and especially cancer, soon realizes the difficulties in maintaining an adequate nutritional status. The loss of appetite, pronounced likes and dislikes, and the apathy of the patient all aggravate as well as complicate his dietary management. In addition to these considerations, there are special ones in relation to the location of the cancer which play such an important part in this aspect of his care. The patient with cancer of the mouth may require that his food be lightly seasoned or flavored, sometimes in liquid form but always adequate in calories and all food elements. Stomach cancer destroys digestive glands; therefore, protein digestion is disturbed with consequent necessary adjustment in meal planning and preparation. The growth may encroach on the openings or cut down on the capacity of the stomach, thus cutting down to a marked degree the form and the amount of nourishment that can be taken at any one time. When the liver is involved, fats may need to be emulsified or taken in smaller amounts. Anemia is a common complication, and the visiting nurse assists the "home nurse" to plan a diet rich in iron and protein. Profuse drainage depletes the body stores of protein; an imbalanced digestion makes for poor use of food elements, minerals, and vitamins. Diet evaluation with adjustment to meet the patient's needs not only promotes or restores physical vigor and temporarily controls or lessens weight loss but adds to the patient's feeling of well being.

Perhaps there is no care which is as satisfying to the patient as good bedside care. We would all agree that keeping him clean and dry, turned frequently, maintaining good body alignment, all make for bodily comfort. Irrigating the colostomy and bladder, if indicated, as well as ulcerating areas, or changing dressings often enough to control odors and care for drainage is essential since families as well as patients are very distressed over these odors. There is ample evidence to support the fact that the well-cared-for patient requests and requires less drugs to control pain. Such drugs usually destroy the appetite and interfere with normal bowel action and thus add to the patient's discomfort and complicate the nursing care.

For a great many cancer patients, physical therapy is another important part of their nursing care in order to prevent crippling or to restore muscle function. This is particularly true in radical breast surgery where certain muscles of the chest have been removed. The exercises recommended by the physician and initiated in the

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hospital must be continued in order to insure steady progress in convalescence. Prolonged disuse of the arm is likely to cause a fixation of the joint, a difficult condition to undo. Good nursing care of this kind of patient aims at maintenance of the use of the arm. Amputees need to be taught how to use crutches and artificial limbs. Helping these patients to be active and useful again is a great asset from any point of view. From the community standpoint, the wife and mother who is again able to function in her special capacity, the wage earner who returns to a job, and the school child who is able to get on with his books and play are again independent. Of course, what such independence means to the individual is our greatest consideration, and this is true even when his improved state is only temporary.

Necrosis and ulceration of tumors complicate nursing care wherever they occur. The ever widening and deepening surface lesion is a gruesome sight to the patient or other members of the family who care for him. In addition to the loss of body fluids and protein through the drainage, the open lesion is of real concern for the nurse for other reasons. She knows that there is a great possibility for a gross secondary infection to occur and that it is easier to prevent infection than to overcome it. It is usually necessary for the "home nurse" to change dressings between the nurse's visits, consequently, she must be taught how to sterilize dressings and to use a good technique in handling them. The control of infection in cancer usually results in an improved general condition—better appetite, better sleep, less pain, et cetera. Then, too, the ulcerating lesion has a real potential for sudden, severe hemorrhage—more so in treated cancer than in the untreated lesion. The visiting nurse is cognizant of this possibility and in the event that it does occur prepares the family for proper action such as keeping the patient quiet, reassuring him, calling the physician and applying pressure if the bleeding area is accessible.

For some cancer patients, their experience with radiation reaction from a first series of x-ray treatments comes while they are at home. Much can be done to allay their fears when the skin turns to a dark plum color on the ninth or tenth day after treatments have started. It is equally important that adequate instruction be given in interpreting the orders given by the doctor for the purpose of soothing the annoying burning and itching. Also, it is necessary that the patient be taught to take over his own care, if at all feasible, in order that he be kept more comfortable. This is particularly so in the case of mouth care, when hourly rinsing or irrigations may afford the greatest relief.

What real contribution does the nurse make to the patient's care when she does these things for him or the family? Should the patient or his family ever be taught to share in his care? What are the advantages of "self-help" for any patient?

Naturally it is very important for the nurse to give care until the patient's strength returns or until a psychological adjustment to his illness occurs. Another great advantage to the patient allows for building a relationship that will result in his acceptance of the nurse's instruction, currently or later. There are definite advantages to the nurse, too. While giving care, she has an unsurpassed opportunity to learn to know the patient as an individual, his personal needs, his frustrations, his fears, his hopes and his reaction to his family. Likewise, there is usually an opportunity to learn to know the family and how the patient and the patient's illness affect them. The patient, plus his environment, must be reckoned with since his improvement may be materially hastened or retarded because of elements in the home situation. Evaluation of all these factors plays an important part when making nursing care plans. Patient and family should be taught as soon as feasible to take over all of those aspects of care that they can safely assume. Teaching others is one of the nurse's most important functions, and what better time is there than at the bedside while giving care? In this way it is possible for the patient to be kept comfortable between the nurse's visits. Personal independence of the patient is a potent morale builder. The nurse, however, maintains as close supervision as the situation indicates, assists the physician and the family with new problems as they arise, and stands ready to assume active care when again needed.

As many of you know, the Detroit Visiting Nurse Association has for several years shared in the basic training of student practical nurses by giving them experience in the home care of chronically ill patients. Under a grant from the American Cancer Society, experience with cancer patients has received emphasis. When patients or their families require more care than can be

given on a visit basis, practical nursing students are assigned in homes for four- or eight-hour periods. We call this "placement service." They are placed only where the experience has educational aspects for them. In these situations the student is responsible first of all for the nursing care of the patient. At all times she is under the direction and supervision of a professional staff nurse. Also, she prepares meals for the patient and sometimes for the family, cares for children, and does minor household duties. As a rule students do not stay in any one home for more than one week. From April 1, 1950, to April 1, 1951, 85 per cent of the students had placement experience, 38 per cent of which was with cancer patients. About three-quarters of their time in the home was spent in nursing, one-quarter in home management activities. In many instances this kind of service has brought enthusiastic response from patients and family members because it has afforded more adequate care for the patient, has given the "home nurse" some much needed rest and has brought comfort to all of the family. Student placement service has made it possible for some of our patients to receive convalescent or terminal care at home—the only other alternative being care in the hospital or a nursing home, away from the family members who are the most concerned over their welfare, and at a cost which is prohibitive to most families.

I do not mean to imply that home care is always indicated, but rather that when adequate medical and nursing care can be given at home and there are no other contraindications, patients usually are much happier at home, and the student placement has often been the factor that made good home care possible.

Sometimes, of course, it is important to have the patient nursed with a more objective approach such as may be available in a hospital. Also a terminal illness may be too shocking for young children to observe, and for this reason it is desirable to have the patient hospitalized. However, if adequate nursing care can be given at home, it is far less costly, an item to be reckoned with in most families.

In the foregoing comments I have been concerned with the major aspects of the physical care. No less important are the emotional problems which definitely influence all of the former. Emotional problems vary a great deal and many of them have far-reaching effects. The fear of pain or death, or the patient's resentment over his illness, may become evident through open hostility and rebelliousness to the nurse or any or all members of the family. When the nurse has established a good working relationship with patient and family members, she is in a fine position to work constructively with them to overcome such feelings. It is especially important here to have teamwork with *all* those concerned with his care —namely, not only the total family but also the patient's doctor, his spiritual advisor, as well as the nurse.

The nurse works with many patients who do not know their diagnosis. This often has a way of complicating the general situation. The decision of whether or not to reveal the diagnosis to the patient is the responsibility of the physician and the family. Not all patients want to know the truth, and they certainly vary in their ability to accept it without undue depression. A physician is better able to judge how the patient may react to such information. Because a nurse is with the patient longer than is the physician, the patient may ask her more questions. She is at a distinct disadvantage when she cannot answer in a straightforward manner, because it creates a barrier to the patient's complete confidence in her and to some extent may hinder his co-operation in the treatment. Our experience would indicate that at this time, with all the depressing connotations that such a diagnosis holds, it is a moot question as to whether or not it is best to tell a patient his diagnosis. Certainly we have known patients who have been more co-operative about recommended treatment and follow-up because they knew their diagnosis. There have been some patients with a terminal carcinoma who appreciated knowing in order to help make plans for their families.

In all those homes where the patient is rejected or neglected because there is the belief that cancer is communicable, the nurse has a difficult but not insurmountable problem. There are ever so many people who think the patient is "contaminated," and other family members either leave him strictly alone or indicate by word and action that they do not wish to expose themselves to such hazards. Or he may be neglected because the illness is repulsive to them. It may take a while but patient, persistent teaching usually corrects the misinformation; however, the nurse may not be able to resolve feelings of this nature or accom-

plish a change of attitude necessary to give the patient a sense of being wanted.

Financial worries beset almost every cancer patient. They permeate every aspect of his living and care. For those who cannot afford full or part-cost Visiting Nurse Association care, the Association is able to supply nursing service without cost. To get some patients and families to accept nursing service under such conditions may require considerable persuasion. In many instances a thoroughgoing review of the family's financial assets and liabilities (a painful process to many) may give evidence of real need for public assistance. The nurse's report to a public welfare agency may be the determining factor as to whether or not public assistance is granted. For those items which no public assistance program allows, we have found another agency most helpful in making it possible to give adequate care to the cancer patient. The Southeastern Michigan Division of the American Cancer Society is a striking example. In addition to the making and dispensing of dressings, the large loan closet with beds, mattresses, pillows, bed protectors, wheel chairs, afghans, bed socks, bed jackets, hospital-type gowns, and various and sundry sick room supplies is a ready source for making the patient more comfortable and the care easier, as well as for keeping down the cost of the illness. When the patient needs something which is not already stocked, we have found quick and gracious action to provide it.

The C. family illustrates many of the points I have discussed. Thirty-three-year-old Mrs. C., the patient, was referred to the V.N.A. upon her discharge from the hospital. She had a newly made colostomy and asked assistance to irrigate the colostomy and to change the dressing. The surgery had been done immediately following the diagnosis of cancer of the colon. Our nurse found a very disturbed household, and it wasn't long until most of the following problems came to the surface. It was the second marriage for Mr. C.; his first wife had died following an ectopci pregnancy. There were no children with the first union. Employment in a nearby plant provided a modest income only, so at this time he was taking on extra jobs. The diagnosis of his wife's illness alarmed him to the point that he thought death was imminent. He had a morbid fear that he, too, would die of cancer. A tense relationship between him and Mrs. C. had developed because of the annoying odor, and he felt that she was "contaminated." He refused to share a room with her and didn't want to be near her for these reasons. Activity was already under way to sell the home they lived in—a relatively new dwelling, her "dream house"—in order to meet doctor and hospital bills. The American Cancer Society was berated because they couldn't help him financially.

Two active preschool children, two and one-half and four and one-half years of age, were demanding their mother's love and care now that she was home from the hospital. She was upset because she couldn't give the care she was accustomed to give them. Neighbors tried to be helpful in many ways, but their help was not entirely welcome—apparently the C's found it difficult to accept this kind of attention.

Mrs. C. was ambulatory but had not been taught to care for the colostomy. She gave no evidence that she knew the diagnosis and very obviously showed her distress over a mutilating operation as well as the unnatural body opening. Not having been to church for quite some time made her feel guilty. Her reason for not going was that she didn't want to go alone with the children. She is a Catholic; her husband is a Protestant.

Fortunately one nurse has been able to carry the major portion of the nursing visits. She had an early consultation with the surgeon and physician in charge to obtain the diagnosis and nursing care orders. They reported a poor prognosis. Conferences on special problems presented with her supervisor and the V.N.A. consultant in cancer nursing and a discussion with county social welfare to determine eligibility for public assistance and others have been helpful contacts in making or revising the nursing care plans.

Very gradually Mrs. C. began to take over the colostomy care. Regulation and frequent cleansing have eliminated the odor from it. Adjustments in her diet have helped to control the diarrhea.

Full-time household assistance through the Visiting Homemaker Service was arranged but is gradually being terminated. Mrs. C. feels quite well now and is anxious to take over her role as mother and homemaker even though the Homemaker Service has been most satisfactory.

About six or eight weeks after the visiting nurse began seeing Mrs. C., the patient confided to her

that she had known the diagnosis all along but could not force herself to discuss it. Church attendance has given her a great measure of relief as well as help.

The C's now live in another house. The proceeds from the first netted enough to settle hospital bills. Financial assistance from a veterans' organization helped to make the down payment on another house. It was hard to give up the "dream house" but they have learned there are other more important considerations. Mrs. C. has admitted that there are some features about this place that are advantageous over the other one. Their family life is quite normal, and Mrs. C. appears happy and is grateful for her present state of well being. The prognosis at this time is "fairly good." On two recent occasions she has discussed some future plans she and her husband had been making for the children in the event of her death. She is not despondent because she believes she may live for quite some time.

Dietary guidance for the entire family has resulted in a better selection of food for all. A sound relationship exists between family and nurse. We shall continue to watch over Mrs. C., to encourage medical supervision as her physician requests it and to urge immediate investigation if symptoms develop.

Our experience with the P. family illustrates another kind of nursing problem. This was a difficult situation in which the patient, her husband, the private physician, and the visiting nurse composed the working team.

Mr. and Mrs. P. are in their middle sixties. Mrs. P., the patient, gave a history of five surgical procedures since May, 1949. Two years prior to admission to our service she had undergone surgery and x-ray treatments for cancer of the uterus. Rectal bleeding developed late in December, 1950. Investigation revealed an opening between the rectum and the vagina, with no evidence of cancer. Because repair was impossible, a permanent colostomy and excision of the rectum were done in January, 1951. Various complications necessitated two more operations and hospitalization until late in May. Her weight dropped from 230 pounds to 136 pounds—height 5 feet 2 inches. She knew the diagnosis.

The visiting nurse started care the day after she came home from the hospital. She found a quiet patient; helpless to such an extent that she ate and drank only what was spoon fed to her. She had never assisted with the colostomy care in any way—in fact she had refused to look at the site. We do not know which factors were strongest in reducing the patient to her regressed, dependent state; despondency over her diagnosis or the subsequent satisfaction of having this kind of care given by her husband. At any rate it was an unwholesome situation which called for all of the ingenuity a good public health nurse has at her disposal.

Mr. P. had been a successful automobile salesman but was now staying at home to care for his wife. He also prepared their meals but spoon fed his wife each time she ate.

Daily care was necessary at this time because of the unregulated colostomy and profuse drainage from the posterior wound. A secondary infection near the colostomy raised her temperature and complicated the nursing care by requiring warm, moist packs daily. The patient and her husband refused to touch any of the dressings between the nurse's visits. However, the doctor agreed with the nurse that the patient be encouraged to help herself as much as possible.

The extensive care required on each visit afforded splendid opportunities to work with these people. Mrs. P. wanted to lie in bed, expected to be waited on "hand and foot." In two weeks after repeated encouragement, she did take a quick look at the colostomy, and in another week she was no longer holding her nose during the dressing procedure. After this there was gradual, though reluctant, assistance. Most of the time she was "too tired," she said, to do anything for herself.

To Mr. P. the nurse stressed self-help. She found almost as much resistance from him in this regard as from the patient. "Doing everything for her" was his mode of expressing his devotion. However, gradually though ever so slowly, by demonstration and gentle persuasion, both Mrs. P. and her husband accepted the idea of independent self-care of the patient. Through planning with the nurse he began to devise ways of encouraging Mrs. P. to become more active. His plans provided a step-by-step procedure. For instance in the matter of feeding, he first insisted that she sit in a chair by a small table at the bedside instead of taking her meal in bed. Next it was the dining room, and finally she visited the kitchen. When

she got to this stage, she showed the first spark of interest in her household and started doing little chores.

The final chapter of our care for Mrs. P. has not been written, as an occasional visit for follow-up purposes is being made. After three months of nursing visits one sees a far different picture than might have been expected if treatment with a long-term view had not been initiated. She is no longer the helpless, self-centered, depressed person that she was. All of our care has been directed toward restoring a very sick woman to usefulness in her home and in society. Today she is up and about her home most of the day engaging in many little home-making activities. Automobile rides are a real treat to her. While all of her aversion to caring for the colostomy has not been overcome, she does a satisfactory job of caring for it.

This couple was receptive to suggestions for dietary improvement, and Mrs. P.'s nutritional status now appears to be good. One of the most tangible ways of restoring vigor in patients with a long-term illness is attention to the adequacy of their diet. Mrs. P.'s diet was found to be low in minerals and vitamins and we believe their favorable response to nutrition instruction was a factor in her recovery.

The next step forward would consist of Mr. P.'s return to his job. A mortgage on the automobile and a large loan on his insurance needed to be settled. Mrs. P. does not yet feel able to be left alone, but we are confident that in a reasonable length of time Mr. and Mrs. P. will again resume their accustomed way of life.

Available time today precludes the possibility of going deeper into the many aspects of the nursing problems of cancer patients. The ones mentioned are perhaps some of the more prominent factors which affect the patient's nursing care. But for all the patients who need nursing care in most, if not all, of the communities represented here today, there are public health nurses available, at least on a teaching basis. Flint, Grand Rapids, Holland, Kalamazoo, Lansing, Marquette, Midland, Muskegon, Pontiac, and Saginaw carry on a bedside nursing care program similar to that of the Detroit Visiting Nurse Association. In areas where there are no Visiting Nurse Associations, there are public health nurses employed by the city and county health departments. Regardless of where the nurse serves, she stands ready and eager to assist the physician, his patient and the patient's family in order that Michigan citizens who suffer from cancer may recover as quickly and completely as possible.

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HEREDITY IN CANCER AND ITS ROLE IN CANCER PREVENTION

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4. The only way to avoid dying of ald age under these conditions is to die young.
5. It would be highly undesirable, even if possible, to keep alive an ever-increasing mass of old people who would have to be supported by the young. This, however, is another subject meriting a full discussion in itself.

The most ideal way to die is, while in apparent full health, to go quietly to sleep and forget to wake up in the morning. For all of us, I wish such a happy ending.

HOME CARE OF CANCER PATIENTS: PSYCHIATRIC PROBLEMS

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your ability. In dealing with psychological problems, no one can take for granted that his attitude is therapeutic or that it represents health.

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Peptic Ulcer

Complications and Treatment

By Sara M. Jordan, M.D.

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IN ORDER to discuss the complicated ulcer, one should first comment briefly on the nature of the simple and uncomplicated ulcer.

Many of us who have been dealing with the ulcer problem for years believe that every peptic ulcer, if diagnosed early enough and treated intensively enough, will heal and with adequate care remain healed. Only in the absence of one or all of these conditions does the ulcer become complicated. We believe, therefore, that the complications of peptic ulcer are preventable.

Secondly, there is no question but that it is the complications of peptic ulcer which make this disease a serious and often a formidable one. The complications of hemorrhage, perforation and obstruction are found in duodenal ulcer in from 18 to 20 per cent of cases. The diagnosis of all these complications is usually not difficult to make, especially if hemorrhage is massive, perforation acute and obstruction severe or complete. All three complications may, however, be mild or subacute and for a time escape diagnosis and adequate treatment.

Hemorrhage is the complication which presents most difficulties, especially if, when the patient is first seen, there have been multiple hemorrhages, a condition which in a large percentage of cases appears to indicate a "tendency to hemorrhage" with any type of treatment.

Perforation may be subacute and produce the so-called "plastered" ulcer, namely, the ulcer which has penetrated into the pancreas or liver, thus making healing by medical measures impossible and producing the intractable ulcer. Or perforation may be acute and dramatic and require immediate surgery.

Obstruction may be due either to inflammation and edema in the acutely active ulcer or to cicatricial healing or to a combination of both. A few days' observation with a special diagnostic technique of drainage is helpful in differentiation of these causes and in choice of treatment, surgical or medical.

In gastric ulcer, the possibility of malignancy, present or future, is an additional and menacing complication. The early detection of cancer of the stomach is one of the most important medical projects of our times. Furthermore, resection of the stomach for gastric ulcer is highly successful as far as recurrence of ulcer is concerned. Hence it follows that resection is considered by some to be indicated in every gastric ulcer. On the other side of the picture, however, we know that acute erosions of the stomach heal readily and that chronic gastric ulcers, if diagnosed early and treated intensively, may be healed completely and permanently. It therefore seems more logical to most of us that if a gastric ulcer with its first appearance may be completely healed and evidence thereof be adequately controlled, medical treatment is still a first choice and resection indicated only when there is inadequate evidence of healing or recurrence.

Intractability, whether it be in the esophageal, gastric, duodenal or gastrojejunal ulcer, is actually also an ulcer complication, usually arising from late diagnosis and inadequate treatment. It must be correctly diagnosed, however, for not infrequently it is the patient and not the ulcer which is intractable. An intractable ulcer without the complications of hemorrhage, obstruction or acute perforation, is usually due to a "plastering" process into the pancreas or liver and requires resection. An intractable patient, however, more often than at first seems possible, is amenable to the usual measures of education and encouragement which are required in all ulcer treatment.

The complications following otherwise successful surgical treatment are also part of the picture of the complicated ulcer. They are chiefly (1) the so-called dumping syndrome and (2) failure to gain or maintain normal weight. With improved surgical technique, the former is less often seen and when it occurs it is usually temporary. The second complication is usually also temporary and can be relieved by increased intake of food and supplementary vitamins.

No discussion of the complications of ulcer should be concluded without an earnest exhortation to the medical profession for an all-out effort toward their prevention by early diagnosis, intensive treatment and adequate instruction and supervision to prevent recurrence.

From the Department of Gastroenterology, the Lahey Clinic, Boston.

Abstract of paper presented at the Eighty-sixth Annual Session of the Michigan State Medical Society at Grand Rapids, September 26, 1951.

Chronic Intestinal Amebiasis

Diagnosis and Treatment

By Thomas T. Mackie, M.D.
Winston-Salem, North Carolina

CHRONIC INFECTION by the *Endamoeba histolytica* in the absence of diarrhoea or dysentery is commonly regarded as having little or no clinical or public health significance. This misconception may be attributed to several causes. Until comparatively recently, the infection has been thought to be largely restricted to the tropics and the subtropics. Because of its high prevalence in these areas of the world, the literature is restricted predominantly to the specialized publications dealing with tropical medicine. The nomenclature of the older literature classifying all types of intestinal infections by this parasite under the generic term "amebic dysentery" has inevitably created the impression that dysentery is the characteristic and significant expression of infection. Similarly, the introduction of the term "asymptomatic cyst-passer" has further strengthened the concept that chronic amebiasis may be, and frequently is, of no importance to the host or to the clinician. Furthermore, the recognition that there are large and small races of the parasite which exhibit apparent differences in pathogenicity in the experimental laboratory has lent additional support to the concept that the *Endamoeba histolytica* is not an obligatory parasite and that it may live in symbiosis with the human host.

It is not surprising, therefore, that there are widely divergent viewpoints concerning the importance of the infection. Clinicians have been confused by the infreqency with which actual dysentery occurs and commonly believe that demonstration of the encysted forms implies a different type or site of infection which has no clinical importance. The opposed school of thought, numerically much smaller and composed for the most part of physicians trained in tropical medicine, places much more importance on the presence of the *Endamoeba histolytica.*

Presented at the Eighty-Sixth Annual Session of the Michigan State Medical Society at Grand Rapids, September 27, 1951.

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It is generally recognized now that the distribution of this parasite is not primarily restricted by climatic conditions. The determining factor in any area is the level of local sanitation. While infections are more numerous in the unsanitated areas of the tropics and the subtropics, it is endemic throughout the world. Thus, the writer has seen several cases of amebiasis which were acquired almost certainly in Alaska and in the Aleutian Islands.

The results of numerous surveys indicate that the prevalence of the infection in the United States as a whole is at least 10 per cent and probably higher. Faust[7] has called attention to the fact that most of the data upon which the prevalence rates have been estimated are based upon single fecal examinations, and that if more effective techniques had been used, the actual percentage might be as high as 20. It has likewise been shown that the prevalence is greater in certain parts of the South than in other regions, and that infection is much more frequent in rural than in large metropolitan areas where local sanitation is highly developed. It is to be expected that surveys reported from different regions should yield widely varying results. The extremes range from 0.2 per cent among 522 individuals in Baltimore, Maryland, to highs of 38 per cent among 374 individuals examined in a rural community in Tennessee,[3] and 55 per cent among 119 inmates of an orphan asylum in New Orleans.[4]

Transmission of the infection is accomplished by ingestion of the relatively resistant encysted stage of the ameba. In this form the organism may survive considerable periods outside the human body ultimately to reach a new host in contaminated food or drink. The cysts are not destroyed by the concentrations of chlorine ordinarily used for water purification; they survive for prolonged periods of time in ice, and remain viable in the intestinal tract of the housefly for many hours. The infected food handler has long been suspected as a source of spread of the infection although conclusive proof of this mechanism is lacking, and opinion concerning its potential importance is divided. It is apparent, however, that in an environment in which unsanitary methods of sewage disposal are practiced, numerous opportunities for dissemination of the infection will exist.

The clinical significance of infection by the

Endamoeba histolytica depends upon its role as an obligatory parasite within the tissues of the human host. The weight of authoritative opinion supports this concept. Dobell and O'Connor,[6] in 1921, stated that this organism is invariably pathogenic and that its presence is always associated with tissue damage even though clinical evidence may be lacking. Craig has concurred in this dictum, stating:

". . . we know that *Endamoeba histolytica* is a pathogenic parasite and up to the present time, there is no scientific proof that it can live indefinitely in the lumen of the bowel without penetrating the tissues and producing pathological lesions."

Clinical studies of amebic cyst-passers who failed to reveal what was considered to be significant symptomatology and objective findings gave rise to the term "asymptomatic cyst-passer." And this in turn has led many to assume that the finding of encysted forms unaccompanied by trophozoites is valid evidence of lack of pathogenicity. Such interpretation does not take into account the life cycle of the ameba nor the type of stool specimen examined. Trophozoites are not to be found in formed fecal specimens. Conversely, when an infected individual passing formed stools containing the cysts is given a saline cathartic and fluid stools are obtained from the proximal colon, numerous trophozoites can almost invariably be found.

Similarly, demonstration of the fact that small races of the ameba are commonly found in carriers, and large races in cases of active dysentery, has also led to the belief that strains producing small cysts are non-pathogenic. While there is evidence to indicate that the small-cyst strains are less pathogenic for experimental animals than the large-cyst strains, there is no evidence to prove that they are non-pathogenic.[5] Studies of strains from amebic dysentery and from asymptomatic cyst-passers led Kessel[10] to the conclusion that the resistance of the host is more important in determining the development of clinical amebiasis than variations in virulence of the parasite. Meleney and Frye[13] likewise demonstrated variations in virulence for experimental animals using different strains of the *Endamoeba histolytica*. In discussing this experimental work, they stated:

"Although our observations seem to indicate that some strains of *Endamoeba histolytica* possess a low degree of virulence for kittens, and probably for human beings as well, this conclusion does not lessen the importance of instituting treatment in every case of amebiasis encountered in medical practice even though there is no history of symptoms which might be interpreted as amebic in origin. The least virulent strains which we have encountered have produced lesions in a few kittens and it is reasonable to suppose that they would do so in man, also."

With such weight of opinion and evidence, as Craig has stated,[3,4] there is no justification for refusal to accept the dictum laid down by Magath and Brown[12] in 1930:

"At this time it is quite unnecessary to defend the pathogenic role of *Endamoeba histolytica*. The pathologic lesions that it produces have been so well described and so frequently encountered as not to leave a shadow of a doubt but that the organism can produce serious injury to tissue. Koch's postulates have been so repeatedly confirmed that an adequate defense cannot be offered for this parasite's harmlessness."

The pathology of asymptomatic intestinal amebiasis and of acute amebic dysentery differ only in degree and extent. The infective four-nucleate cysts, after reaching the human digestive tract, release four small motile amebae. These undergo multiplication and localize quite strictly to the cecum and the proximal colon.

Superficial destruction of the mucous membrane without appreciable invasion of the deeper tissues constitutes the initial lesion.[9] This may be limited to small areas, or it may occur over a considerable extent of the mucous membrane. On gross inspection, these changes may be barely visible. Congestion and thrombosis of minute vascular radicles occur beneath these areas with progressive necrosis of tissue and extension of the lesion. Frequently, lateral extension in the mucosa produces the characteristic flask-ulcer. In other instances, the process leads to the development of a shallow ulcer, the base of which progressively extends into the deeper layers.

The muscularis mucosa appears to act as a relatively effective temporary barrier to further extension. However, in selected tissue sections one may see that the lacunae, through which the penetrating vascular channels and lymphatics pass, provide a route by which the amebae finally reach the submucosa. Here again multiplication of the parasites and lateral and deep extension lead to progressive necrosis. At this stage of the process, before secondary bacterial infection has occurred,

the lesion is essentially a pure necrosis. With further progression, amebae may gain entry into radicles of the portal vein and be transported to the liver.

Ultimately, the pathologic process reaches the muscularis. This structure, like the muscularis mucosae, acts as a barrier to deeper extension. In the presence of a progressive process, however, invasion of the muscularis also occurs primarily along the penetrating vessels from which foci lateral extension again occurs. In the presence of an uncontrolled infection, these deep areas of ulceration and necrosis may lead ultimately to perforation.

Coincident with the progressive invasion of the bowel wall, the necrotic tissue is sloughed out, producing the typical discrete isolated ulcer. At this time secondary bacterial invasion occurs with the appearance of an inflammatory exudate of polymorphonuclear leukocytes. This secondary bacterial infection is an important factor since it sets into operation a dual etiologic mechanism, a significant change in the underlying pathology, and leads to the appearance of an inflammatory exudate in the stools which is frequently a confusing factor in diagnosis.

The characteristic gross lesions of intestinal amebiasis are the development of discrete ulcers separated by areas of normal mucosa. The most common sites of these ulcers are, in the order of frequency, the cecum, the ascending colon, rectum, sigmoid and the appendix.[1] Definite parallelism exists between the number and the distribution of the ulcers and the accompanying clinical picture. When the pathologic changes are largely restricted to the proximal colon, the accompanying symptomatology is usually mild; conversely, when the ulcers are widely distributed throughout the colon, the clinical severity is much greater.

It is obvious that an infection producing such variation in the severity and the distribution of the lesions must be accompanied by great variation in the clinical picture, and consequent difficulties in diagnosis. In our experience actual dysentery is so rare as almost to justify its classification as a complication. A significant number of patients give a history of recurrent periods of mild diarrhoea often accompanied by cramps, but not by tenesmus. Mucus may or may not be noted in the stools and blood, if present, is usually seen only infrequently and then in very small amounts. The intervals between these diarrhoeal episodes are commonly characterized by normal bowel function, moderate constipation, or a combination of both. Such individuals do not constitute a problem in diagnosis provided competent laboratory assistance is available.

By far the greatest number of the cases of chronic intestinal amebiasis, however, present a completely atypical clinical picture. Chronic constipation accompanied by persistent mild abdominal pain and flatulence is frequent. The pain may be referred to the right lower quadrant or it may be localized in the epigastrium and suggest pylorospasm. Persistent asthenia with excessive fatiguability and inability to gain weight are frequently observed in such patients. This picture is often accompanied by vague abdominal discomfort which the patient is unable to localize or to describe clearly.

Frequently there is definite intolerance to fats and to alcohol, which, with the other indefinite symptoms, lead to suspicion of chronic gall-bladder disease. The confused and indefinite clinical picture together with the usually negative findings on x-ray examination of the gall bladder and the gastrointestinal tract not uncommonly form the basis for the diagnosis of psychoneurosis. So common has this been in our experience that we have come to regard the diagnosis of psychoneurosis, when accompanied by chronic abdominal symptoms, atypical of the common pathologic entities as almost pathognomonic of infection by the *Endamoeba histolytica*. Specific treatment in the majority of these cases gives prompt and dramatic results.

Objective findings are seldom striking or significant. Physical examination may reveal a more or less distended cecum with moderate tenderness on palpation, or frequently no abnormalities may be noted. Similarly, in mild cases, in the absence of diarrhoea, it is usually impossible to demonstrate ulcerative lesions in the mucosa of the rectum and recto-sigmoid at proctoscopy. X-ray examination of the colon likewise rarely reveals evidence of ulceration and, when abnormal findings are demonstrated, they are usually indicative of irritation and spasm, but are not of assistance in reaching an etiologic diagnosis.

The diagnosis of chronic intestinal amebiasis is dependent upon demonstration of the organism in the patient's stools. The results of the complement

fixation test are not dependable in intestinal infections. Unfortunately, the clinical microscopy of amebiasis is difficult and is inadequately taught in many medical technology courses. In consequence, many positive infections are not identified by clinical laboratories, and clinicians are further misled by repeated erroneous laboratory reports. Our experience has been convincing that the maximum probability of demonstrating the organism is achieved only when the patient is given a laxative sufficient to produce a number of loose stools in the course of the day. The patient remains in the laboratory to pass the specimens until a minimum of three or four liquid or semi-liquid stools have been obtained for immediate examination by suitable, direct microscopic and concentration techniques.

The treatment of chronic intestinal amebiasis differs widely in different clinics. The number of recommended therapeutic agents is adequate proof of the fact that the ideal amebacide has not yet been developed. However, when the presently available preparations are used efficiently in the light of their pharmacologic limitations, both clinical and protozoologic cure can be obtained in the great majority of cases. The essence of the problem of therapy is recognition by the clinician of the anatomical distribution of the parasite both in the tissues of the host and on the surface of the mucous membrane of the colon, and knowledge of the fact that no single drug acts with maximum efficiency on the amebae in both locations. Familiarity with the site of action of the various drugs is therefore essential to the planning of an efficient treatment regime. It must further be kept in mind that, in the majority of cases, the problem of amebiasis is complicated by secondary bacterial infection of varying magnitude, which contributes to the total clinical picture.

The recommended amebacidal drugs fall into several categories: the arsenicals, the oxyquinoline derivatives, emetine and its compounds, and the antibiotics.

Acetarsone (stovarsol) was the first of the arsenical compounds to be used extensively, but its toxic potential is such that it is no longer recommended. Carbarsone is very much less toxic and has proved to be a useful therapeutic agent, but of lesser amebacidal efficiency than the more recently introduced thioarsenites. More recently still another arsenic compound, milibis, has been developed for the treatment of amebiasis. Its efficiency, however, is apparently less than that of other preparations in this group. All of the arsenic compounds are absorbed from the gastrointestinal tract and consequently are active against the amebae lying actually within the tissues of the host. They are less effective against the organisms in the lumen of the colon and on the surface of the mucous membrane.

The oxyquinoline derivatives include a number of preparations as chiniofon, vioform, anayodin, diodoquin and chloroquine. The first four of these are halogenated compounds which are incompletely absorbed and, therefore, theoretically exert their maximum effect against amebae which have not penetrated deeply into the host's tissues. Chloroquine, on the other hand, is almost completely absorbed and is concentrated particularly in the liver. It has been reported to be an effective agent in the treatment of amebic hepatitis.[2]

Emetine and its compounds is historically the first effective amebacidal drug. Its site of action is within the tissues of the host, and its lack of efficiency against the organisms in the intestinal lumen, and on the surface of the mucosa, is demonstrated by Craig's observation that approximately 90 per cent of cases of intestinal amebiasis treated by emetine alone relapse. Despite this limitation, it remains one of the most important therapeutic agents available. However, its use is not without danger since it is a protoplasmic poison with cumulative effect. Changes in the electrocardiogram are not unusual in the course of standard treatment, and while these are transitory, they demonstrate the need for caution and careful observation to avoid overdosage. The oral preparation emetine bismuth iodide has the same limitations of usefulness and the added drawback of inducing nausea and vomiting during the period of administration.

In the course of the last two years, certain of the antibiotics have been reported to be effective therapeutic agents. Aureomycin appears to have given the best results, but neither protozoologic nor clinical cures have been obtained in all cases. It seems probable, therefore, that these preparations will likewise fall into the class of useful adjuncts to therapy, but fail to meet the criteria for the ideal antiamebic agent.[8,11]

It has long been the experience of the writer that protozoologic cure is not difficult to accomplish if combined therapy is used with emetine hydrochloride and diodoquin administered con-

currently over a period of eight to ten days. This therapeutic regime permits simultaneous attack on the amebae both on the surface of the mucous membrane and within the tissues of the host. It takes cognizance of the anatomical distribution of the parasites and utilitizes the maximal therapeutic potential of each drug. Clinical cure, however, does not result in all cases. Chronic gastrointestinal symptoms of lesser severity continue in certain instances. Not infrequently this appears to be related to secondary bacterial infection. Aureomycin has given excellent results in numerous such cases when this preparation is added to the regime referred to above. It has, therefore, become our routine to use all three drugs in the majority of cases of chronic intestinal amebiasis.

Summary and Conclusions

1. Intestinal amebiasis is prevalent in at least 10 per cent of the population of this country. The distribution of the infection is determined by conditions of local sanitation rather than by climate. The prevalence is necessarily greater in rural than in urban populations, and the great increase in foreign travel exposes large numbers of individuals to greater risk of infection than they would normally encounter in the United States.

2. Chronic intestinal amebiasis commonly presents a clinical picture which is atypical and confusing. The mixed symptomatology and the frequent absence of significant objective findings frequently lead to an erroneous diagnosis of psychoneurosis.

3. The pathogenic potential of the *Endamoeba histolytica* is such that definitive therapy should be given in all cases irrespective of the associated clinical picture.

4. Effective therapy must be based upon recognition of the anatomical distribution of the parasites in the tissues of the host as shown by the histologic pathology, and upon the restricted sites of amebacidal activity provided by the various therapeutic agents presently available.

5. The most satisfactory therapeutic results are obtained by the concurrent administration of emetine hydrochloride and diodoquin over a period of eight to ten days, combined with or followed by a course of aureomycin to control secondary bacterial infection in the bowel wall.

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MSMS

A CANCER MANUAL FOR HIGH SCHOOLS

(Continued from Page 414)

medical profession who have prepared "The Story of Cancer for High Schools" for use in Michigan's schools.

Sincerely yours,
LEE M. THURSTON, *Superintendent*
Department of Public Instruction

February 21, 1952.

The only remaining hurdle in the completion of this project is that of printing and distribution to the more than 800 public and parochial high schools of Michigan. If funds can be found, it is expected the manual will be in the hands of high school teachers with the opening of the next school year.

Nephroptosis

Indications for Surgical Treatment

By Austin I. Dodson, M.D.
Richmond, Virginia

THE MOVABLE kidney was first described in the fourteenth century by Franciscus dePedemontanus. In 1841, Rayer called the attention of the medical profession to the movable kidney as a definite clinical entity causing characteristic signs and symptoms. In 1864, Dietl described the acute type of pain associated with movable kidney. This has since been known as Dietl's crisis. Rayer noted that relief from symptoms was obtained by rest in bed and by mechanical support in the forms of pads or belts.

In 1870, Gilmore successfully removed a painful atrophied floating kidney, the second successful deliberate nephrectomy in history. For the next ten years nephrectomy became a popular operation for renal ptosis, eliciting the admonition from Keppler that extirpation of the movable kidney should be carried out only when lasting results were to be expected.

In 1875, Dr. Greensville Dowell, of Galveston, attempted to fix a movable kidney in place by passing a type seton threaded on a needle through the wall of the abdomen, the lower pole of the kidney and out through the lumbar region. The patient was suffering from attacks of severe pain in the upper abdomen. Postoperative hematuria indicated that the seton had pierced the kidney. The patient experienced some relief, but nephrectomy was required four years later for complete relief. In 1881, Hand performed the first deliberate surgical suspension of the kidney. The kidney could not be removed because he suspected stone on the opposite side. Hand approached the kidney through a lumbar incision, resected a portion of the fatty capsule and suspended the kidney by suturing the perirenal fat to the lumbar wound. A year later this operation was improved by Bassini who removed the perirenal fat and sutured the renal capsule to the lumbar wound. From this time, nephropexy gained considerable favor until by the end of the century many surgeons were able to report a fairly large series of cases, and numerous modifications had been added to the operation.

In 1890, William W. Keene, Professor of Surgery at the Jefferson Medical School, reviewed 134 cases of nephropexy, including four that he had done himself. Of these 134 cases 52 per cent were cured, 21 per cent obtained some improvement and 19 per cent were unrelieved. During this period, many chronic illnesses, particularly manifestations of diseases of the alimentary tract, the gall bladder and the nervous system were attributed to renal ptosis, a palpable kidney was the only indication required for surgical intervention. It is, therefore, not surprising that the results obtained left much to be desired. In a large percentage of the cases so treated ptosis had not disturbed the physiology of the kidney and there was no relationship between the abnormal position of the kidney and the patient's symptoms.

The many cases in which nephropexy failed to give relief caused doubts to rise in the minds of both internists and surgeons, and the pendulum swung far to the opposite direction and even at the present time nephropexy remains to some extent a controversial subject. I recently heard a very prominent urologist state that he had never done a nephropexy for the relief of uncomplicated nephroptosis. On the other hand some urologists do large numbers of nephropexies and seem convinced that fixation of the movable kidney is necessary in the majority of cases. Nephropexy is an easy operation and it is easy to convince a woman with a movable kidney that it should be fixed in place. It is unfortunate for many of these patients, however, that the looked-for relief is not obtained. Pathological changes in the kidney are not at all dependent upon the degree of renal mobility. A kidney that is entirely palpable may be physiologically normal; if the ureter descends with the kidney there is no interference with drainage and usually no pathological change or discomfort resulting from the ptosis. Pathological changes in the ptosed kidney and the resulting discomfort to the patient are usually caused by interference with renal drainage. This is caused by kinking of the ureter over aberrant blood vessels or adhesions to perirenal fascia or peritoneum, which prevents the ureter from descending with the kidney. Renal ptosis has been estimated by various authors to be present in from ten to 20 per cent of women and approximately 2 per cent of men, but instances in which

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From the Urological Service of the Hospital Division of the Medical College of Virginia.

there is demonstrable pathology or sufficient discomfort to require treatment are relatively few.

Braasch and his co-workers presented a study of 230 patients with simple ptosis or ptosis with mild degrees of pyelectasis without other evidence of obstruction at the ureteropelvic area. Approximately one-third of these had no symptoms which were related in any way to the kidneys. In the remainder of the patients, symptoms attributable to the kidney seemed not to be influenced by the degree of ptosis. Of twenty-one patients operated upon, there were more than 50 per cent failures. These poor results from nephropexy may be partly explained by the fact that only patients with simple ptosis or ptosis complicated by minor degrees of pyelectasis were included in the study. It has been my experience in most cases in which delayed emptying or dilatation of the renal pelvis has been found that the ptosis complicated or was complicated by some extrinsic or intrinsic obstructive lesion.

It has been my custom for a number of years to make one radiograph in the upright position in the majority of patients examined. It has been interesting to note the frequent instances of rather pronounced degrees of renal ptosis without any evidence of pathological change in the kidney. Frequently, the disease for which the patient is being examined is in the opposite kidney.

I recall a woman of fifty-two who consulted me because of pain in the left lumbar area. She was reasonably obese and not at all the physical type that one would think of having a nephroptosis. Her health had been excellent. There had never been any evidence of renal pain until the onset of the acute infection. Examination showed a left perirenal abscess and her right kidney sufficiently movable to drop below the crest of the ilium when the patient was in the upright position.

It must be remembered, however, that renal ptosis is a possible predisposing cause of renal pathology. Many years ago Crabtree and Shedden found ptosis of the kidney a frequent causative factor in persistent and recurrent renal infection. Of 3,856 kidney cases treated at the Squiree Clinic between May, 1928, and January, 1938, 263 were found to have symptoms producing nephroptosis, unilateral or bilateral. The outstanding pathological changes were hydronephrosis and pyelitis. J. C. Birdsall studied 150 patients with renal ptosis, and out of this group there were eighty-one instances of hydronephrosis, twenty-two of calculi and fifty-seven of renal infection.

It is, therefore, evident that the treatment of renal ptosis, particularly the selection of patients for surgical correction, depends upon an accurate diagnosis. It is not sufficient to know that the kidney is extremely movable. The effect of ptosis upon the emptying time of the renal pelvis must be determined and evidence of early hydronephrotic changes recognized. The urogram is the most important procedure in making an accurate diagnosis. The intravenous urogram is quite valuable and in some cases gives all the information needed. Needless to say, the picture should be taken in both the recumbent and upright positions. A very good idea of the function of the two kidneys can be obtained. Delayed emptying of the ptosed kidney in comparison with that of its fellow may be noted. Dilatation of one or both pelves will be recognized. A retrograde pyelogram will give more accurate information as to the degree of pelvic dilatation and the emptying time of the pelvis. A renal pelvis which appears only slightly dilated by the intravenous method will often be found to be quite large by the retrograde method. The tip of the catheter should be withdrawn to the lower portion of the ureter while the fluid is being run into the pelvis so that the outline of both pelvis and ureter will be obtained. The procedure is repeated with the patient in the upright position to determine the degree of ptosis. The ureteral catheter or catheters should then be removed and films taken at five- and ten-minute intervals to determine the rate of pelvic emptying. There should be very little contrast substance left in the renal pelvis at the end of ten minutes.

When ptosis of the kidney is discovered accidentally by the patient or incidentally during an abdominal examination by the physician, no treatment is indicated unless there is persistent pyelitis or a history of intermittent attacks of renal infection or other associated renal disease. There is little probability of relieving gastric disturbances or neuropsychiatric manifestations by the treatment of renal ptosis unless the ptosis is also causing sufficient interference with the physiology of the kidney to produce some physical manifestation of renal disease.

I have a very vivid recollection of a woman who was sent to me by a gastroenterologist. She had suffered a long time from colitis. She was a thin woman, forty years of age, and complained of

indigestion almost every day. She complained of abdominal pain most frequently located around the right side of the abdomen and occasionally she had what she described as a tugging and discomfort around the right loin. The gastroenterologist treated her over a period of five or six years. On examination, he repeatedly palpated the right kidney, which was tender. He decided if the kidney were put in place that she would be relieved of her right-sided pain and perhaps some of her gastrointestinal symptoms. A pyelogram showed a decided renal ptosis, but only a suggestion of dilatation of the pelvis. With the enthusiastic approval of the internists and the patient, a nephropexy was done. Now, three years later, there is no improvement in the colitis or digestive trouble and very little improvement in the loin pain. Following this experience, I have insisted that regardless of the patient's symptoms and the degree of renal ptosis, if the renal pelvis is not appreciably enlarged and if it has practically emptied itself of contrast substance in ten minutes, nephropexy is not indicated. I have seen a few patients with reasonably normal pelves complain of intense discomfort when on their feet or moving around, who were completely relieved when lying in bed. These, however, are exceptions.

No patient with a physiologically normal kidney should have a nephropexy done until adequate and prolonged medical treatment has been tried. Many patients who suffer from renal ptosis are undernourished and tire easily. Frequently, freedom from their usual routine duties, rest periods in bed and a diet high in calories and vitamins is very helpful. Exercises designed to improve the posture and the tone of the abdominal muscles and a properly adjusted abdominal support are also useful measures. Abdominal supports rarely hold the kidney in place even with the kidney pad, but the support gives a measure of relief and should be tried when there is no dilatation of the renal pelvis or chronic renal infection.

Nephropexy is indicated when non-surgical measures have failed to relieve incapacitating pain, when there is persistent retention of urine in the renal pelvis, and when there is infection of the kidney unrelieved by medical treatment. When complications such as aberrant vessels, bands of adhesions, or pathological changes at the ureteropelvic orifice can be demonstrated, operative treatment is the only means of relief. Nephrectomy is indicated when the kidney is of no functional value.

The most satisfactory results that I have obtained from nephropexy are illustrated by the following patients:

Case 1.—A young man of about thirty years came into the hospital with an attack of acute abdominal pain. The pain was most severe in the right lower quadrant of the abdomen, but radiated into the right loin. This was the most severe of a number of such attacks which had occurred at varying intervals during the past twelve months. His occupation as meat cutter required him to be on his feet most of the time and on a number of occasions he had found it necessary to return home and lie down before his day's work was finished. The recumbent position almost always gave him a measure of relief. He was referred to the hospital with the belief that he had an acute appendicitis. His surgeon finding pus in the urine did a cystoscopic examination and pyelogram. A very bizarre appearance of the renal pelvis was noted. I was requested to see him, and a complete urological study disclosed a decidedly ptosed right kidney and adhesions at the ureteropelvic area which caused a rather sharp kink when the patient was in the upright position. There was moderate dilatation of the renal pelvis and definite renal stasis. Following the liberation of adhesions and nephropexy, he was completely relieved and gained considerable weight. This operation was performed five years ago, and the patient is now completely well.

Case 2.—A child of thirteen years was assigned to the Urological Service because of an acute attack of pyelitis with chills and fever. She had had many such attacks and had lost much time from school during the previous three or four years. Her renal pelvis was dilated and there was moderate renal ptosis with tortuosity of the upper third of the ureter. At operation there were many bands of adhesions which produced fixed kinks in the upper portion of the ureter. The ureter and renal pelvis were completely liberated and the kidney placed in normal position. The urine was free of infection before leaving the hospital and she has remained entirely well.

Case 3.—A young woman who had complained of urinary frequency, mild attacks of fever and failure to gain weight for a period of five or six years, had recently married a shoe salesman and accompanied him on his trips in an automobile. Following a long day's ride, she frequently noticed soreness in both lumbar areas. While in a distant city, she had an acute attack of pyelitis with chills and fever. On examination, the urologist found that she had bilateral renal ptosis with definite blunting of the calyces of both kidneys. She returned to Richmond, and bilateral nephropexy was done. She has remained well. She can drive all day without soreness or fatigue and has gained considerable weight.

Case 4.—A fifty-six-year-old school teacher was in an automobile accident in December, 1949, and sustained fractures of the fourth and sixth thoracic vertebrae and

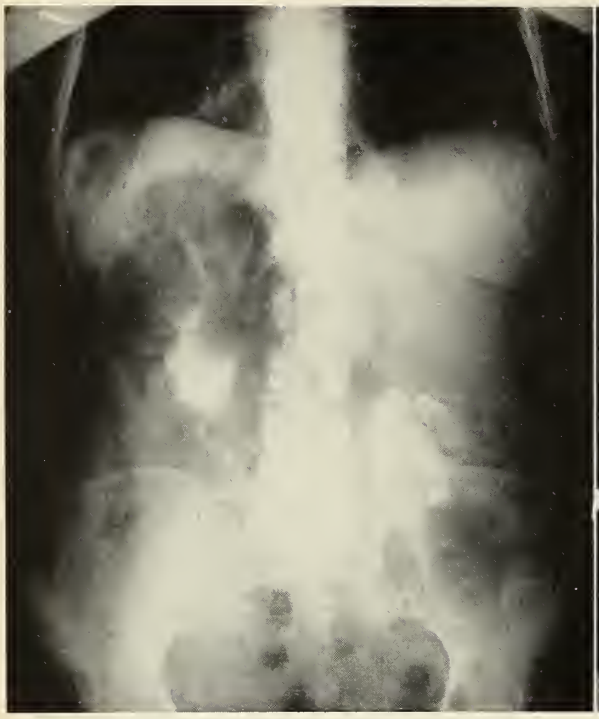


Fig. 1. Definite bilateral nephroptosis with moderate hydronephrosis. While there was narrowing at the ureteropelvic area on both sides, there is little doubt that nephroptosis was a decided causative factor of poor renal drainage.



Fig. 2. Intravenous urogram three months following ureteroplasty and nephropexy. Appearance of calyces has improved. Contrast material can be seen in the ureters. The patient is symptom-free, and the urine is free of infection.

other serious injuries. She was hospitalized for three months and ultimately recovered. Shortly after the accident, she developed hematuria and frequency, and noted inconstant pain in the left flank. She had episodes of chills and fever until the time of admission to the hospital on August 15, 1950. On several occasions, pus was found in the urine on catheterized specimen. All other laboratory studies were normal.

Cystoscopy and retrograde pyelograms were made and showed marked bilateral renal ptosis with apparent obstruction at the ureteropelvic junction on each side (Fig. 1). On the third hospital day, operation was done on the left kidney, including a plastic procedure on the left ureteropelvic junction and nephropexy. The ureteropelvic repair was performed after the method of vonLichtenburg. The patient made an uneventful recovery and thirteen days after the first operation the right kidney was exposed and a Rammstedt type of operation done on the right ureter and the kidney suspended. The patient's convalescence was uneventful, and she was discharged from the hospital eighteen days after the second operation.

Postoperative intravenous urogram revealed excellent position and function of both kidneys (Fig. 2). She has remained symptom-free.

These patients all had evidence of renal stasis. All four had prolonged histories of renal infection as the result of poor drainage. In such cases, an adequate nephropexy is a useful operation.

Numerous methods for suspending the kidney have been devised. Most of these when properly executed in properly selected cases will give good results. The purpose of nephropexy is to place the kidney in a normal position and to add support or create adhesions that will hold it in place, thereby improving drainage and preventing traction on the vascular pedicle and adjacent organs. In addition to the correction of abnormal mobility of the kidney, I find nephropexy useful following plastic operations upon the kidney pelvis or when during any conservative operation the kidney has been completely mobilized. Probably the most important part of the operation is the complete liberation of the upper ureter and renal pelvis and careful dissection of all perirenal fat and fascia from the kidney.

The ptosed kidney is often complicated by adhesions to the ureter, aberrant vessels or ureteropelvic pathology. When these accessory causes of obstruction are not recognized and corrected, unsatisfactory results may be expected. Adequate exposure is necessary so that the kidney, the proximal portion of the ureter, and the renal fossa can be easily seen. After making the incision and ligat-

ing all bleeding vessels the operation is continued by first separating the posterior portion of the perirenal fascia from the lumbar muscles. A longitudinal incision is then made in the fascia about opposite the medial border of the kidney and is extended both upward and downward. A clean incision in the fascia permits it to be reflected forward and preserved intact for use in protecting and supporting the kidney when it has been placed in its normal location. The fascia, after having been divided, is carefully dissected from the kidney and together with the perirenal fat is reflected medially, carrying before it the peritoneum. These structures are retracted anteriorly giving adequate exposure to the kidney and renal fossa. I prefer to divide adhesions to the kidney with scissors to prevent tearing the renal fascia. The kidney thus exposed is held by an assistant while the surgeon separates all adhesions from the upper pole of the kidney beginning at the convex border and continuing around the upper pole until the renal vessels are reached. Small blood vessels entering the upper pole are ligated and divided. Vessels large enough to supply an extensive area of the kidney should be preserved. The kidney is then retracted upward, slightly elevating the lower pole while fat and adhesions are separated from this area. When the ureteropelvic area is reached, the ureter is identified and carefully liberated as far downward as can be done with safety. All adhesions are divided and any kinks or obstructive lesions are corrected. Aberrant vessels are ligated and divided unless they supply an extensive area of the kidney. Adhesions are then separated from the renal pelvis and the ureteropelvic area is examined. If there is stenosis of the pelvic orifice or a high implantation of the ureter, an appropriate plastic operation should be done. The renal fossa is prepared by removing all fat and fascia from the lumbar muscles well above the costal margin. Occasionally the liver encroaches upon this area and light adhesions must be broken up to permit the kidney to be placed in a sufficiently elevated position.

The kidney may then be held in its normal position and retained by any of numerous methods. Personally, I prefer to suspend the kidney by suturing the perirenal fat and fascia to the lumbar muscles beneath the lower pole of the kidney according to the method of Deming. This operation appears to me to be more physiological than other methods. It provides a sling beneath the lower pole of the kidney which, in my experience, always holds it in place. By this method in my hands the kidney can be placed in a more elevated position than by the other procedures. I have never seen the advantage of stripping a portion of the capsule away. Adequate adhesions are formed by leaving the capsule intact.

Following the operation, the patient should lie upon the operated side or upon the back for about a week. I feel that this helps to keep the kidney in a normal position while healing occurs. It is my custom to elevate the foot of the bed just enough so that the hips will be higher than the shoulders. Sufficient elevation to make the patient uncomfortable in bed is not necessary. At the end of about a week, the bed is lowered and the patient is permitted to lie on either side, but is kept flat in bed for a second week. A snug abdominal binder is then applied and the patient is permitted to sit up in bed or in a chair. The patient is allowed to return home in from fourteen to sixteen days, but is advised to avoid strenuous exercise, lifting or long rides for a period of at least a month.

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Painless hematuria from a renal tumor usually means that the tumor has broken into the renal pelvis.

* * *

The painless character of hematuria from a renal tumor causes physicians and patients to disregard the symptom until pain occurs weeks or months later.

* * *

Differential diagnosis of Wilms' tumor should include adrenal neuroblastoma, hydronephrosis or pyonephrosis, congenital polycystic kidney, solitary cyst of the kidney, omental cysts and splenic enlargements.

* * *

The cardinal symptoms of tumor of the kidney are hematuria, pain, tumor, loss of weight and anemia. The most important of these is hematuria.

* * *

The sudden appearance of a varicocele may be caused by tumor obstruction of the spermatic vein by a renal tumor.

* * *

Radioactive iodine is most effective in well-differentiated colloid-forming carcinomas of low malignancy the majority of which are amenable to cure by surgical removal.

* * *

The usefulness of radioactive iodine in treatment of carcinoma of the thyroid is limited to the small group of carcinomas of low malignancy which have metastasized or extended beyond the scope of surgical removal.

Pulmonary Artery Thrombosis

A Case Report

By Rear Admiral Fredric L. Conklin, (MC)
USN (Ret.) and
Lewis E. Litwin, M.D.
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ONLY A FEW more than 100 cases of pulmonary artery thrombosis have appeared in the literature since the syndrome was first reported in 1837. This condition is usually found in older age groups and is often preceded by some form of associated pulmonary or cardiac disease. It is rather insidious in its onset, and frequently the only presenting symptom is dyspnea, which occurs in 90 per cent of the cases. Hemoptysis, cyanosis, cough, and pain are seen less frequently as presenting or associated symptoms. The thrombosis usually extends into both branches of the pulmonary artery, although only one side may be affected. If only one side is affected, it is usually the right. The following case report is quite typical in that both branches of the pulmonary artery were involved, and dyspnea was the only well marked symptom.

Case Report

A seventy-four-year-old white farmer was first seen at Berrien County Hospital on October 16, 1950, with an injury of the left chest which was incurred five days before admission when he fell off a ladder while pruning trees. He stated that he was unconscious after the fall and on two occasions had hemoptysis. During these five days he was treated by a private physician and his chest was strapped with adhesive tape. The family history was negative and history of past health was negative except for an old fracture of the left forearm. Physical examination of the chest revealed many coarse rhonchi in both lung fields. The percussion note was normal throughout. There was tenderness over the entire left chest wall.

Laboratory.—Red blood count 4,900,000. White blood count 13,000, polymorphonuclear leukocytes 75 per cent, lymphocytes 25 per cent. Hemoglobin 88 per cent. Color index 0.9. Kahn test, negative. X-ray on October 17, 1950, showed multiple fractures of the ribs on the left side, with old fractures of the fourth and fifth ribs, and double linear fractures of sixth, seventh, eighth, ninth and tenth ribs. There were fractures of the third to eleventh ribs, inclusive. Urinalysis: Specific gravity 1.032, albumen and sugar absent. White blood cells, 1 to 2 per high power field. Red blood cells absent, occasional hyaline casts seen. Blood pressure 160/90. The temperature, pulse, and respiration remained within normal limits. The patient was given mild sedation. His course was uneventful and he was discharged November 2, 1950, to convalesce at home.

He was next seen in the outpatient department on February 14, 1951, with the complaint of dyspnea on exertion. The blood pressure was 140/100 and the pulse 105. Physical examination of the heart and lungs was essentially negative. There was no ankle edema and no pain or tenderness over the body. At this time it was felt that the patient had myocarditis or possibly arteriosclerotic heart disease with a left ventricular weakness. He was advised to live within the limits of his abilities and was given mild digitalization.

On February 21, 1951, he was seen again in the outpatient department. His complaint at that time was poor appetite. He was given elixir of I.Q.S. and Lextron to stimulate the appetite. The digitalization was continued. The red blood count was 5,050,000, the white blood count 15,100, with 82 per cent polymorphonuclear leukocytes and 18 per cent lymphocytes. The hemoglobin was 87 per cent. Physical examination of the heart and lungs was still negative to percussion and auscultation.

He was readmitted to the hospital on February 26, 1951, at which time he had become dyspneic on mild exertion. He was unable to walk short distances and discovered that he was orthopneic. Physical examination of the heart and and lungs was negative, and there was no pitting edema of the extremities. The blood pressure was 100/78, temperature 97.4° F., pulse 75 per minute, respiration 27 per minute.

Laboratory.—Red blood count was 5,000,000. White blood count 19,200, polymorphonuclear leukocytes 79 per cent, lymphocytes 21 per cent. Hemoglobin 75 per cent. Color index 0.75. Urinalysis showed specific gravity 1.030, albumen 2 plus, sugar absent, and there were red cells and white cells in the sediment. The nonprotein nitrogen was 62 mg. per cent.

The patient was put to bed and given oxygen. An x-ray of the lungs and electrocardiogram were ordered but could not be taken due to the patient's rapidly failing condition. He became progressively dyspneic and slightly cyanotic. The next day the heart action became slightly irregular and faint. The lungs remained clear. He expired February 27, 1951, at 2:15 p.m.

An autopsy was performed with the following pertinent findings in the chest:

Thorax.—When the thoracic cavities are opened, the lungs are found to be approximately 20 per cent inflated. Each lung is bound to the posterolateral parietal pleura by numerous firm fibrous bands. The mucosa of the trachea and bronchi is pale red and moist. The external surfaces of the lungs are pinkish to reddish gray and finely mottled with black. Surfaces made by cutting through the lung parenchyma show considerable crepitation and are well aerated and pinkish to reddish gray in color.

Cardiovascular.—The pericardium is smooth and glistening, and the pericardial sac contains an estimated 25 cc. of clear amber fluid. The heart is approximately twice

normal size, and the myocardium is soft and flabby. Although the chambers are dilated, there is no appreciable hypertrophy of the myocardium itself. The epicardium is smooth and glistening and contains a moderate amount of infiltrated fat. The myocardium is of average thickness and red brown in color. The leaflets of the mitral valve are slightly thicker and more opaque than average normal, and the leaflets of the tricuspid valve and cusps of the aortic and pulmonary valves are essentially normal. The coronary vessels are thick walled and their lumens are approximately 50 to 75 per cent obliterated. In the apex of the right ventricle and intimately adherent to the endocardium is a mass of purple and grayish brown tissue of moderately firm but soft consistence. This tissue is approximately 2.0 cm. thick and has a somewhat laminated appearance. Masses of this same tissue are found to be nearly completely occluding the main branches of the pulmonary artery. This tissue is adherent to the intima at various points and assumes a cylindrical shape corresponding to the lumen of the vessels. It extends into the secondary and tertiary ramifications of the pulmonary artery. In the major branches of the pulmonary artery this reddish brown tissue is intermingled with gray lamina and appears fairly well organized. However, in the smaller ramifications of the pulmonary artery this tissue becomes friable and dark purple in color.

Gross Anatomical Diagnosis.—

1. Pulmonary artery thrombosis
2. Mural thrombus of the right ventricle of the heart
3. Myocardial dilatation
4. Bilateral chronic fibrous pleuritis

Microscopic Autopsy.—

Heart.—Sections reveal a marked hypertrophy of the myocardial fibers. Sections through the mural thrombus described in the right ventricle reveal this organizing blood clot to be attached by fibroblastic proliferation to the endocardium. In one area this myocardium is replaced by a fibrous connective tissue scar which is continuous with the organizing blood clot. Sections of the coronary vessels reveal marked thickening and sclerosis of the walls.

Lungs.—Sections of the pulmonary artery reveal the blood clot described grossly to be an ante-mortem one, which shows evidence of propagation; namely, the deposition of recently clotted blood on the outer layer. There is no evidence that this thrombus is attached to the endothelium of the pulmonary artery. Sections of the lungs also reveal extensive atelectasis in some areas. In addition to the atelectasis, there is evidence of infarction with the hemorrhage within the alveoli showing evidence of organization. In many of the small vessels organizing thrombi can be seen. The remaining alveoli show a marked emphysema.

Final Anatomical Diagnosis.—

1. Myocardial infarction, old, right ventricle.
2. Mural thrombus in the right ventricle, secondary to 1.
2. Pulmonary artery thrombosis, secondary to 1 and 2.
4. Pulmonary atelectasis, secondary to 3.
5. Compensatory emphysema, secondary to 4.
6. Congestion of the lungs, liver, spleen and kidneys.
7. Myocardial dilatation.
8. Bilateral chronic fibrous pleuritis.

Conclusion

Pulmonary artery thrombosis must be included in the differential diagnosis when the chief or only complaint is dyspnea. Ordinarily one considers three common categories when dyspnea is the presenting symptom. These are (1) cardiac disease, (2) pulmonary disease, (3) anemia. If, on the other hand, clinical and roentgenological evaluation of the heart and lungs is essentially negative for physical findings, one must also consider the possibility of pulmonary artery thrombosis. It is significant that cardiac dyspnea and pulmonary dyspnea are generally associated with the finding of râles in the lungs on auscultation. However, if the cause of the dyspnea is pulmonary artery thrombosis uncomplicated by terminal cardiac failure, one may not expect to find râles in the lungs. Pulmonary dryness and absence of râles is considered an important clue in the diagnosis of this syndrome and is the result of the thrombus causing a mechanical decrease in the volume of blood entering the lung tissue.

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Oral Use of Procaine

By Michael E. Ellis, M.D.
Grand Rapids, Michigan

THE USE OF procaine hydrochloride for the relief of pain, pruritus, muscle spasm, ventricular ectopic rhythm and other states by local or intravenous administration is well known. Recently, G. Roka and L. G. Lajtha reported in the *British Medical Journal* (2:1174, May 20, 1950) the use of oral procaine in the abolition of pyloric spasm, as well as to control chronic vomiting associated with gastric ulcer. Its use in the control of severe asthma was reported by M. M. Schapiro and M. Sadove in *Annals of Allergy* (8:85, 1950).

Since procaine is readily absorbed from the gastrointestinal tract, it was thought that if a sufficient amount could be absorbed without ill effect, a generalized systemic effect could be achieved, as it is when procaine is injected intravenously. Several cases are presented who were given oral procaine to relieve their pain and pruritus.

Case 1.—A forty-year-old white woman had infectious eczematoid dermatitis which was pruritic. This was spreading from one area on the extremities to another. She was treated with penicillin parenterally and wet soaks of Burow's solution with aureomycin locally. To control the pruritus she was given oral procaine, 1 gram dissolved in orange juice with sugar, every three to six hours as she needed it. Shortly after the first dose the pruritus was relieved. Each time that it recurred the procaine relieved her. After two days the infection was subsiding and no more procaine was necessary.

Case 2.—A seventy-two-year-old white man was treated at the Mayo Clinic in Jan., 1951, for Hodgkin's disease with x-ray therapy. On May 9, 1951, I saw this man. He had a temperature of 102° F., generalized lymphadenopathy, brownish discolored skin with deep excoriated areas all over the body surface from his digging into the skin. The white blood cell count was 1,600 with 60 per cent lymphocytes, of which 70 per cent were abnormal. Repeat white blood cell counts had the same distribution. He was treated with penicillin daily. To control the severe pruritus he was given 1, then 2, grams of procaine orally in orange juice with sugar every three to four hours. This controlled his pruritus very well. The excoriated skin lesions healed completely. Six weeks later, when the white blood cell count was 4,500 with normal differentials, he was given a course of nitrogen mustard therapy. This gave very little relief. Since then, procaine was used only when the pruritus appeared to disturb him, usually at night. He died of this illness on July 9, 1951, but was kept quite comfortable from the pruritus with the oral procaine.

Case 3.—A forty-six-year-old colored woman with essential hypertension has also the menopausal syndrome with hot flashes followed by sweating. She also has vague muscular aches about the neck and in the left leg. A muscle biopsy was not abnormal. Estrogens relieved the menopausal symptoms. Only codeine or other narcotics would relieve the muscle pains. She was given procaine orally, as above. The pains were relieved for four to six hours. After taking this for about ten days these pains were minimal for a month. Subsequent recurrences of the pain have been relieved by the oral procaine.

Case 4.—A fifty-seven-year-old white woman complained of pain in the left wrist. On examination there was redness, and some swelling and tenderness in the soft tissues about the ulna. She could not rotate the hand toward the ulnar side. She was given salicylates without relief. Then she was given oral procaine, 1 gram every four to six hours. This gave her relief from the pain until gradually the inflammatory process subsided.

Case 5.—A sixty-four-year-old white male developed rheumatoid arthritis of the spine about two years ago. He has been treated off and on with x-ray therapy with relief of the severe pain. Recently, x-ray therapy has not relieved him as much as it did at first. He was given oral procaine in 2 gram doses. This gives him relief for four to six hours.

Case 6.—A twenty-eight-year-old white woman has severe occipital headaches which extend down into both shoulders. These headaches always occur the day after she does sewing and ironing, when she keeps her head down for a long period of time. At the end of the day's work she feels a slight stiffness in the neck and knows that she will awaken with a headache the next morning. She was told to take 2 grams of procaine orally at the end of the day's work when she felt that she was going to have a headache. She has done this. The headaches still occur but are now very mild.

Case 7.—A sixty-two-year-old colored man lifted a heavy piece of equipment one day. A few days later he had severe pain in the region of the left sacroiliac joint. There was spasm of the gluteal muscles in this area. This was injected locally with procaine. He was told to take 1 gram of procaine every four to six hours thereafter. He did not have any more severe pain. In two days he did not need to take the procaine any more.

Case 8.—A thirty-year-old white man has severe midepigastric pain which awakens him from sleep. One upper gastrointestinal x-ray was done. There was marked pylorospasm. This was repeated again in two days. Fifteen minutes before the second study was to be done he was given 1 gram of procaine in 100 cc. of water to drink. There was no pylorospasm present and a satisfactory study was made. No ulcer was found. Since then, he has taken 0.5 gram of procaine orally for the pain. He

gets relief in a few minutes, but must take milk or an antacid to maintain this relief.

Case 9.—A fifty-seven-year-old colored woman had pain in both knees for many months. This was aggravated by being on her feet many hours of the day, and was relieved to a great degree by bed rest. She also complained of occipital headaches on awakening in the morning the past couple of weeks. She was obese, 5 feet 2 inches, weighing 189 pounds. The blood pressure was 190/120. There was a grating feeling on palpation of the knee joints upon motion of the leg. She was given 3 grams of procaine in orange juice every four to six hours. The pain in the knees was relieved to a great degree. She is on a reduction diet and 2 grams of procaine, as needed, to relieve the pain in her knees.

Case 10.—A thoroughbred German Shepherd dog at the age of six months developed a pruritic scaly, erythematous, skin eruption on the abdomen and inner thighs. This was getting progressively worse. It was seen by veterinarians, a dermatologist, and finally at the veterinary school at Michigan State College. Nothing specific could be found as the cause, and no remedy tried was of any value. After four months of illness the dog was given 500 mg. of procaine orally, morning and evening, for a few days, and then 750 mg. in the evening when it bit itself the most. The pruritus was promptly relieved. In about ten days the lesions were almost all healed. In fifteen days there were no more lesions, and the dog was free from pruritus. This has been the longest that the dog has been free of skin lesions or pruritus since it was first discovered.

Case 11.—A thirty-five-year-old white man off and on developed an erythematous pruritic rash on the palms of his hands and on the soles of his feet which lasted a few days. He noticed this more when he got "nervous." He was given 1 gram of procaine orally. This relieved him for a period of three to five hours.

Case 12.—A thirty-year-old woman has had psoriasis since the age of four. Pruritus was marked. She was given 1 gram of procaine orally every three to six hours as needed. This relieved her pruritus for a few doses. Later, it had to be increased to 2 grams at the same interval. The pruritus has been controlled for over one week.

Cases 13 and 14.—Two young men, aged twenty-one and thirty-four, had had substernal pain for one and three years, respectively. No obvious causes for the pain could be elicited by physical examination or x-ray studies. Both were given oral procaine in 2 gram doses. No relief from the symptoms occurred.

Discussion

Procaine hydrochloride is a white crystalline substance easily soluble in water. It has a very bitter taste. For this reason, in order to make it palatable, it was given in orange juice plus sugar. Later, the Pitman-Moore Company supplied some 250 mg. sugar-coated tablets which eliminated the unsavory taste.

The only side effect complained of by three of the patients was a transient lightheadedness when 2 or 3 grams were ingested. Otherwise, it was well tolerated.

Although the number of cases reported here is small, the number of doses of procaine given was large, over 200. In each patient reported who had relief, this occurred regularly after every dose, especially in the cases of pruritus, where objective evidence of cessation of scratching could be seen, as well as the patient's word that relief was obtained.

Graubard and Peterson give an excellent review of the use of procaine parenterally in their monograph "Clinical Use of Intravenous Procaine." They quote references which state that procaine is detoxified mainly by the liver. However, if this is so, a generalized systemic effect could not be obtained by the oral route, as the absorbed procaine passes first through the liver. It may be that in the dosages used by these patients the liver was not able to detoxify all of the procaine immediately after absorption from the gastrointestinal tract, so that enough was present in the circulation to be effective at the site of action.

Summary

Oral procaine was effective in the relief of severe pruritus and some types of pain, namely pylorospasm and arthralgic and myalgic states. The dosages ranged from 1 to 3 grams every three to six hours.

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Studies on the Metabolism of the Isolated Islet Tissue of Fish by Means of Micro-Analytical Techniques and Their Relation to the Diabetes Problem

ARNOLD LAZAROW, M.D., Ph.D.
(Department of Anatomy, Western Reserve University, Cleveland, Ohio)

The finding that alloxan produces selective necrosis of the beta cells of the pancreas (Dunn, Sheehan, and McLetchie) has suggested that chemical agents similar to alloxan may play a role in causing human diabetes. In order to learn more about the mechanism of alloxan action, we have studied the chemical properties and the diabetogenic potency of a series of compounds related to alloxan. It was found that although alloxan reacted with sulfhydryl groups, a simple reduction product of alloxan i.e. dialuric acid, did not produce diabetes nor did it combine with sulfhydryl groups. The injection of sulfhydryl compounds (glutathione, cysteine, and BAL) immediately preceding a diabetogenic dose of alloxan, protected rats against the development of diabetes. Since other investigators have shown that active sulfydryl groups are necessary for the action of a number of enzymes, we have suggested that alloxan produces diabetes because it combines with essential sulfhydryl groups of enzymes.

Although large doses of alloxan will kill other cells, small doses selectively destroy the beta cells. This selectivity of alloxan for the insulin producing cells may result from their biochemical specialization. Insulin is an unusual protein in that 12 per cent of its amino acid residues are cystine. (Cystine is the oxidized form of the sulfhydryl amino acid, cysteine). Presumably, during the synthesis of insulin, cysteine is oxidized to cystine. The synthesis of insulin may therefore produce a localized depletion of sulfhydryl compounds such as glutathione within the beta cells and thus explain the selectivity of alloxan.

Although alloxan can be reduced to a non-diabetogenic derivative, i.e. dialuric acid, this product is reoxidized to its diabetogenic derivative by cytochrome *c*. Since cytochrome *c* is capable of oxidizing the sulfhydryl group of cysteine to its disulfide derivative (cystine), it is possible that the specialization of the beta cells for insulin synthesis would selectively favor the accumulation of diabetogenic compounds in these cells in addition to depleting their sulfhydryl groups.

We have undertaken a study of the enzyme systems in islet tissue by using fish as an experimental animal. In the toadfish the insulin-producing cells are separated from the ascinar tissue and they are concentrated in a principal islet located in the mesentery. We have shown that alloxan injection produces diabetes in fish. Although the islet weighs only a few milligrams, it is possible, by means of micro analytical techniques, to carry out micro colorimetric, micro-titrometric, micro-gasometric, and micro-respirometric analyses on a single islet. Details of the various micro-analytical methods were discussed. Using the cartesian diver, respirometric studies were carried out on samples of tissue weighing only 0.1 milligram. The distribution of the enzyme systems which reduce and oxidize cytochrome *c*, i.e. cytochrome oxidase and succinic-dehydrogenase have been studied. It was found that the quantitative distribution of these enzymes in the islet tissue differs markedly from most other tissues studied. We are now characterizing the other enzyme systems of islet tissue and determining the effect of alloxan on these enzyme systems. It is hoped that these studies may aid in understanding the cause of human diabetes.

Business grants to education and research ought to be increased, says Beardsley Ruml. He urges business to take full advantage of the Federal tax laws permitting corporations to deduct 5% of their total net income before taxes for educational, scientific, and welfare purposes. In a pamphlet issued by the National Planning Association, he states that deductions for this purpose have been running less than 1%. Contributions of this type create good will for the companies.

Detroit Surgical Association

MEETING OF OCTOBER 22, 1951

Fat Embolism: A Clinical Investigation

M. M. Musselman, M.D., W. W. Glas, M.D., and T. D. Grekin, M.D.

Fat embolism may be expected in about one-half of all persons who have been either moderately or severely injured. It is most common in persons with fractures and burns but will occur in about one-fourth of the patients with other injuries. Significant symptoms will develop in at least one-third of the patients with fat embolism.

The symptoms are frequently confused with those of delirium tremens, post-traumatic psychosis, pulmonary contusion, bronchopneumonia, cardiac contusion, and surgical shock. About 10 per cent of the patients having fat embolism will die as a result of it.

A diagnosis of fat embolism is justified in a patient who has suffered injury and exhibits characteristic clinical manifestations, no other cause for which can be demonstrated. The diagnosis may be supported by the demonstration of characteristic pulmonary changes in the x-ray. We agree with those who believe that the demonstration of free fat in the urine is a practical and reasonably accurate test for fat embolism.

The Arterial Blood Supply of the Human Stomach

Lyle Jacobson, M.D., John R. Brown, M.D., and John W. Derr, M.D.

The arteries of the stomach have been restudied by latex injections of fresh human autopsy specimens. Injections were carried out with all vessels intact, after which the relative importance of the left and right gastric and right and left gastroepiploic arteries was determined by injecting each after ligation of the other three. Resulting specimens, cleared, demonstrate the abundant anastomoses within the gastric wall and the relative proportions of the blood supply which are or can be contributed by each of these vessels. The results are of great interest in relation to operative procedures upon the stomach.

Transposition of the Ileocolic Segment as Food-Pouch after Total Gastrectomy

D. Emerick Szilagyi, M.D.

From the Department of Surgery of the Henry Ford Hospital

In order to alleviate or remedy the nutritional problems of the totally gastrectomized patient, which to a considerable degree are due to the lack of space for holding the ingested food, Lee has recently recommended the interesophagoduodenal transposition of the ileocolic segment to serve as a food reservoir after total gastrectomy.

This procedure, which appears to have sound anatomical merits, has been carried out at the Henry Ford Hospital in three cases of total gastrectomy for cancer. One patient died eleven days after his operation from generalized peritonitis apparently originating in acute (traumatic) pancreatitis. One patient, a man of sixty-five, lived for six months before succumbing to a recurrence of his original disease, and one patient, a sixty-two-year-old woman, is alive and well eleven months after her operation.

In the last-named two cases studies were carried out on the secretory and motor functions as well as holding capacity of the food-pouch and on the patients' utilization of proteins, fats, and carbohydrates.

From the clinical and laboratory observations made in these cases the following conclusions can be drawn: The fashioning of a substitute stomach out of an ileocolic segment after total gastrectomy is a relatively simple technical task. The added surgical trauma the operation entails is not prohibitive, but it can be assumed to increase long-range mortality and morbidity rates. It is too early to estimate whether the advantages this procedure affords as regards the patients' nutritional rehabilitation are commensurate with

its complexity and its expected greater operative risk. Some of the unpleasant symptoms of conventional total gastrectomy have been corrected by the man-made food-pouch. However, the return of gastrectomized patients to relatively normal eating habits and adequate food utilization even after ileocolic transposition is a matter of gradual readjustment quite similar to that after conventional total gastrectomy. With the ileocolic pouch this readjustment may be quicker and somewhat more nearly complete. The procedure deserves further evaluation.

MEETING OF NOVEMBER 26, 1951

Operative Treatment of Spinal Cord Compression in Paget's Disease

Fred Lattimer, E. S. Gurdjian, M.D., and J. Webster, M.D.

Generally speaking, therapy of any type in Paget's disease has proved disappointing. The surgical treatment of spinal cord compression in Osteitis Deformans has also been viewed with pessimism by some.

However, three cases of cord involvement by bone proliferation are presented in which the results of treatment were satisfactory, although admittedly only palliative. Management consisted of localization of the lesion by myelography followed by surgical decompression of the involved segments of laminectomy.

An Evaluation of the Transmetatarsal Amputations in Peripheral Vascular Disease

Herbert E. Pedersen, M.D., and A. Jackson Day, M.D.

The combination of reduced surgical mortality and morbidity, and increased life expectancy in the elderly patient with peripheral vascular insufficiency makes function a basic consideration in selecting the level of amputation. Early transmetatarsal amputation, when gangrene of toes appears, leaves a good functioning stump for which no prosthesis is needed, and may prevent the necessity of a major amputation.

Twelve consecutive transmetatarsal amputations are presented. In three there was primary healing, and in five secondary healing. One patient is still healing, one is a probable failure and two were failures. The possibility of success can be best assessed by noting the extent of gangrene and the nutrition and warmth of the skin of the foot. Healing occurs frequently in the absence of a palpable pulse below the femoral vessels, and in spite of gross wound infection. There was no evidence that previously performed lumbar sympathectomies contributed to success. Unless one is prepared to treat delayed healing the operation should not be performed. It is felt especially significant that in the presence of an open lesion of the toes, severe rest pain may be relieved by transmetatarsal amputation when conservative measures, including sympathectomy have failed.

MEETING OF DECEMBER 17, 1951

The Effect of Direct Implantation of the Common Bile Duct into the Duodenum: An Experimental Study

Alfred Large, M.D.

The recent controversy concerning the most satisfactory method of reconstruction of the common bile duct prompted this study. Dogs were used as experimental animals. Following previous obstruction of the common bile duct, this duct was anastomosed directly to the duodenum, and the subsequent progress of the animals observed for periods up to 18 months. The effects of elimination of the sphincter of Oddi from the extrahepatic biliary system were discussed, together with certain clinical implications.

Development of the Human Shoulder

Ernest Gardner, M.D.

The shoulder joint has a pattern of development which is basically similar to that for other

large synovial joints, such as knee, hip and elbow. The axial condensation or blastema of the limb buds becomes segmented in the region of future joints. The segmentation is indicated by what is termed a homogeneous interzone. This cellular region becomes less cellular in its middle portion and thus acquires a three-layered appearance. This middle lighter portion is directly continuous with adjacent mesenchyme which is becoming part of the joint and which is distinguished by the fact that it is vascular. This vascular mesenchyme gives rise to synovial tissue, to capsule and to intra-articular structures such as glenoid lip, cruciate ligaments and menisci. At the time that an interzone becomes three-layered, all adult characteristics such as recognizable shape, ligaments, muscles, nerves, are present. This stage is reached before the end of the embryonic period and the time from blastema to a formed joint is probably two weeks or less, that is, the period from six to eight weeks of development. Subsequent changes are mainly maturation, although villi, some bursae, intra-articular fat and other structures do not appear until later in the fetal period. The fetal stage is particularly valuable for studying many anatomical features not readily demonstrated by dissection. For example, various vursae and ligaments, such as the subscapularis bursa and its relationship to the glenohumeral ligaments, can be readily studied in serial sections of fetal shoulders.

Mitral Commissurotomy for Multiple Valvular Lesions

James B. Blodgett, M.D.

This is a report of seventeen consecutive mitral commissurotomies carried out at the Grace Hospital. Commissurotomy was done for patients with progressive failure when the primary valve lesion was mitral stenosis. Moderate degrees of associated valve lesions, particularly mitral regurgitation and aortic regurgitation were not considered contraindications to operation since increased ventricular filling permitted by commissurotomy might be considered to permit functional compensation for the associated valve defects.

The group of seventeen, consists of four patients with "pure mitral stenosis"; seven patients with mitral stenosis and mitral regurgitation; two patients with mitral stenosis, regurgitation, and aortic regurgitation; four patients with mitral stenosis, regurgitation, aortic regurgitation and aortic stenosis. One patient had all four valve lesions plus tricuspid insufficiency. The age distribution was from twenty-five to fifty years. There were fourteen women and three men. Four patients had suffered arterial emboli before operation; two, pulmonary emboli.

During operation direct writing electrocardiograms were taken on all patients. Two patients had cardiac arrest during the operation with uneventful resuscitation. Lateral commissurotomy only was done on all patients. The postoperative valve size in ten cases was approximately 2.3 square centimeters; in seven, about 4 square centimeters. There was one hospital mortality which occurred as a result of an operative hemorrhage from a fracture of the auricle wall.

Of the sixteen patients discharged from the hospital, thirteen are distinctly improved, as measured by their increase in functional capacity. Two were moderately improved to such degree as to make the procedure worthwhile. One patient who had five valve lesions was moderately improved for six months when she began to have recurrent pulmonary emboli and terminated her own life at the end of a year. No patients have shown any sign of recurrence of the mitral stenosis.

The preoperative, operative and postoperative care is discussed. The quantitative functional improvement of each patient is measured by the increase in stair climbing capacity—this is represented in graphic form.

Michigan Hospital Service (Blue Cross).—E. Dwight Barnett, M.D., President, and W. S. McNary, Executive Vice President, of Michigan Hospital Service, are most anxious to see that information furnished by their district office personnel is accurate and is given in a courteous manner. Writes Mr. McNary: "The best way the medical profession can aid us in taking constructive action to correct any untoward situations which may exist is to give us the complete details of any actual complaints which reach them. We should have the data on any such incidents just as quickly as possible after they occur."

Through this praiseworthy co-operation, the medical profession is assured of good accurate service in the Michigan Hospital Service-Michigan Medical Service (Blue Cross-Blue Shield) branch offices.

Editorial

LYMPHATIC LEUKEMIA IS CANCER

THAT lymphatic leukemia is cancer is now a recognized fact but many years ago such was not the case. The Editor, in 1908, read a paper before the Michigan State Medical Society annual session in June, which was published in THE JOURNAL on January, 1909, entitled "Lymphatic Leukemia with Report of Three Cases." Quoting from Page 10:

"There were many poikilocytes present as well as various sizes of red cells; a large number of polychromatiphilic red cells and an equally large number with only rings of hemoglobin. There were a few normoblasts, with mitotic nuclei, and six large lymphocytes undergoing karyokenesis. Hydrops of nuclei was present in a few cases, and some of the lymphocytes were vacuolated. On the day of death I found five large lymphocytes in the process of cell division."

Several paragraphs were given to the discussion of the possibility that leukemia might be malignant, and then:

"Personally, I accept this theory, believing that the disease is due to a malignant change in the blood-forming cells of these blood-forming organs . . . I found a few mitotic figures in the large lymphocytes of each of these cases . . . In Case I there were a few red cells with mitotic neuclei."

In the descriptions also was mentioned the fact that we found small unaccountable cocci present in nearly every smear. During the discussion following the paper, George Dock, M.D., then Professor of Medicine at the University of Michigan, said many had looked for these figures but only artecfacts had been reported previously.

ANOTHER CREEP IN CREEPING SOCIALISM

THE PROPOSED Covenant of Human Rights now before the United Nations, if adopted and ratified by the Senate, will commit the United States to a permanent, all-out welfare state and Socialist program.

The provisions which will have this appalling effect are found in Part III of the Covenant, which section is entitled "Economic, Social and Cultural Rights." Article 19 provides:

"The states (nations) parties to the present covenant . . . undertake to take steps, individually and through international co-operation, to the maximum of their available resources, with a view to achieving progressively the full realization of the rights recognized in this part of the present, covenant."

These so-called "rights" which the *Government* of the United States would seek to achieve progressively include, under the terms of the Covenant: (1) The right of everyone to social security; (2) the right of everyone to adequate housing; (3) the right of everyone to an adequate standard of living and the continuous improvement of living conditions; (4) the right of everyone to just and favorable conditions of work—including, among other items, "periodic holidays with pay"; (5) the right of everyone to enjoyment of the highest standard of health obtainable, and (6) the right of everyone to education.

(These above two paragraphs are quoted from the weekly News Letter of Congressman, Paul Shafer, February 18, 1952.)

Article VI of the Constitution of the United States, second paragraph, reads: "This Constitution and the Laws of the United States which shall be made in Persuance thereof; and all Treaties made, or which shall be made under the authority of the United States shall be the supreme Law of the Land; and the Judges in every State shall be bound thereby, any Thing in the Constitution or Laws of any State to the Contrary notwithstanding."

The Covenant of the United Nations has been held by The Supreme Court to be the same as a treaty, and like some other covenants and agreements is in effect the Law of the Land. Now consider *four* other paragraphs from Mr. Shafer's letter:

"No one disputes that these are legitimate aspirations of free men everywhere. But that is something vastly different from legal 'rights,'

(Continued on Page 498)

President's Message



To Every Member,
Michigan State Medical Society.

Dear Doctor:

The new MSMS brochure of the proposed Beaumont Memorial on Mackinac Island, honoring Dr. William Beaumont, gives you, to a slight degree, some information of the project undertaken by your State Society.

The contributions made by Dr. Beaumont to medicine are too numerous to list in this letter, but to express it briefly, "He was the pioneer physiologist of this country, the first to make an important and enduring contribution to this science."

By reconstructing the American Fur Trading Company Store where Doctor Beaumont began his famous work, we can symbolize the thought that service to humanity is the basis of the profession of medicine. Each individual doctor of medicine in the State of Michigan should take a personal pride in the restoration of this medical landmark.

I am suggesting that every M.D. in Michigan join with the rest of us in subscribing the relatively small amount of $40,000. With over 5,000 members in our Society, the individual contribution need not be large.

Your contribution now to the Beaumont Memorial will allow us to start work this spring on what should become a shrine to every doctor of medicine.

Sincerely yours,

Otto O. Becke

President, Michigan State Medical Society

ANOTHER CREEP IN CREEPING SOCIALISM

(Continued from Page 496)

which the so-called Covenant on Human Rights would have guaranteed by government. And the Covenant asserts the Socialist-Communist doctrine that these rights 'are provided by the state.'

"Obviously, the Government of the United States could not make such a pledge or undertake such an obligation without committing itself to a permanent welfare state and Socialist order. Note, for example, the further provision regarding 'the right of everyone to enjoyment of the highest standards of health obtainable.'

"With a view to implementing and safeguarding this right each state (nation) party hereto undertakes to provide legislative measures to promote and protect health and, in particular . . . to provide conditions which would assure the right of all to medical service and medical attention in the event of sickness.

"It is one thing for Americans to seek—as they are seeking—the highest standard of health and medical service obtainable. It is quite another thing for the government to guarantee this by legislative measures which, obviously, could only mean socialized medicine."

On reading of these frequent nibbles or gestures toward the socialist state, or the nationalization of some department or area of medical care one is often prompted to consider that each one may fail; or none may be a big advance, forgetting that the sum total is amazingly large. These Utopian planners, the sponsors of such schemes are playing for keeps; they mean business, and will not desist.

The American Bar Association considers the premise at the beginning of this editorial to be of alarming significance. Witness two editorial comments:

BAR BOARD OPPOSES UN SOVEREIGNTY

The American Bar Association Board of Governors, meeting here, recommended that the association's House of Delegates propose a constitutional amendment to insure that no United Nations covenant or other foreign treaty supersede any domestic laws.

The board also favored rejection of the UN press covenant governing American foreign correspondents and the idea of an international criminal court.

The board recommended approval of a report from the Committee on Peace and Law through the UN, of which Alfred J. Schweppe, Seattle, Wash., is chairman.

Opposition to this report is expected from the Section on International and Comparative Law, headed by Lyman Tondel, of New York. This committee has often reflected the views of the State Department.—*Chicago Tribune,* Feb. 22, 1952.

CHARTER vs. CONSTITUTION

The American Bar Association's Board of Governors has recommended that its House of Delegates propose an amendment to the Constitution that would prevent any United Nations covenant or other foreign treaty from superseding domestic laws in the United States.

A similar purpose is behind the "Ohio Amendment" which Senator Bricker proposed earlier this month in the Senate, with the support of Senator Taft and more than 50 of their colleagues of both parties.

The effect of such an amendment would be to take out of the Constitution the provision that makes all treaties ratified by Congress "the supreme law of the land." The United States is the only member of the United Nations whose constitution elevates treaties above domestic law.

The American Bar Association has long fought the ratification of such multilateral treaties as the Genocide Convention and Covenant on Human Rights solely because of this provision, which was written into the Constitution when no one dreamed that it would ever be used to make over our whole internal political setup.

The loophole through which influential groups are now seeking to substitute UN sovereignty for United States sovereignty should be promptly and firmly plugged.—*Detroit Free Press,* Feb. 26, 1952.

GENERAL EISENHOWER AND SOCIALIZED MEDICINE

—On January 7, 1952, General Eisenhower announced that he was a Republican, and if offered the nomination for President would accept. He would make no statement of policy, and has made none. Other candidates have expressed themselves on the subject of compulsory health insurance as some wish to call it, but not the General.

Senator Henry Cabot Lodge, General Eisenhower's national campaign manager, just back from a conference with the General, spoke at a CIO convention in Boston as reported in an article entitled "Inside Labor" by Victor Riesel which appeared in a recent issue of *Labor.*

Quoting from the article:

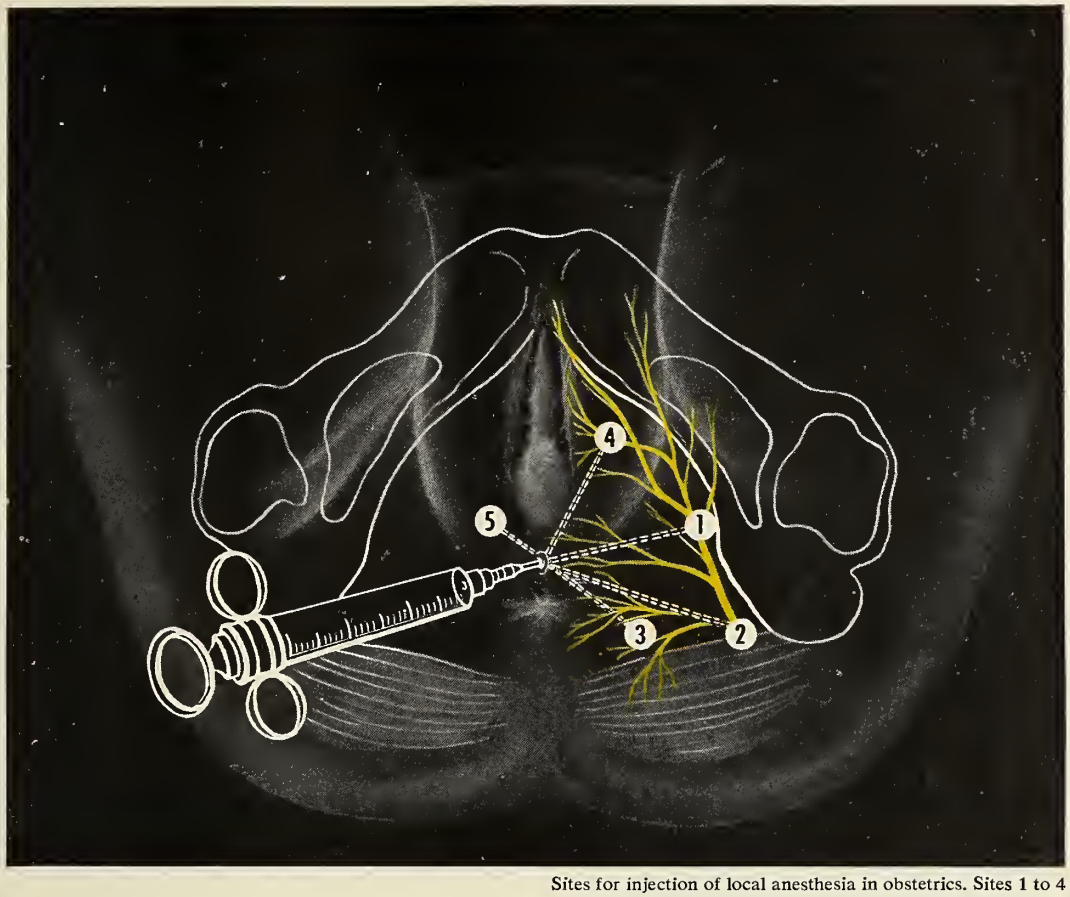
"Then down to the platform he went, and for the first time, an important policy-making Eisenhower spokesman outlined a domestic program. He attacked corruption in Washington, blamed the administration for failing to build a durable peace, and literally quoted the high prices of bread, hamburger, milk, lamb, right down to coffee."

We skip considerable, but quote the following:

"If Senator Lodge did not come out for socialized medicine, he came closer to it than he believes. The Eisenhower sparkplug said:

" 'We should consider measures (which) will in-

(Continued on Page 518)



Sites for injection of local anesthesia in obstetrics. Sites 1 to 4 should be similarly injected on the contralateral side. Site 5 is for episiotomy. Adapted from Johnson, O. J.: Nerve Block in Painless Childbirth, J.A.M.A. *145*:401 (Feb. 10) 1951.

Pudendal Block in Obstetrics Simplified with **ALIDASE**

Using a local anesthetic with hyaluronidase, Heins[1] reports: "Complete perineal anesthesia is practically instantaneous. . . . The technique of pudendal block is greatly simplified. The operator does not have to inject the nerve per se, but infiltration in the vicinity of the nerve will accomplish an effective block."

Baum[2] states: "The use of hyaluronidase is found to be a safe and simple method for increasing the efficiency of pudendal block in obstetrics and for overcoming many of the objections to this type of obstetrical anesthetic."

ALIDASE®—highly purified, well tolerated brand of hyaluronidase—definitely shortens the period between completion of the block and establishment of operating analgesia. Swelling, induration and discomfort are almost negligible with Alidase.

[1]Heins, H. C.: Pudendal Block with Hyaluronidase, J. South Carolina M. A. *46*:309 (Oct.) 1950.
[2]Baum, F. E.: The Use of Hyaluronidase in Pudendal Block, Am. J. Obst. & Gynec. *60*:1356 (Dec.) 1950.

ACCEPTED COUNCIL ON PHARMACY AND CHEMISTRY AMERICAN MEDICAL ASSOCIATION

RESEARCH IN THE SERVICE OF MEDICINE **SEARLE**

Michigan's Department of Health

Albert E. Heustis, M.D., Commissioner

Revised immunization recommendations of the Michigan Department of Health stress the use of triple combined antigens starting at three months of age followed by three more doses at monthly intervals.

The Department recommends that the smallpox vaccination be given at five months of age so the reaction can be read when the child is six months old and returns for his fourth dose of triple vaccine.

There have been no changes in the recommendations for booster doses.

The revised immunization schedule has been recommended by the State Health Department with the approval of the Child Welfare Committee of the Michigan State Medical Society, the Academy of Pediatrics (Michigan Branch) and the Department of Pediatrics, University of Michigan.

The suggested schedule that appears below can be modified in many ways by the use of single antigens and by varying the ages at which certain antigens are given.

Age	*Dosage*
3 months	One dose of diphtheria toxoid alum precipitated, tetanus toxoid alum precipitated, and pertussis vaccine (15 billion organisms) combined.
4 months	Repeat above.
5 months	Repeat above; vaccinate against smallpox.
6 months	Repeat triple antigens and read smallpox vaccination.
2 to 3 years	Repeat triple antigens; do a tuberculin test.
5 to 6 years	One dose of diphtheria toxoid alum precipitated and tetanus toxoid alum precipitated combined; repeat smallpox vaccination.
10 years	Repeat double antigen and smallpox vaccination.

* * *

Construction has finally begun on the new building to house the Western Michigan Section of the Division of Laboratories, replacing the obsolete structure which has served since the laboratories were established there in 1926. Service to southwestern Michigan counties will be greatly facilitated by adequate quarters.

* * *

The Department's training facilities are constantly in use by a wide variety of students. Eleven students started work March 3 in the Laboratory Training School. Of these, five are from Michigan State College, two from Albion College, one from the Michigan College of Mining and Technology at Houghton, one from College of St. Teresa, Winona, Minnesota, and one a special student from Flint. Police Administration students from MSC spend a week in the Department's Crime Detection Laboratories as a part of their course. One MSC Public Administration Student is working in the Division of Administrative Services on inter-organization communications, and a PHS trainee is getting field training in x-ray techniques in the Division of Tuberculosis and Venereal Disease Control.

* * *

"Hearing Aids for Children," a mimeographed booklet prepared by the Hearing Conservation Service of the Section of Maternal and Child Health, is written for parents of children for whom a hearing aid has been recommended. It advises on selection and care of instruments and reprints the Trouble Shooting Chart prepared by S. Gordon Taylor. Copies of the booklet are available to any physician wishing to use them.

* * *

Charles Scott Miller, M.D., resigned as director of the Mecosta-Osceola District Health Department. Mr. Lloyd C. Rehkopf, sanitarian, was appointed acting director.

* * *

The Michigan Department of Health is now legally responsible for licensing and bonding persons, including partnerships, associations and corporations engaged in servicing and cleaning septic tanks, seepage pits and cesspools. The law, Act 243 P.A. 1951, requires that any person engaged in this work in Michigan after July 1 have not only the license and bond to operate his business but also a license for each truck or vehicle transporting the wastes.

* * *

Rheumatic fever was the subject of a state-wide news release from the Department which emphasized that each year it took the lives of more children of school age than any other disease, and urging immediate attention of a physician to minimize danger of heart damage.

* * *

"Mental Health in Community Health Program" was the topic of a three-day conference in Ann Arbor on March 27, 28 and 29 sponsored by the University School of Public Health, the Michigan Department of Mental Health, the Michigan Department of Health and the Michigan Society for Mental Health. Planned primarily to help health officers to develop more effectively integrated programs of mental health using existing facilities, the conference was attended by health directors and members of their public health nursing staffs.

* * *

Physicians are asked to suggest to persons inquiring about birth certificates that they may save time by trying first through local sources before writing or visiting the Michigan Department of Health. Certified copies can usually be obtained from the County Clerk of the County in which the person was born or through the clerk of the city, village or township.

Legal Opinions

Wm. J. Burns, Executive Director
Michigan State Medical Society
Lansing 15, Michigan

Dear Mr. Burns:

You have referred to me for opinion an inquiry which states that three general practitioners who do their own surgery and OB are forming a "partnership or association." His questions: "If we take the name of 'X Clinic,' do we assume a greater responsibility or liability? Would 'X Medical Group' be better? Does 'clinic' assume we are a charitable or non-profit group?"

The meaning of the first question is not clear. If by it, it is meant whether or not a partnership results in any greater liability to the partners, then the answer is "Yes," to the same extent that any partner assumes liability and responsibility for the acts and obligations of the partnership. If by the question it is meant whether a greater legal liability is incurred through the use of the name "X Clinic" rather than the designation of the partnership as "X Medical Group," or merely by the names of the partners, the answer is "No."

As to the second question, it is not possible to determine from the facts given whether "medical group" or "clinic" is the "better" designation. From a legal standpoint, there is probably little choice.

The answer to the third question is "No."

As to the implications arising from the use of the word "clinic" bearing perhaps on the ethical propriety of its use by doctors of medicine, reference is had to a discussion entitled "What is a Clinic" in the September, 1951, number of THE JOURNAL of the Michigan State Medical Society on page 980.

Very truly yours
J. JOSEPH HERBERT
Legal Counsel

December 11, 1951

Wm. J. Burns, Executive Director
Michigan State Medical Society
Lansing 15, Michigan.

Dear Mr. Burns:

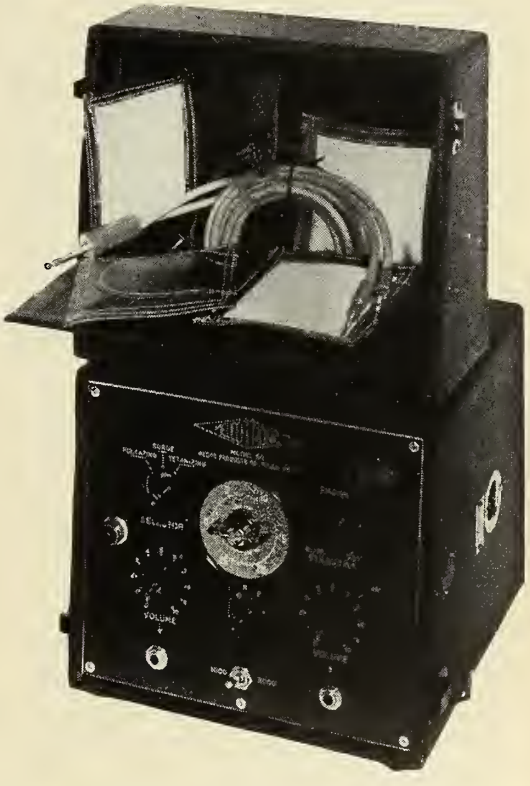
Concerning a recent inquiry on the following matters:

May an attending physician order intravenous medications or materials to be given by registered nurses, laboratory technicians, or others, to his patients at the hospital, and have them administered outside of his immediate presence either while the physician is in the hospital building or absent from the hospital building?

The attending physician may properly order intravenous medications, blood transfusions, injection of dyes, etc., to be performed by persons who are qualified so to do, and authorized by law to engage in such procedures. Except in emergencies, and when the attendance of a physician is not available, nurses are only authorized to undertake such procedures under the direction and supervision of a licensed physician.

MEDCOTRON STIMULATOR MODEL 50

For the stimulation of innervated muscle or muscle groups . . . In rehabilitation therapy, ancillary to treatment by massage . . .



The Medcotron Stimulator, Model 50, operates on 110 volt, 50 to 60 cycle alternating current. The current generated by the apparatus is non-sinusoidal alternating current. Output circuits have no direct connection to the power supply. The maximum voltage output is from 15 to 18 volts R.M.S. The protective mechanism consists of a 1 amp. line fuse that will open, should a short circuit ever occur.

By means of the Medcotron Pad Electrodes the current from the Stimulator is applied to individual muscles or groups of muscles, with comparative freedom of discomfort to the patient. Control of stimulation is attained by the operator regulating the type of stimulus provided, and the voltage and frequency of the current.

NOBLE-BLACKMER, Inc.

Jackson, Mich.

Phone 28148

Implicit in the question, however, is the degree of direction and/or supervision which is required by the law. The statutes do not specify in exact terms the extent of supervision. Because the doctor has a direct responsibility and liability for the proper medical care and treatment of his patient, his duty requires him to exercise the necessary care and diligence in carrying out such responsibility. If a doctor delegates to persons procedures for the benefit of the patient, which such person is not authorized by law or is not competent to carry out, he is in violation of his legal duties and must be prepared to take the consequences of an untoward result.

Whether the physician must be immediately present when the nurse or technician undertakes the intravenous procedure will depend on the condition of the patient, the competence of the person undertaking the procedure, the extent of medical hazard of the particular procedure, and upon a variety of circumstances which must be gauged by the judgment and medical sense of the physician. There are certainly some intravenous procedures in ordinary cases which nurses are competent to perform, even without the immediate presence of a physician, and, indeed, are customarily so performed. In such cases, it would not seem to be material whether the physician were within or without the hospital. On the other hand, there are cases which should indicate to the medical judgment of the physician that he should be personally present, or, at least, be readily available to the nurse to whom the directions have been given. No categorical rule in this regard can be laid down to cover every case. The doctor's duty is to employ his best skill and apply the accepted and recognized methods of treatment and procedure as practiced in his community.

The nurse or other assistant working under the direction and supervision of the doctor is also required to use skill, good judgment, and accepted practice, and is liable for the failure to perform such duty.

To carry out its responsibility, the hospital should establish and maintain proper rules of procedure conducive to good medical care, insofar as hospital procedures are concerned, and has the duty of exercising care in the selection of competent and skilled nurses, technicians, and other hospital assistants. Whether or not a hospital is actionably liable for the breach of these duties by reason of the fact that it is a charitable or public institution does not seem to be relevant to the present inquiry.

Thus, it may be seen that the answer to the question involves something more than legal considerations. It would be wise for the hospital administrator, the governing board, and medical staff to acquaint themselves with the recommended practices in this regard, as adopted by recognized hospitals and clinics of high standing. Usual practice in good hospitals and clinics is often accepted by courts as a criterion of duty. That is not to say, however, that small rural hospitals are necessarily to be governed by criteria of practices in large city or teaching hospitals.

The duty of the physician in the given case may be summarized as follows: The attending physician is primarily responsible for the proper medical care and treatment of the patient. If he delegates intravenous procedures to another, it is his duty (1) to see to it that such person is authorized by law to undertake the procedures generally, and is competent, skilled and instructed in the performance of the delegated act; (2) to exercise the degree of supervision and direction of the procedure which a reasonably careful physician would exercise under like or similar circumstances, having regard for the experience, skill, and training of the person delegated to perform the act, the condition of the patient, the relative difficulty and hazard of the particular procedure and all other pertinent factors; (3) to abide by all reasonable regulations of the hospital applicable thereto.

Very truly yours,

J. Joseph Herbert
Legal Counsel

January 24, 1952.

Sickness absenteeism in industry now claims 400 million to 500 million man-days a year, with a loss of 4.2 billion dollars in wages and a corresponding loss in production and profits. Dr. Rusk, in an article in the *New York Times* (August 5, 1951), contends that adequate in-plant medical services can reduce such losses. "During World War II sickness absenteeism rates in industrial plants with inadequate or poor medical services varied from 4 to 6 per cent daily as compared to 2 to 3 per cent in plants where good medical services were available." The report asserts that "the great majority of workers today are employed in plants that have little or no medical services except routine pre-employment physical examinations."

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Correspondence

Wilfrid Haughey, M.D., Editor
Journal of the Michigan State Medical Society
Battle Creek, Michigan

Dear Doctor Haughey:

As you know, we were very happy with the December (Heart) issue of THE JOURNAL of the Michigan State Medical Society. We were particularly proud that this bulky issue of THE JOURNAL was devoted exclusively to articles from workers whose investigations were supported by means of grants from the Michigan Heart Association.

We have been flooded with very laudatory comments to an extent not previously encountered and are fairly glowing with satisfaction and pride. The Michigan Heart Association, through your wonderful co-operation, has been able to do its part in the continuing educational program of the physicians of Michigan.

Sincerely yours,

DOUGLAS DONALD, M.D.
President
Michigan Heart Association

February 12, 1952

Wilfrid Haughey, M.D.
Battle Creek, Michigan

Dear Dr. Haughey:

I thought you might be interested, from THE JOURNAL standpoint, in the enclosed news release from the AMA about the talk of Dr. Kaisch of South Dakota at the Denver meeting of the National Rural Health Conference.

Dr. Kaisch is one of our Michigan products, and we ought to be proud of him. I heard his talk, and it was an excellent one. South Dakota, incidentally, has just completed a "Health Survey" for the years 1940-1950 (under the leadership of Dr. Foster's nephew, John), and this study showed that whereas the state's population increased only 1 per cent in this ten-year period, the M.D. population went up 21 per cent.

Dr. Kaisch's story* was also written up last year in the *Farm Journal,* and copied as a reprint for wide distribution on "How to Get a Doctor" by the AMA. Enclosed is my copy.

Sincerely,

JOHN R. RODGER, M.D.

March 8, 1952

Dr. Wilfrid Haughey, Editor
Journal of Michigan State Medical Society
Battle Creek, Michigan

Dear Doctor Haughey:

Your part in helping to promote the American Medical Association's public relations office plaque, "To

*See article in Medical News section, "Rural Doctor Gives Advice on Keeping Physician," page 511.



Immediately after the patient's arrival an admitting physician takes a complete medical history.

Treatment of the alcoholic is more than a sobering-up process; it is a rehabilitative procedure tailored to the needs of the individual.

The physicians at The Keeley Institute have had many years' experience in treating this class of patient and are specialists in their chosen field.

On arrival the patient is taken in hand by an admitting physician who obtains a complete medical history. This constitutes the first step toward instituting individualized care and treatment.

Subsequently, following a thorough physical examination and indicated laboratory studies, a detailed course of management can be outlined. It should be emphasized that no patient is continued under treatment unless he recognizes his problem and cooperates with the staff physicians.

[*This is the first of a series outlining the successive steps in the treatment of the "Problem Drinker" under Keeley management.*]

Complete information, including rates, will be furnished to physicians on request.

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All My Patients," has contributed much to the success of the campaign.

We appreciate your allotting space for the plaque advertisements in your State Journal. And your editorial comments have helped immensely. Without your help, plaque sales would not have rolled in as they have.

We sincerely appreciate your efforts. Thank you very much for everything!

Cordially,

Leo E. Brown
Assistant to the
General Manager
American Medical Association

February 4, 1952

Wilfrid Haughey, M.D.
Editor, The Journal MSMS
Battle Creek, Michigan

Dear Wilfrid:

The doctors' committee, which was formed to present Community Hospital's expansion program to the medical staff, wishes to express to each individual doctor its appreciation for the receptive attitude and generous participation which made possible an over-subscription of the committee's $75,000 objective.

The staff's complete 100 per cent acceptance of its proportionate share in this project is clearly indicated by the fact that the $76,120 we now have in seventy-two subscriptions compares most favorably with the $23,860 we received five years ago from forty-eight doctors, forty-six of whom are represented in the present total by an additional subscription.

The members of the staff of Community Hospital can be justly proud of their achievement, not only for the substantial sum added to the fund, but also in the knowledge that their generous support, early in the campaign, has had a stimulating effect on the whole community and is now helping materially to assure the ultimate success of this important project.

Sincerely yours,
George W. Slagle
For the Committee

February 18, 1952

Wilfrid Haughey, M.D., Editor
Journal of the Michigan State Medical Society
Battle Creek, Michigan

Dear Doctor Haughey:

We are writing to extend a cordial invitation to your readers to attend a three-day Sectional Meeting of the American College of Surgeons on May 15, 16 and 17, 1952, in Toronto, Ontario.

On May 15 there will be a day of teaching clinics and demonstrations in Toronto hospitals and scientific sessions at the Royal York Hotel on May 16 and 17. Distinguished speakers will present papers, panels and symposia on current surgical problems, and new surgical motion pictures will be shown including several which were prepared especially for the Cine Clinics at the 1951 Clinical Congress; also, a stereoscopic colored film on Radical Resection for Carcinoma of the Stomach, which is attracting a great deal of attention wherever it is shown.

Dr. Stuart Douglas Gordon and his Committee on Arrangements have made extensive preparations to assure a good meeting and a warm welcome to Toronto for all visiting surgeons. Hotel accommodations may be obtained by writing to Mr. G. R. Street, Convention Manager, Royal York Hotel, Toronto, Ontario.

Sincerely yours,

H. P. Saunders, M.D., F.A.C.S.
Associate Director
American College of Surgeons

March 11, 1952
S/BMc

Dr. Wilfrid Haughey
Editor, The Journal MSMS
Battle Creek, Michigan

Dear Dr. Haughey:

I read with great interest your article in regard to the use of adrenalin hypodermically on your mother, for severe asthma. This is undoubtedly the first instance of the use of adrenalin injections for the relief of asthma, and I am sorry that your experience was not published many years ago. I am sure that all allergists will be very much interested in your pioneer and trail-blazing experience with adrenalin.



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You mention in the article that the dose produced what appeared to be "anaphylactic shock." We have noticed on many occasions that when an overdose of adrenalin is given that a patient becomes extremely pale and develops a rapid pulse and other symptoms of shock. However, I do not think that this is anaphylactic but merely symptoms of overdosage of adrenalin and I am wondering if you mistakenly used the word "anaphylactic" in this instance.

With kindest personal regards, I remain,

Yours sincerely,

SAMUEL J. LEVIN, M.D.

March 10, 1952
sjl:nb

EDITOR'S NOTE: The writer admits an inaccurate choice of word.

8,000 WITH EYE DISABILITIES REHABILITATED

U. S. Office of Vocational Rehabilitation reports rehabilitation and employment of more than 8,000 persons suffering eye disabilities during the last fiscal year. Three thousand were blind and one in ten of the group had never worked prior to rehabilitation. Since the start of the federal-state vocational rehabilitation program in 1943, about 48,000 persons with visual impairments have been rehabilitated to the point where they can be employed.

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$10,000.00 accidental death *$50.00 weekly indemnity, accident and sickness*	$16.00 *Quarterly*
$15,000.00 accidental death *$75.00 weekly indemnity, accident and sickness*	$24.00 *Quarterly*
$20,000.00 accidental death *$100.00 weekly indemnity, accident and sickness*	$32.00 *Quarterly*

Cost has never exceeded amounts shown.
Also Hospital Policies for Members, Wives and Children at Small Additional Cost

85c out of each $1.00 gross income used for members' benefits

$4,000,000.00 INVESTED ASSETS

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In Memoriam

ANDREW S. BRUNK, M.D.

1884-1952

WHEREAS, the medical profession has lost a great and good leader in the death of Andrew S. Brunk, M.D.; and

WHEREAS, Doctor Brunk served the Michigan State Medical Society during a twenty-two-year period as Councilor, Chairman of The Council, President, and Treasurer; and

WHEREAS, Doctor Brunk gave generously of his valuable talents and boundless energy in founding and maintaining several organizations of lasting value to the medical profession, including the Michigan Health Council (founding President, 1943 to 1950, and charter member Board of Trustees, 1943 to 1952); Michigan Medical Service (charter member Board of Directors, 1940 to 1952); the Conference of Presidents and Other Officers of State Medical Associations (founding President, 1945, and charter member of Executive Committee, 1945 to 1952); the Michigan Foundation for Medical and Health Education, Inc. (charter member, 1945 to 1952); and

WHEREAS, Doctor Brunk increased medical science through tangible contributions to postgraduate medical education and by constant efforts to bring to Michigan the best clinicians and teachers; and

WHEREAS, Doctor Brunk was a fine doctor beloved by his patients, a good friend who was constant in his help, and a man of great moral stature and character; therefore be it

RESOLVED: That the Michigan State Medical Society, through its Executive Committee of The Council in session on February 20, 1952, records the deep sense of regret of the Society's 5,214 members at the sudden passing of Andrew S. Brunk, M.D., and be it further

RESOLVED: That a copy of this Resolution be published in THE JOURNAL of the Michigan State Medical Society in memory of Andrew S. Brunk, M.D.; and be it further

RESOLVED: That the bereaved family of Doctor Brunk be supplied with a copy of this Resolution, symbolic of the true sympathy of all his fellow doctors of medicine.

EGBERT F. DAVIS, M.D., of Wyandotte, died January 12, 1952, at the age of seventy-five.

Dr. Davis received his medical degree from the Detroit College of Medicine in 1908. He practiced in Detroit for twenty-five years, then moved to Wyandotte and practiced there for seven years.

Dr. Davis was a member of the staff of Wyandotte General Hospital. He was also a member of the Wayne County Medical Society and was elected a Life Member of the Michigan State Medical Society in 1947.

Dr. Davis is survived by his wife, Almina; a daughter, Mrs. George Smock, and three grandchildren.

GEORGE L. KOESSLER, M.D., of Detroit, died February 20, 1952, at Detroit, at the age of seventy-two.

Dr. Koessler was graduated from the Detroit Homeopathic College in 1905 and served his internship at Grace Hospital. He practiced in Detroit for forty-seven years and was on the staff of the William Booth Memorial Hospital.

Dr. Koessler became a Life Member of the Michigan State Medical Society in 1949.

He is survived by his wife, Edith; a daughter, Mrs. E. R. Anwiler, of Monroe; and four sons, Edward, George, Harry and John.

MYRON V. SUSSKIND, M.D., of Jackson, died January 29, 1952, at the age of forty-nine.

Dr. Susskind began his college career in Russia where he was born. He continued his education in the United States and received his A.B. and M.A. at Western Reserve in 1926-27. He was graduated from the University of Michigan Medical School in 1933.

Dr. Susskind served his internship at the Illinois Masonic Hospital in 1933 and interned also at Mercy Hospital in Jackson in 1934-35. At the University of Michigan, Dr. Susskind was an assistant in anatomy and histology for four years.

Dr. Susskind enlisted in 1942 in the Air Force, and went to England as an Air Force surgeon. He was discharged with the rank of major in 1945 and resumed practice.

Dr. Susskind is survived by his wife, Marie; one son, Jerry; and a brother, Julius, of Cleveland.

HARRY B. WEAVER, M.D., of Greenville, died January 25, 1952, at the age of seventy.

Dr. Weaver served the community of Greenville for thirty years from 1918 until his retirement in 1948. Before that he practiced in Mecosta. Dr. Weaver was graduated from Wayne University College of Medicine in 1908 and interned at Harper Hospital.

He was president of the Ionia-Montcalm County Medical Society in 1950. During World War I, Dr. Weaver served in the armed forces.

He is survived by his wife, Irene.

THE FEDERAL BUDGET

The budget for next year as presented by the President, is a book of 1,800 pages, weighing seven pounds. It proposes to spend 85 billions of dollars. Ninety per cent of this expenditure is for war, past, present and future.

Out of every dollar, 60 cents will go for arms, ammunition, planes, tanks—for the military foreign help, arming and supplying our "sister nations" will be 12 cents; Veterans (pensions, medical care, education) will cost 5 cents; interest on the public debt, most of which is due to war will be 7 cents; atomic energy, stockpiling, and other miscellaneous costs will be 3 cents, and our civil defense such as airfields, defense highways, ships, will take another 3 cents. That leaves only 10 cents for all other expenses of government, but 3 cents of this goes to social welfare and 2 cents to agriculture. Only 5 cents of the dollar actually goes for government.



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. NEWS MEDICAL

MICHIGAN AUTHORS

Edgar E. Poos, M.D., of Detroit, is the author of an article, "Allergy of the Eye," published in the *Digest of Ophthalmology and Otolaryngology,* February, 1952.

Herman Pinkus, M.D., of Monroe, is the author of an article, "Koebner Phenomenon in Lichen Nitidus," published in the *Archives of Dermatology and Syphilology,* January, 1952. He is also the author of "Multiple Hairs (Fleming-Giovannini). Report of Two Cases of Pili Multigemini and Discussion of Some Other Anomalies of the Pilary Complex," published in *The Journal of Investigative Dermatology,* November, 1951, and "Examination of the Epidermis by the Strip Method of Removing Horny Layers," published in *The Journal of Investigative Dermatology,* June, 1951.

Cyrus C. Sturgis, M.D., University of Michigan Medical School, Ann Arbor, is the author of an article, "Etiology and Treatment of Pernicious Anemia," published in *Postgraduate Medicine,* February, 1952.

Maurice Croll, M.D., and **Leo J. Croll, M.D.,** of Detroit, are the authors of an article, "Corneal Transplantation," reprinted from THE JOURNAL of the Michigan State Medical Society of April, 1950, in *Guildcraft,* January, 1952.

Raymond A. Sokolov, M.D., of Detroit, is the author of an article, "Coarctation of Aorta with Surgical Correction at Age Forty," published in *The Journal of the American Medical Association,* February 23, 1952.

Daniel A. Russell, M.D., John M. Moore, M.D., San Antonio, Texas, and **Lida H. Mattman, Ph.D.,** of Detroit, are the authors of an article, "Rhinoscleroma Successfully Treated with Streptomycin," published in *The Journal of the American Medical Association,* February 23, 1952.

Theodore E. Keats, M.D., Dumont S. Staatz, M.D., and **Robert W. Bailey, M.D.,** are the authors of an article, "Pneumoarthrography of the Knee," published in *Surgery, Gynecology and Obstetrics,* March, 1952.

* * *

Geographic Magazine in its March, 1952, issue carries an article "Work-hard, Play-hard Michigan" in which the author Andrew H. Brown devotes a portion of his interesting article to Dr. William Beaumont's medical discoveries on Mackinac Island.

* * *

More than 175 students and faculty members from the University of Michigan School of Medicine visited Parke, Davis & Company, Detroit, March 6 and 7. They learned that the eighty-five-year-old firm makes more than 1,000 different products.

The University visitors went through the company's fifty-year-old research building—the first in America to be erected by any commercial institution solely for the purpose of scientific research. Parke-Davis' research activities now extend into all important fields of medicine and pharmacy.

* * *

The American Society of Medical Technologists' twentieth annual convention will be held June 22-26, 1952, in Portland, Oregon. All members of the medical profession are cordially invited to attend the lectures.

* * *

Michigan Medical Service contributed to the Michigan Foundation for Medical and Health Education, Inc., in honor of the late Andrew S. Brunk, M.D., the sum of $25, in lieu of flowers.

Doctor Brunk was a long-time member of the Board of Directors of Michigan Medical Service and was one of the prime movers in the creation of the Michigan Foundation for Medical and Health Education, Inc. Dr. Brunk also was Past President of the Michigan State Medical Society which sponsored both Michigan Medical Service and the Foundation, during the years that Dr. Brunk was a member of the MSMS Council.

* * *

Wonders of Bureaucracy.—A U. S. Chamber bulletin states there are: 297 words in the Ten Commandments, 266 words in Lincoln's Gettysburg Address, 12,962 words in OPS order establishing the ceiling price of manually-operated fog horns and other manufactured items.

* * *

Have you a Bulletin Board? If so, here's a bit about "It" well worth posting.

WHAT IS *IT?*

It pays most of the rates and taxes.
It provides most of the jobs.
It has always done most to raise wages.
It has given us all our factories and shops.
It has built our ships and railways.
It develops inventors and business builders.
It originated the principles of efficiency.
It has done most to lower costs and prices.
It created the whole structure of business.
It alone can raise our standard of living.
It is the hope of the human race.

Y-E-T

Karl Marx said it must be destroyed . . .
It is Private Enterprise.

—*Mutual Moments*

* * *

The Psychiatric Bulletin will be supplied without cost to members of the Michigan State Medical Society by the Michigan Department of Mental Health. This will

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Under direction of
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Newly reorganized and modernized for individualized care and treatment of the nervous and mentally ill and alcoholics.

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be a first annual subscription to this highly recommended quarterly *Bulletin* which presents in a direct practical and useful manner sound psychiatric information designed for the use of the physician in general practice. *The Psychiatric Bulletin* complimentary subscriptions are limited and will be supplied on a first-come, first-served basis. Write the Michigan Department of Mental Health, Att: C. F. Wagg, Director, 403 Bank of Lansing Building, Lansing 16, Michigan.

* * *

Hill-Burton Hospital Construction Program.—According to a year-end analysis of the Hospital Facilities Division of the U. S. Public Health Service, 58 per cent of the 1,023 new projects are located in communities of less than 5,000 population and 10 per cent are in cities of 50,000 or more. Of the new hospitals, 57 per cent have less than fifty beds and only 19 per cent have more than 100 beds. In the aggregate, estimated total cost will be $1,288,936,793, of which the federal share will be $466,014,715.

* * *

J. S. DeTar, M.D., Milan, President of the Michigan Health Council, was the guest speaker at the National Health Council's thirty-second annual meeting in New York on March 13. Dr. DeTar's subject was "What's in the Health Council Idea?" Dr. DeTar also participated in a symposium on "Health Planning and Action Through State Health Councils."

Robin C. Buerki, M.D., Detroit, Vice President of the National Health Council, moderated this panel discussion.

"The Picture of Health" is the title of the new Michigan Health Council film. For a showing, write the Health Council, c/o Eugene H. Wiard, 706 N. Washington, Lansing.

* * *

"You Are the AMA" is the title of an article by Edward J. McCormick, M.D., of Toledo (Guest Essayist on the 1952 Michigan Clinical Institute program) which was presented before the Colorado State Medical Society at its Annual Session, Denver, September, 1951.

* * *

The American College of Chest Physicians will hold its eighteenth annual meeting at the Congress Hotel, Chicago, June 5-8, 1952. For program, write the College at 112 E. Chestnut Street, Chicago 11, Illinois.

William A. Hudson, M.D., of Detroit, is Second Vice President of the College, Willard B. Howes, M.D., of Detroit, is Regent for the district, and C. P. Mehas, M.D., of Pontiac, serves as Governor of the College of Michigan. Officers of the Michigan Chapter are Benjamin E. Goodrich, M.D., Detroit, President, and Lawrence A. Pratt, M.D., Detroit, Secretary.

* * *

Mason County was the first component county medical society of the Michigan State Medical Society to report all its members paid for the year 1952, including American Medical Association dues.

* * *

The AMA second revised edition of the booklet "Reviews of Medical Motion Pictures" may be obtained by

writing the Committee on Medical Motion Pictures, AMA, 535 N. Dearborn, Chicago 10, Illinois. This booklet includes the 90 films reviewed in JAMA in the year 1951.

* * *

The Foundation of the American Society of Plastic and Reconstructive Surgery, Inc., announces its 1952 Essay-Contest in plastic and reconstructive surgery for original contributions in this field. All entries must be received by the Award Committee not later than September 1, 1952. For further information write The Committee, c/o Jacques W. Maliniac, M.D., 11 East 68th Street, New York 21.

* * *

The American College of Physicians announces a post-graduate course in "Internal Medicine: Selected Subjects" to be held at the University of Michigan Medical School, Ann Arbor, April 14-18, 1952, under the direction of C. C. Sturgis, M.D.

For application blank and additional information write E. R. Loveland, Executive Secretary of the College, 4200 Pine St., Philadelphia 4, Pa.

Other courses announced by the College include "Trends and Newer Developments in Internal Medicine" at Philadelphia, May 12-16, 1952; and "Physiological Basis for Internal Medicine" at Toronto, Ontario, June 2-6, 1952.

* * *

A Testimonial Banquet for Michigan's Foremost Family Physician, Clayton Willison, M.D., of Sault Ste. Marie, was held by the citizens of the Soo on February 21.

The citizens of Dr. Willison's "home town" for over half a century recognized his service to the city with an outpouring of friends, patients, and some of the approximately 5,000 babies he had delivered during his long practice. Representatives of the Michigan State Medical Society also were on hand to pay tribute to the top general practitioner of 1951.

A. H. Miller, M.D., Gladstone, Councilor of the Michigan State Medical Society, summed up the lifetime of service which brought recognition to Dr. Willison "that comes to few in our profession."

L. Fernald Foster, M.D., Bay City, MSMS Secretary, stated that the 5,214 doctors of medicine in MSMS are "thankful to Dr. Willison for his leadership and the pattern he has set for them to follow."

E. S. Rhind, M.D., of Sault Ste. Marie, was chairman of arrangements and introduced the honored guests at the banquet, including MSMS Councilor and Mrs. G. B. Saltonstall, Charlevoix; AMA Legislative Committeeman and Mrs. W. H. Huron, Iron Mountain; Wm. J. Burns, Lansing, MSMS Executive Director; Hugh W. Brenneman, Lansing, MSMS Public Relations Counsel; Stuart A. Campbell, Grand Rapids, MSMS Public Relations Field Secretary; Louis A. Freye, Muskegon, Field Assistant to the Director of Michigan Medical Service.

* * *

F. E. Luger, M.D., President of the Saginaw County Medical Society, writes in *The Bulletin,* official publication of the Saginaw County Medical Society, February, 1952, number: "The main theme of the MSMS Annual County Secretaries-Public Relations Conference was of course the Formula For Freedom which was also discussed in our January county society meeting. Many of you may feel, as I did at first, that this was merely a publicity man's dream. However, after hearing the various discussions, it dawned on me that here at last was a positive approach to our public relations problems. Instead of being constantly on the defense against various ideas such as the State Medicine proposals, we can actually bring to the public a clearer concept of what the medical profession is doing and will continue to do for them when unhampered by bureaucratic agencies."

* * *

The American Academy of General Practice has announced an annual scholarship award for outstanding students, to extend formal training beyond a one-year internship, in order to equip the general practitioner for his responsibilities.

A $1,000 cash award will be given each year to five selected medical graduates who wish to pursue, following internship, a year of residency training, in general practice.

The awards will be made by the Academy from a fund created by Mead Johnson & Company, Evansville, Indiana. The winners are announced at the AAGP Annual Assembly.

* * *

Ingham County Medical Society Pioneers in Adult Education.—Healthful Living Today, a course of eight weekly forum-type lectures designed to aid people to live healthy lives under present-day conditions, will be offered to interested persons beginning Thursday, February 21, by the Ingham County Medical Society in conjunction with the Lansing adult education program.

Topics of general health interest have been selected for the first six meetings, with subjects for the last two sessions to be selected from suggestions offered by persons enrolled in the course.

The list of subjects and speakers includes:

1. Losing or Gaining Weight—R. C. Bates, M.D.
2. High Blood Pressure and Living Tensions—William Hayford, M.D.
3. The Importance of a Family—L. R. McElmurry, M.D.
4. Home Emergency Medical Care—K. W. Toothaker, M.D.
5. Cancer Detection and Cure—H. T. Johnson, M.D.
6. Pre-Natal and Post-Natal Care—R. J. Bowersox, M.D.

Sessions will be held at 7:30 p.m., Thursday evenings, in room 109 at the Technical High School. A nominal fee of $1.00 will be charged for the course, which is being organized as a part of the education program of the state medical society.—From *Ingham County Medical Society Bulletin,* February, 1952.

* * *

A contribution to the Beaumont Memorial Restoration should be something very satisfying to every doctor of medicine in Michigan. We thereby perpetuate one of



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the really great contributions to physiology which took place within the bounds of our own State. Don't forget it. Make a contribution now.—*Ingham County Medical Society Bulletin,* February, 1952.

Routine admission chest x-rays in general hospitals, in the experience of New York State, not only detect more unsuspected disease—tuberculous and non-tuberculous—in older age groups than in younger, but they also detect more among men than among women.

A summary† of findings by sex on tentative diagnosis per thousand x-rayed in the New York program follows:

	Tentative Diagnosis per 1,000 X-rayed	
MALE	Tuberculous	Non-tuberculous
Ages 15-44	17.8	90.2
Ages 45 and over	47.0	300.5
Male all ages	33.2	201.5
FEMALE		
Ages 15-44	10.4	59.3
Ages 45 and over	26.1	273.0
Female all ages	14.3	113.3

In Michigan, in 1950, more than 70 per cent of all tuberculosis deaths were among males; almost 50 per cent of all tuberculosis deaths were men forty-five and older.

— MICHIGAN TUBERCULOSIS ASSOCIATION

†Based on "Chest X-rays on Admission Pay Off"—Siegal Plunkett and Hilleboe, The Modern Hospital, July, 1951.

Rural Doctor Gives Advice on Keeping Physician.—A doctor who gave up practice in Detroit to serve the people of a South Dakota town of 900 population gives a few simple rules which will help a small town to get and hold a doctor.

These rules, presented by Dr. Kenneth Kaisch of Philip, S. D., at the seventh National Conference on Rural Health in the Shirley-Savoy Hotel, Denver, February 29, 1952, are:

1. *To obtain a doctor:* Provide adequate hospital facilities and personnel, office space for a doctor to rent and the type of town in which a person would want to live.

2. *To keep a doctor:* Treat him as a human being with the same mental outlook and physical stamina as yourselves; try working with him instead of against him. Some small towns have more difficulty in keeping a doctor than in getting one.

Dr. Kaisch spoke before approximately 700 medical, farm and agricultural education leaders from all over the country at a meeting sponsored by the Council on Rural Health of the American Medical Association, with the co-operation of national farm organizations.

He took up practice in Detroit after graduation from the *University of Michigan Medical School in 1946.* He found the lot of a young doctor in a big city a grueling one under a highly competitive situation. The personal relationship with patients also was lacking. To a great

extent, patients were of a transient type and not easy or very satisfying to treat.

Consequently, he began to look for a place in a small town west of the Mississippi River. He selected Philip, which had a 50-mile circumference trading area and no doctor within 26 miles. Philip has had four doctors, including Dr. Kaisch, in ten years.

The town was not ideal from a doctor's standpoint, he found. The hospital was a converted old wooden house. One room in the hospital was the only available office space. But the community promised to make improvements. Rental housing was obtainable, and the school system was reported to be good. So, Dr. Kaisch moved. Some of the promised improvements remain to be made.

Since practicing in a small town, Dr. Kaisch has had occasion to talk with other physicians serving small communities. Among the difficulties encountered is gossip. Let a doctor make a slight mistake, and the fact not only is spread but is magnified many times.

Another deterrent to service in a small community is the feeling that a city physician is a better trained man, with the result that the doctor in a small town frequently is by-passed except for emergencies or ordinary ills.

Also the inhabitants of a town should not think their doctor is available for any and all illnesses twenty-four hours a day. "The least they can do is to regard him as a human being and with the same capacity for work as they." Calls to treat a child have been made late at night because parents were too busy during the day to bring the child to the doctor.

"If the townspeople would only regard their doctor in the same light as themselves, many small town practitioners would not go to an early grave," he advised.

* * *

The America Clinica for February, 1952, carries a paper by Dr. John R. McDonald and Dr. Lewis B. Woolner, of Minnesota, which appeared in The Journal of the Michigan State Medical Society in April, 1951, on "Clinical Importance of Early Cancer." This has been translated into Spanish "Importancia Clinica del carcinoma preinvasor."

This journal, *America Clinica,* is distributed throughout Spanish-America and carries translations of articles published in the American journals.

* * *

Justis J. Austin, M.D., of East Tawas, and **B. C. Baron, M.D.,** of Munsing, are attending postgraduate courses at the Cook County Graduate School of Medicine.

* * *

Chairman Fogarty (D.-R.I.), of House Appropriations subcommittee on Federal Security Agency-Labor Department, has warned government officials not to count on any increases in funds above budget requests. "There is a real drive for economy on throughout the country. We felt it on the (House) floor last year and likely will again this year," he declared during hearings on FSA's 1953 budget. Mr. Fogarty also said he did not think the States were assuming enough responsibility in many programs set up by Congress. "I think a better job can be done in the states in that respect."

* * *

The Veterans Administration has informed Congress that *475 medical posts,* for which funds have been appropriated, remain unfilled because of inability to procure physicians. Dr. C. F. Bayer, chairman of a special board, listed these VA vacancies in testimony before Senate Committee on Expenditures in the Executive Departments as: neuro-psychiatrists, 140; general medicine, 113; surgery and sub-specialties, 106; tuberculosis, 54; radiologists, 18; pathologists, 24; administration, 11; and physical medicine, 9. Dr. Bayer said there was a shortage of 300 nurses for general medicine; 192 for tuberculosis and 186 for NP hospitals. He described the situation as "abnormal."

* * *

PHS Surgeon General Leonard A. Scheele cautions physicians and the public *to be on the alert for any outbreak of parrot fever (psittacosis)* as a result of two cases reported in Minnesota from an infected parakeet brought there from southern Florida. The disease was contracted by a physican and his wife. The Surgeon General noted it was a viral disease, with symptoms similar to pneumonia and influenza.

Dr. Scheele stated that additional cases, as yet unrecognized and unreported, may be occurring in other parts of the country. Visitors, he said, are known to have purchased and transported a number of tropical birds from the infected area. Dr. Scheele added there was no real danger of a widespread epidemic, however.

PHS also is keeping close watch on foot and mouth disease in Saskatchewan, Canada, with possible implications in this country. As result of an outbreak among livestock in Canada, the U. S. government has ordered a ban on livestock importations. The disease may be contracted by humans, PHS states, although it usually is not of a serious nature. Livestock are more seriously affected.

* * *

America's Huge Welfare Program is lacking in coordination and efficiency. This is one of the major conclusions reached in the study, "Community Planning for Human Services," which was conducted by Bradley Buell and Associates. The study indicates that social and welfare agencies and their services failed to provide "a purposeful, comprehensive, well integrated program." The conclusions were based on several years' study of St. Paul, Minnesota. Forty thousand families or 40 per cent of the community of St. Paul, were studied with the co-operation of 108 public and private health, welfare, and recreational agencies. It was found that 6 per cent of the community's families were absorbing more than half of the combined services of all dependency, health, and adjustment agencies.

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This study asserts that a tremendous amount of effort is being expended on a small segment of the needy population and that, until community services are more efficiently and economically organized, other families cannot receive adequate attention. The overlapping and duplication of effort is held to be responsible for inefficient utilization of funds. The St. Paul Survey strongly suggests that better planning and more careful integration of community activities are needed.

* * *

The Veterans Administration Service shortage of trained personnel is keeping 4,000 VA beds out of operation. The Veterans Administration as of February 20, 1951, was employing the same number of full-time physicians as of June, 1950, 3,991. In November 4,000 beds were not in use because of shortage of trained personnel.

The VA annual report showed that only 12 per cent of the general medical and surgical patients in VA hospitals were service-connected cases. The over-all figure for all types of patients was 33 per cent service connected. The average length of stay per patient was 50 days and the cost estimated at $10.90 per day.

By February, 1951, 123 physicians and 242 residents had been taken into the armed forces from the VA service and 71 had been deferred on VA recommendation, but 105 were taken over VA objection.

In 1950 there were 577,715 hospital admissions and 577,275 discharged, and approximately 2,500,000 outpatient examinations.

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Acknowledgment of all books received will be made in this column, and this will be deemed by us as full compensation to those sending them. A selection will be made for review, as expedient.

REGIONAL ORTHOPEDIC SURGERY. By Paul C. Colonna, M.D., Professor of Orthopedic Surgery, University of Pennsylvania Medical School. Philadelphia: W. B. Saunders Co., 1950. Price $11.50.

Regional Orthopedic Surgery is one of the finest orthopedic reference books to come off the press in recent years. As the author states, "the scope of this specialty has been greatly broadened—and is concerned with physiologic function of the musculo-skeletal system as well as the prevention, correction and investigation of injury, diseases and anomalies of this system." Physiology and Pathology of bones and joints is briefly but adequately covered. Not only are the findings of the common everyday conditions described, but the unusual entities are also discussed.

The unique plan of this book is that the author has taken each region of the body individually and described the anatomy, deformities, diseases, injuries, and tumors as they apply to each region. For each condition, whether it be disease, injury, or congenital deformity, the clinical picture is given and then followed by the treatment as indicated for each separate region of the body. By doing this he has written an exceedingly useful reference book whereby one need not review a disease process in toto—but merely that part which applies to the region in question.

This volume, I am sure, will become one of the most popular and used books in any doctor's library.

P.C.K.

TWENTY-THIRD ANNIVERSARY NUMBER OF THE HEBREW MEDICAL JOURNAL.

The appearance of Volume 2, 1950, of *The Hebrew Medical Journal* (Harofé Haivri), concludes the twenty-third successful year of its publication under the editorship of Moses Einhorn, M.D. Written in Hebrew, with English summaries, the Journal is a contribution to the development of the Hebrew medical literature, and thus aids the newly established Hebrew University Medical School in Jerusalem.

In the medical section, among the articles of interest are "Surgical Treatment of the Painful, Stiff Hip—(The resection-angulation operation)" by Henry Milch, M.D., "Electroencephalography and the Epilepsies" by Samuel J. Lipnitzky, M.D., and an article by Dr. M. Temkin on the various infectious diseases which prevailed in Palestine, such as Malaria, Typhoid Fever, Pappataci and Amoebiasis, and have lately been checked by the Health Department of the Government of Israel.

In the section "Old Hebrew Medical Manuscripts," Dr. Zussmann Muntner of Jerusalem presents a 12th Centry manuscript on Diarrhea, by Abu'l Walid Ibn Rosh (Averroes, the Philosopher). In the section "Personalia," are included biographical sketches on the well-known Dr. David Israel Macht, on the occasion of the fortieth anniversary of his scientific research, and also on the life and work of the late physicians, Dr. Harry Friedenwald, Dr. Abraham J. Rongy and Dr. Nathan Ratnoff.

A PORTFOLIO ON MEDICAL GROUPS AND PARTNERSHIPS. Rutherford, N. J.: Medical Economics, Inc., 1951. Price $2.00.

This is an imitation leather folder with two pockets containing reprints of articles which have appeared in *Medical Economics* on group practice and the formation of partnerships during the past five years. There are thirteen such reprints of from four to twelve pages. These articles are all interesting and very instructive.

ANNUAL BULLETIN OF THE MOUNT CARMEL MERCY HOSPITAL for 1951.

This bulletin contains, besides reports, statistical facts and administrative material, a number of scientific articles by various members of the staff. It is sixty-eight pages, and a very creditable pamphlet.

MICHIGAN HEART ASSOCIATION, 2nd Annual Report.

More than $185,000.00 has been allocated by the Michigan Heart Association during the past two and one-half years for research studies into diseases of the heart and circulatory system. The figure was contained in the Michigan Heart Association's Second Annual Report just released by Douglas Donald, M.D., President of the Association. The report lists all the research projects under direction of the Association.

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RECENT ADVANCES IN NUTRITION WITH PARTICULAR REFERENCE TO PROTEIN METABOLISM. By Paul R. Cannon, Ph.D., M.D., Chairman of the Department of Pathology, University of Chicago. In collaboration with Earl P. Benditt, M.D., Laurence E. Frazier, M.A., Eleanor M. Humphreys, M.D., Harold C. Steffee, M.D., Ph.D., Robert W. Wissler, M.D., Ph.D., Robert Wooldridge, M.A. Porter Lectures, Series 14. Lawrence, Kansas: University of Kansas Press, 1950. Price $2.00.

AN INTRODUCTION TO UNIVERSAL SEROLOGIC REACTION IN HEALTH AND DISEASE. By Reuben L. Kahn, D.Sc., University of Michigan Medical School and Hospital, Ann Arbor, Michigan. New York: The Commonwealth Fund, 1951. Price $3.50.

This volume is an account of Dr. Kahn's extensive research on his discovery of the universal serological reaction, and should prove stimulating to all those interested in this particular field. It is quite probable that this introduction to a new use of the serological reaction by an eminent authority should open up new vistas of considerable diagnostic importance. The subsidization by the Commonwealth Fund is indicative of the value of this work, and the consequent low cost should warrant its purchase and study. A.A.H.

METABOLIC METHODS. Clinical Procedures in the Study of Metabolic Functions. By C. Frank Consolazio, Chief of Biochemistry, United States Army Medical Nutrition Laboratory, Chicago, Illinois; Robert E. Johnson, M.D., D.Phi. (Oxford) Professor and Head of the Department of Physiology, University of Illinois, Urbana, Illinois, and Evelyn Marek, M.A., Biochemist, United States Army Medical Nutrition Laboratory, Chicago, Illinois. Illustrated. St. Louis: The C. V. Mosby Co., 1951. Price, $6.75.

This book is an invaluable supplement to any library devoted to clinical pathology or medical research, as it contains material found in no other single ordinary text. It is concise, and all but a small portion of it is a step-by-step explanation of the one method the authors feel the most acceptable for the specific procedure. There is very little in the way of comment, other than a description of the pitfalls one might encounter in the method described. Such current topics as flame photometry and paper chromatography are discussed and in the latter instance, a long bibliography is appended. The book is highly recommended. A.A.H.

THE CLINICAL USE OF FLUID AND ELECTROLYTE. By John H. Bland, M.D., Assistant Professor of Medicine, University of Vermont College of Medicine. Illustrated. Philadelphia: W. B. Saunders Co. 1952. Price, $6.50.

This book is another in a series of inexpensive monographs published to bring before the medical profession the practical results of research. This volume deals with the chemical anatomy of body fluids and its behavior with electrolytes in health and disease.

Not all physicians can be chemical pathologists, but certainly all physicians who treat the patient must be increasingly aware of the newer concepts of fluid, elec-

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trolyte and nutritional balance. The author stresses this point. Clinical application is made specific in chapters devoted to pediatric patients, to the aged and aging, to surgical patients and to specific clinical problems as found in renal disease, diabetes mellitus, adrenal cortical insufficiency, heat, cold, shock, burns and other stress. Many charts original and modified are used for illustration. Perhaps the text could have been more concise but it is readable.

The busy physician will be well advised to add this monograph to his library. J.W.H.

A COURSE IN PRACTICAL THERAPEUTICS. By Martin Emil Rehfuss, M.D., F.A.C.P., Professor of Clinical Medicine, and Sutherland M. Prevost, Lecturer in Therapeutics, The Jefferson Medical College, Philadelphia; Attending Physician, The Jefferson Medical College Hospital, Philadelphia; Alison Howe Price, A.B., M.D., Associate Professor of Medicine, The Jefferson Medical College, Philadelphia; Assistant Physician to The Jefferson Medical College Hospital, Philadelphia; Chief of Diabetic Clinic, Curtis Clinic, Philadelphia. Second Edition. Baltimore: The Williams & Wilkins Co., 1951. Price $15.00.

Any attempt to revise this most excellent text is likely to fall short of the merit it deserves. The authors, in presenting their second edition of the latest in therapeutics, have compiled a most comprehensive survey.

The first section is devoted to an elementary presentation of those subjects the authors believe are important in the treatment of disease. The principles are very essential in the general management of the patient. Prescription writing is emphasized in this section. The second section emphasizes differential diagnosis and symptomatic medications. This does not preclude accurate diagnosis, but rather emphasizes the value of time gained to make a more complete diagostic survey. It makes apparent "the need to do something for the patient."

The third section deals with the great body of internal medicine, insofar as a general discussion is concerned. Specific differential diagnosis is not discussed, as it is outside the realm of the text. The final section is devoted to those specialities in medicine and therapeutics which are of value to the student and practitioner.

In this text, illustrations are used more widely than is usually seen and they are of superb quality. This, plus the excellent format, makes this text one of the finest of its type that the reviewer has ever seen. He unhesitantly recommends it to each and every member of the medical profession. It is a worthy addition to all of the libraries. G.W.S.

THE SERPENT-WREATHED STAFF. A novel by Alice Tisdale Hobart. 402 pages. New York: Bobbs-Merrill Co., 1951.

If Mrs. Alice Tisdale Hobart had managed to devise a suitable ending for her 402-page novel, "The Serpent-Wreathed Staff," about sixty pages sooner than she did, a tolerant critic would be able to say that she had written a faulty but highly interesting story of human conflicts and loyalties.

Unfortunately, however, the latter part of the book degenerates swiftly and recklessly into an amazing propaganda piece for National Compulsory Health Insurance. The last forty or fifty pages sound as if Mrs. Hobart knocked them out hastily at a desk piled high with pamphlets, speeches and news releases handed out by Federal Security Administrator Oscar Ewing and the Committee for the Nation's Health.

This uncraftsmanlike abuse of artistic license, added to some of the implications built up in earlier pages, creates the impression that the entire novel was designed as a subtle presentation of the case for Socialized Medi-

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cine. As a result, Mrs. Hobart undermines much of the validity that does exist in some of the earlier parts of this book about doctors, modern medicine and a changing world.

When the facile, all-inclusive plot is used as a mechanism for discussion of the social, economic and political aspects of modern medicine, the book suffers not only from the standpoint of literary merit but also from the standpoint of accurate reporting. On this level the book is dangerously superficial. Complex problems and issues affecting the practice of medicine are introduced in rapid-fire, hop-skip-and-jump fashion—over-simplified and over-dramatized, but mixed with just enough truth and half-truth to give credence to a distorted picture.

Before Mrs. Hobart writes another novel on this subject, someone should familiarize her with the major facts and realities in the field of modern medical economics.

Someone, for example, should tell her about the many famous clinics and countless other forms of group practice which are in successful operation throughout the country, some of them since around the turn of the century.

Everyone interested in American medicine, and in the effort to find intelligent solutions to our medical care problems, should read "The Serpent-Wreathed Staff"—if for no other reason than to help repair the damage which the book does.

Read simply as a novel, it is a moving, absorbing story.

Read as a source of information affecting public opinion on medical-economic issues, it unfortunately is an example of careless, superficial writing, with a built-in conclusion contrary to the convictions of the great majority of Americans today. F.B.E.

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On the advice of a famous restaurateur, army officers in Korea are trying a bit of practical psychology. At first the cooks wore any sort of old garments that came handy. But now they are told to wear a chef's cap and also white suits if possible. It is believed that this change in dress will be effective in making the food seem cleaner and more palatable. Hence morale will be improved. The army has soilless gardens in Japan for growing vegetables. They reach Korean camps in thirty hours by plane. It is not suggested that housewives wear chef's caps and white uniforms, but anything they can do to improve the appearance of meals and of the kitchen and dining room will certainly be to the family's advantage.

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APPROVED RESIDENCY IN GENERAL PRACTICE: St. Luke's Hospital, Saginaw, Michigan. 140 adult bed capacity has an opening for two resident physicians in General Practice, approved by the American Medical Association. Salary $300-$350 per month with partial maintenance. Mail communications to Olive E. Lebold, R.N., Superintendent, St. Luke's Hospital, Saginaw, Michigan.

Government invasion of the insurance business is all that is being talked about right now. The theory, of course, is that the government should guarantee security and the more abundant life to everybody. This concept started out on a so-called subsistence level, as a humane substitute for the poor-house and other galling forms of charity. But it has long been obvious that many proponents of social insurance are aiming far above the subsistence level.—Insurance Economics Survey, February, 1952.

GENERAL EISENHOWER AND SOCIALIZED MEDICINE

(Continued from Page 498)

crease the number of high quality young doctors with inducements so that they will practice in the places where they are most needed. We should lower the cost of the hospital bill by using public funds for hospital construction, for the maintenance of such hospital services as the care of the invalid, the education of internes and nurses and the maintenance of accident wards and ambulances.

" 'WE SHOULD PROVIDE FREE DIAGNOSTIC CLINICS, INCLUDING X-RAY SERVICE, FURNISH HEALTH EXAMINATIONS FOR ALL SCHOOL CHILDREN AND MAKE AVAILABLE TO THOSE WHO CANNOT AFFORD EXPENSES—MEDICINE —FREE OF CHARGE.' " (Emphasis ours, Editor.)

The Editor wrote a letter to the General enclosing this clipping, calling his attention to the more than 5,000 members of the Michigan State Medical Society who have a right to know his position in view of the above. Following is his reply:

Dear Doctor Haughey:

General Eisenhower has asked me to thank you for your letter and to acknowledge it on his behalf.

I reget that the General cannot respond to your query at the present time. His position, as announced in his statement of the 7th of January, remains unchanged.

Sincerely yours,

(*Signed*) C. T. Lanham,
Brigadier General, USA
Chief of Public Information.

February 21, 1952.

A PERSONAL NOTE

Once Socialism has been well established and permitted for a few years to take its toll in production and progress, once it has been allowed to eat away at the heart and body and moral fibre of a nation, it cannot then he suddenly replaced with private capitalism.

You can't press a button or mark a ballot and transform a bankrupt Socialist nation into something better. But there is more than irony in England's present predicament. The nation has come face to face with the truth about Socialism: it is like quicksand; once you put both feet in it you are caught fast.

Evidently, the reason the English didn't vote the Conservatives in by a larger margin was that not even Churchill, who had opposed every step of the Socialist program, could promise to reverse it. Realizing this, England still registered a condemnation of Socialism as a mode of government and way of life.—Dr. George S. Benson, President, Harding College.

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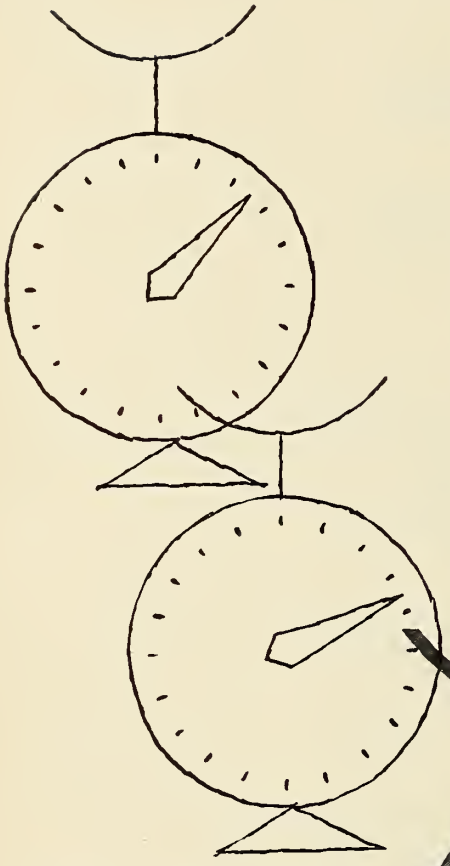
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1 Gordner, L. I., Butler, A. M., et al.: Pediatrics 5:228, 1950
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3 Bull. National Research Council No. 119 Jan. 1950
4 Recommended Daily Dietary Allowances, Revised 1948, Food and Nutrition Board, National Research Council

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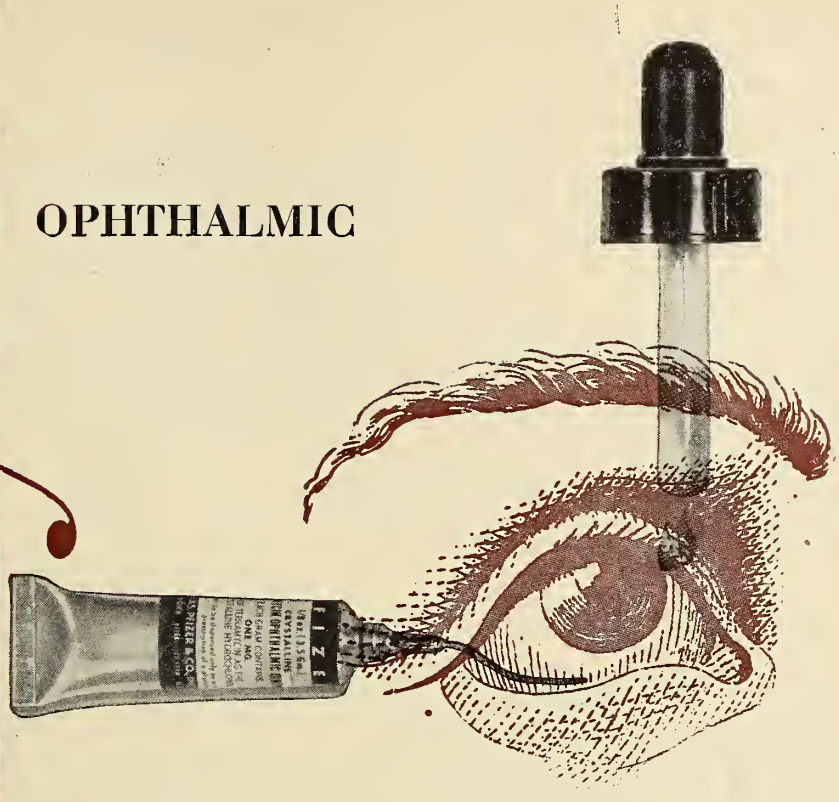
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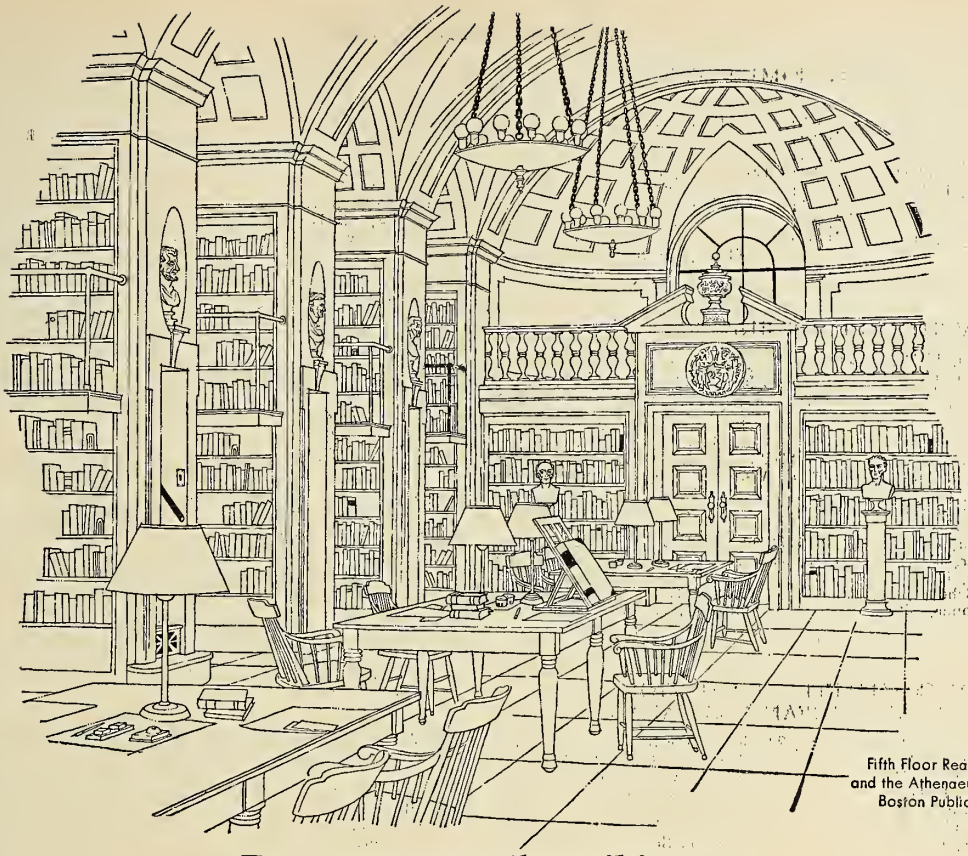
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After moderate relief is established, reduce daily dosage step-wise every three or four days, to smallest suitable maintenance level.



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You and Your Business

MICHIGAN STATE MEDICAL SOCIETY ANNUAL SESSION
DETROIT—September 24-25-26, 1952

WORD GETS AROUND ABOUT MSMS ACTIVITIES

What they are saying about the MSMS Public Relations program:

Samuel M. Day, M.D., Secretary-Treasurer, Florida Medical Association—"May I take this opportunity to compliment you and the officers and members of the Michigan State Medical Society on an outstanding public relations program."

What they are saying about the pamphlet, "Planning Your Career."

Sister M. Adele, Assistant Administrator, The St. Francis Hospital, Pittsburgh, Pennsylvania—"This is an excellent piece of work."

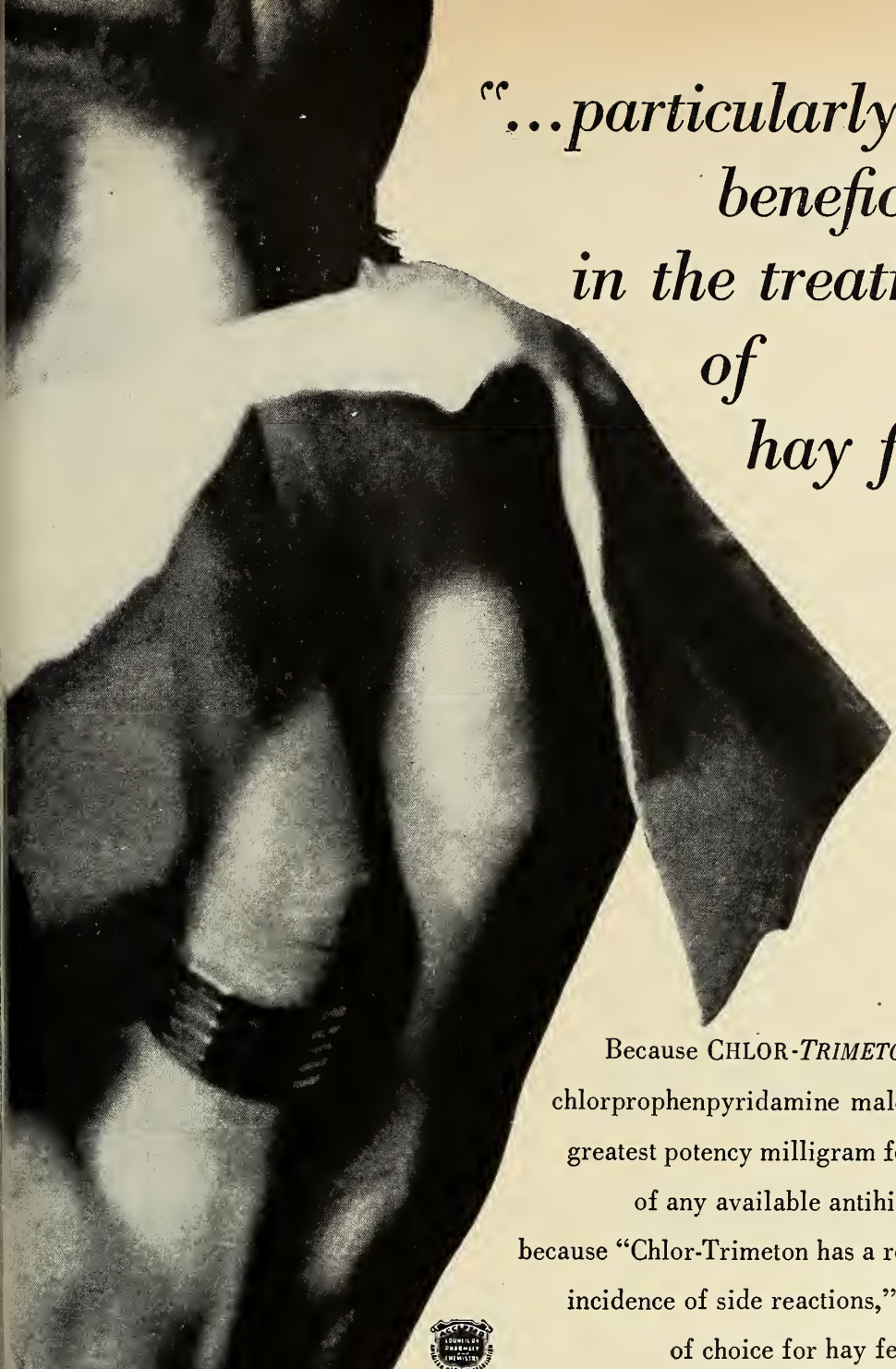
Bess Graham, Assistant Administrator, Peoples Hospital, Akron, Ohio—"We do want to commend you on a very good job in presenting the openings for workers in the medical field. Your booklet is one of the most attractive we have ever seen and we know it must be very effective in helping recruit good employes."

HIGHLIGHTS OF MEETING OF EXECUTIVE COMMITTEE OF THE COUNCIL
March 20, 1952

Sixty-three items were presented to the Executive Committee of The Council at its March 20 meeting in Detroit. Chief in importance were:

- Monthly financial reports were presented and approved. Statement on contributions to the Beaumont Memorial Fund was presented. Bills payable were inspected and payment was authorized.
- William A. Hyland, M.D., Grand Rapids, Past President and Past Treasurer of the Michigan State Medical Society, was elected as Treasurer of the Michigan State Medical Society to fill the unexpired term of the late A. S. Brunk, M.D.
- Group health and accident program for Michigan doctors of medicine. Progress report was presented by W. S. Jones, M.D., Menominee, Chairman of the Special Committee (Drs. Jones, L. Fernald Foster and Mr. J. Joseph Herbert), which was authorized to meet with insurance brokers so that a plan may be developed and presented to insurance companies; the plan will be presented to the MSMS House of Delegates in September, 1952.
- Veterans Administration Hospitals Policy. Pursuant to resolution of Washtenaw County Medical Society, approved by Executive Committee of The MSMS Council, the following Study Committee was appointed: R. W. Teed, M.D., Chairman, Ann Arbor; Gaylord S. Bates, M.D., Dearborn; W. H. Huron, M.D., Iron Mountain; J. E. Manning, M.D., Saginaw; H. Marvin Pollard, M.D., Ann Arbor; and L. A. Pratt, M.D., Detroit.
- Teaching medical ethics in medical schools—the report of the two Michigan Medical School Deans was presented and referred to the 1952 MSMS House of Delegates.
- Committee reports: (a) Finance Committee, meeting of March 20; (b) Rheumatic Fever Control Committee, meeting of February 27; (c) Meeting of Ubiquitous Hosts for Michigan Clinical Institute, March 6; (d) Hospital Relations Committee, meeting of March 7; (e) Report of Councilor G. B. Saltonstall, M.D., Charlevoix on February 17, American Medical Education Foundation Annual Meeting in Chicago; (f) Report of John R. Rodger, M.D., Bellaire, on National Rural Health Conference held in Denver, February, 1952; (g) Special Committee on Developing Model Code on M.D. Announcements—report presented by Chairman D. Bruce Wiley, M.D., and ordered published in THE JOURNAL of the Michigan State Medical Society. (See page 554.)
- Liaison Committee between Rheumatic Fever Control Committee and Child Welfare Committee: at the suggestion of the MSMS Rheumatic Fever Control Committee, the following Liaison Committee with the MSMS Child Welfare Committee was appointed: R. J. Mason, M.D., Chairman, Birmingham, Leon DeVel,

(Continued on Page 534)



"...particularly beneficial in the treatment of hay fever."[1]

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1. Silbert, N. E.: New England J. Med. 242:931, 1950.
2. Eisenstadt, W. S.: Journal Lancet 70:26. 1950.

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(Continued from Page 532)

M.D., Grand Rapids, and Frank Van Schoick, M.D., Jackson.

- The principle of a bill licensing practical nurses was approved by the Executive Committee of The Council.
- J. S. DeTar, M.D., Milan, and R. W. Teed, M.D., Ann Arbor, were selected as Delegate and Alternate, respectively, to the Michigan Health Council, as MSMS representatives.
- The House of Delegates Press Relations Committee for the 1952 MSMS Annual Session was appointed: R. H. Baker, M.D., Pontiac, H. F. Dibble, M.D., Detroit, L. Fernald Foster, M.D., Bay City, Ralph Johnson, M.D., Detroit, and J. E. Livesay, M.D., Flint.

 Chairmen and Secretaries for the Assemblies and Leaders for the three Discussion Conferences were selected.

 "Upper Peninsula Day," with luncheon, was authorized for Wednesday (Sept. 24) at the MSMS Annual Session, with W. S. Jones, M.D., of Menominee as Chairman.
- Board of United Health and Welfare Fund. This Fund requested MSMS to nominate doctors of medicine for its Board. Twelve names, selected on a geographical basis, were submitted.
- J. Milton Robb, M.D., Detroit, was appointed as Chairman of the 1953 Michigan Clinical Institute scheduled for Detroit, March 11-12-13, 1953.

 The "block system" so successful at the 1952 MCI, is to be repeated at the 1953 Institute, with surgery being featured on Wednesday morning, obstetrics-gynecology on Wednesday afternoon; cancer control on Thursday morning, trauma on Thursday afternoon; heart will again be the subject of Friday morning and internal medicine on Friday afternoon.

 Daily Discussion Conferences (question and answer periods) are to be held from 12:00 M to 1:00 p.m. with all speakers of that particular day on the platform.
- The Public Relations Counsel's report included progress report on current legislation, both national and state; on MSMS films; on "Formula For Freedom" Nights; and on TV and radio activity.
- The report of the Legal Counsel included two items, both covering matters of ethics.

MEDICAL MEETINGS AND CLINIC DAYS

A list of known medical meetings and clinic days, sponsored by county medical societies and other physicians' groups in Michigan, follows:

1952

Spring	MSMS Postgraduate Extramural Courses State-wide
June 9-13	AMA Annual Session.....Chicago
June 27-28	Upper Peninsula Medical Society Annual Meeting.....Iron Mountain
June	St. Clair County Medical Society Clinic Day.....St. Clair
July 24-25	Annual Coller-Penberthy Medical Surgical Conference.....Traverse City
July 24-26	Conference on Housing of the Aging Ann Arbor
August 21	Third Annual Clinic, Central Michigan Committee, ACS Michigan Committee on Trauma, plus Michigan National Guard Medical Personnel, and Medical Society of North Central Counties Grayling
Sept. 24-26	MICHIGAN STATE MEDICAL SOCIETY ANNUAL SESSION.....Detroit
Oct. 8	Clara Elizabeth Fund—Genesee County Medical Society—Lectures of 1952...Flint
Oct. 9	Fourth Michigan Cancer Conference Kellogg Center, East Lansing
October or November	American Academy of General Practice of Wayne County.....Detroit
Autumn	MSMS Postgraduate Extramural Courses State-wide

Additions to this list of meetings are invited by the Editor of JMSMS, in order to make this monthly announcement complete and accurate.

STATE BOARD OF MEDICINE EXAMINATIONS

June 9-10-11, 1952

Ann Arbor and Detroit

Completed application with fee must be received in office of State Board of Registration in Medicine, 203 Hollister Building, Lansing, Michigan, two weeks prior to examination dates.



after all the mildness tests, CAMEL leads all other brands by BILLIONS!

AAGP Holds Worthy Assembly in Atlantic City

A dramatic new page in medical meeting history was enacted during the week of March 24, in Atlantic City, when the American Academy of General Practice held its Fourth Annual Assembly. Despite a wave of intestinal influenza, the threat of a railroad strike, and two days of cold searing rain, nearly 2,000 physicians were on hand to hear and acclaim a program keyed to the broadest concepts of general practice. During the four-day meeting, the total registration was 4,292, including the doctors of medicine, residents, interns and students, technical exhibitors, guests and the ladies.

More than fifty members of the Michigan Academy of General Practice were registered at the Atlantic City session; about forty of these attended the "Michigan Breakfast" at Haddon Hall on March 26 at the early hour of 8:00 a.m.; R. B. Robins, M.D., of Camden, Arkansas, the new President of the American Academy of General Practice, was guest of honor at the Michigan Breakfast.



MICHIGAN BREAKFAST AT AAGP ASSEMBLY IN ATLANTIC CITY



NEWLY ELECTED OFEICERS AAGP

J. S. DeTar, M.D., Milan, Michigan *(center)* was re-elected Speaker of AAGP Congress of Delegates at its Atlantic City Assembly.

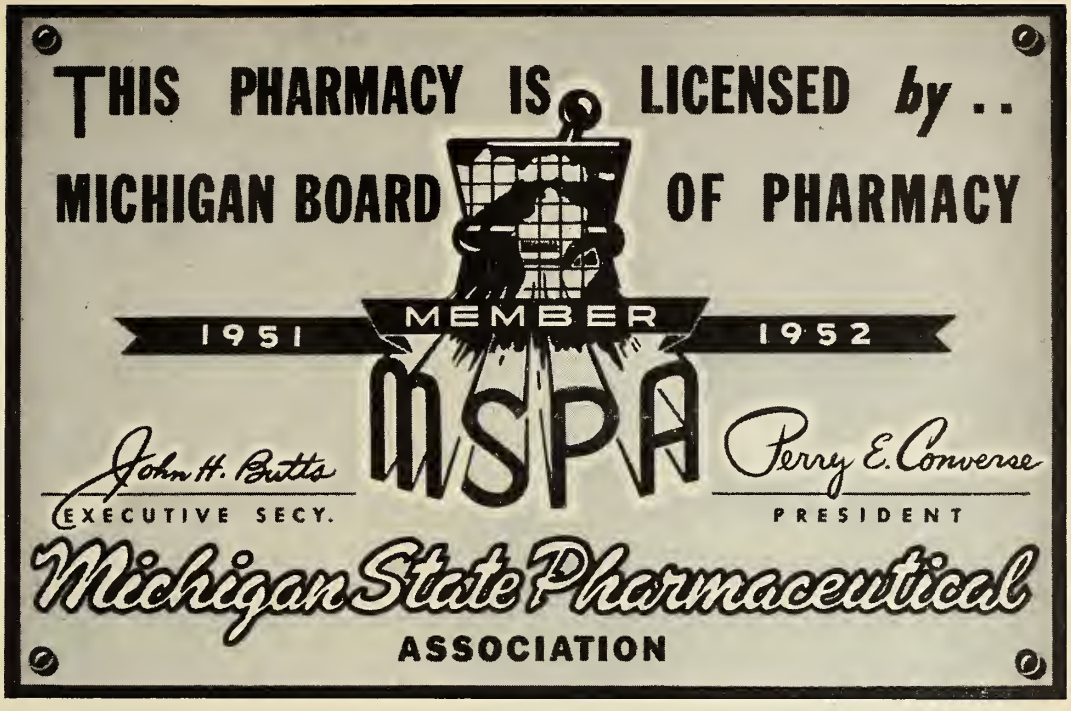
U. R. Bryner, M.D., Salt Lake City *(left)* is President-Elect and R. B. Robins, M.D., Camden, Arkansas *(right)* is President.

Officers of the Michigan AAGP, which stresses the patient-physician relationship, include: E. C. Long, M.D., Detroit, President; F. E. Luger, M.D., Saginaw, Vice President; R. F. Fenton, MD., Detroit, Secretary-Treasurer; J. S. DeTar, M.D., Milan, Delegate; and J. H. Schlemer, M.D., Detroit, Delegate and Parliamentarian.

Doctor DeTar was honored by being re-elected as Speaker of the House of Delegates of the American Academy of General Practice. Chosen as AAGP President-Elect was U. R. Bryner, M.D., of Salt Lake City, one of the early pioneers of the general practice movement.

In addition to the scientific meetings, the AAGP Assembly was highlighted by a large technical and scientific exhibit of 301 spaces.

Among the guest essayists were: J. W. Conn, M.D., Ann Arbor; J. S. DeTar, M.D., Milan; and AMA President, J. W. Cline, M.D., San Francisco.



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A symbol commands respect by all men only in the degree of integrity and responsibility upholding it. It must have a solid foundation, based on good faith and service.

All that is true of professional pharmacy has been caught in the newly designed decal for the store-fronts of members of the Michigan State Pharmaceutical Association. It is symbolic of the integrity of the most ancient of professions, pharmacy.

Look for the symbol of a modern pharmacy. A store dedicated to the public health and to better services for the people in your community.

Michigan State Pharmaceutical
ASSOCIATION

Heart Beats

"Research will continue to be the very forefront of the Michigan Heart Association's unrelenting fight against heart disease," was the reassuring theme of thc Heart Day talk made by F. Janney Smith, M.D., of Detroit, newly elected President



Douglas Donald, M.D., Detroit *(left)* immediate Past President of the Michigan Heart Association, congratulates F. Janney Smith, M.D., Detroit, the new President of the Association, as he takes office at the Annual Heart Day Meeting held in Detroit on March 14, 1952.

of the Michigan Heart Association. "We must all realize," Dr. Smith said, "that research provides the only key for unlocking the hidden secrets of diseases of the heart and circulatory system." Dr. Smith was elected President of the Association at its Third Annual Meeting held in Detroit on March 14, 1952, in conjunction with the Michigan Clinical Institute.

Mr. Charles E. Wilson, President of the General Motors Corporation, was re-elected chairman of the Board of Trustees.

Henry L. Smith, M.D., Detroit, who has actively served on the Board of Trustees, the Executive Committee and the Program Committee of the Michigan Heart Association since its organization in 1949, was elected to the post of President-Elect at the annual meeting.

Other officers elected by the Association at its annual meeting include: Vice Presidents—Mrs. Hugh Wilson of Ann Arbor, Carleton Dean, M.D., Lansing, and Frank Van Schoick, M.D., Jackson; Secretary—L. Fernald Foster, M.D., Bay City; Treasurer—Charles T. Fisher, Jr., Detroit.

Douglas Donald, M.D., Detroit, retiring President of the Heart Association, will continue to serve on the Board of Trustees and the Executive Committee of the Association in addition to his appointment as chairman of the Membership Committee.

The following committee appointments were made by F. Janney Smith, M.D., following his election as President of the Michigan Heart Association:

Research Committee.—Franklin D. Johnson, M.D., Chairman, Detroit; Paul S. Barker, M.D., Ann Arbor; Earle Irvin, M.D., Detroit; Douglas Donald, M.D., Detroit; E. D. Spalding, M.D., Detroit.

Program Committee.—Carleton Dean, M.D., Chairman, Lansing; Paul S. Barker, M.D., Ann Arbor; Warren B. Cooksey, M.D., Detroit; Myer Teitelbaum, M.D., Detroit; M. S. Chambers, M.D., Flint; Robert E. Fisher, M.D., Bay City; C. J. Poppen, M.D., Lansing; Mrs. Hugh Wilson, Ann Arbor.

Finance Committee.—Frank Isbey, Chairman, Detroit; Charles T. Fisher, Jr., Detroit; J. William Hagerty, Detroit.

Membership Committee.—Douglas Donald, M.D., Chairman, Detroit; Milton Shaw, M.D., Lansing; Mrs. James McEvoy, Detroit.

Committee on Cardiovascular Clinics.—B. I. Johnstone, M.D., Detroit; Cecil Corley, M.D., Jackson; L. T. Colvin, M.D., Detroit.

FACTS GLEANED FROM THE HOOVER REPORT

29 agencies lend money.

28 handle welfare projects.

16 are in wildlife preservation.

50 are compiling statistics.

One agency had enough light bulbs to last 93 years.

One had 24 supervisors for 25 employees.

One bureau employs one person for every 32 under its care.

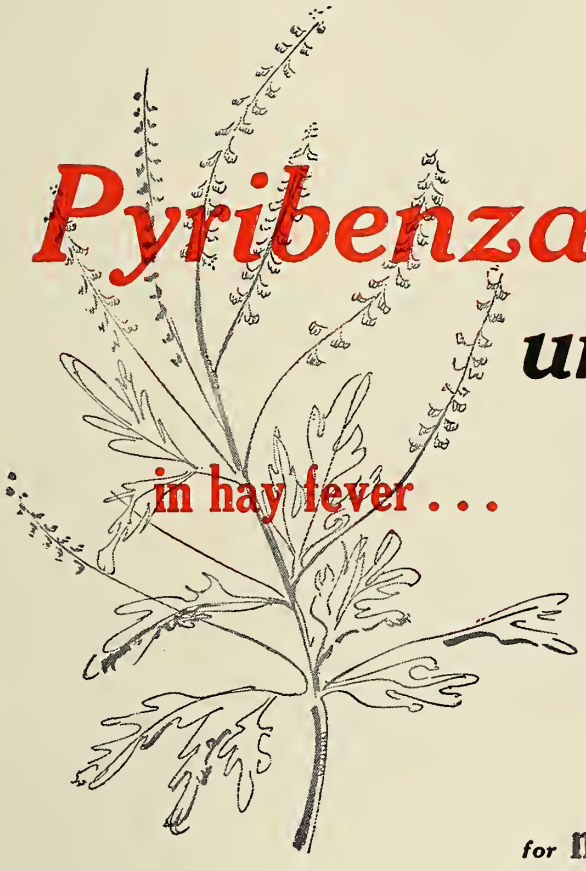
Our Federal Government today employs 2½ million people at a cost of more than $2⅔ billion per month.

One out of every five citizens receives some sort of income from the government.

$1 out of about every $4 we earn goes for taxes to support the Federal Government.

And about $1 in every $10 is being wasted!

To run the Federal Government in 1952 it cost over $71 billions—$456.00 for every man, woman and child —$1,784.00 for every family.



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The Beaumont Memorial

A LITTLE FROM MANY WILL BUILD THE BEAUMONT MEMORIAL

The work of the Michigan State Medical Society Beaumont Memorial Restoration Committee is showing tangible results, according to a report from Committee Chairman A. H. Whittaker, M.D., Detroit.



Otto O. Beck, M.D., Birmingham, President of the Michigan State Medical Society, points to the spot in the American Fur Company Store on Mackinac Island where Alexis St. Martin was shot, June 19, 1822. The scale model of the store reveals how the important landmark will look when it is reproduced on Mackinac Island through the activities of the MSMS Beaumont Restoration Committee and the support of Michigan doctors of medicine.

Every member of MSMS has received a personal letter from Otto O. Beck, M.D., Birmingham, MSMS President, asking for support in the restoration of the American Fur Company store on Mackinac Island as a shrine to the important discoveries of William Beaumont, M.D.

It was in that fur company store that Alexis St. Martin, a French-Canadian voyageur, was shot. Even though Dr. Beaumont held little hope for St. Martin's recovery after the accidental shooting on June 19, 1822, the hardy voyageur lived. The wound left a gaping hole in St. Martin's side. Through this cavity, Dr. Beaumont was able to observe over a period of years and to record the action of the gastric juices.

Dr. Beaumont's contributions to medical science rank with Harvey's discovery of the circulation of blood and are rated above the famed experiments by Ivan Petrovitch Pavlov which contributed to knowledge of the physiology of digestion.

Of the State's more than 5,200 doctors of medicine who received a request for assistance in the restoration project, to date 721 have contributed funds to the project which requires an estimated $40,000 to be completed on Mackinac Island. The average contribution has been $11.39. By JOURNAL press time, the fund had grown to a total of $8,213.50.

Members of the Restoration Committee report that the goal of $40,000 would be reached if each doctor of medicine in Michigan would contribute at least eight dollars.

The medical shrine on Mackinac Island would be a gift of the medical profession. It would also be a constant reminder to the thousands of annual visitors to the Island of the profession's continued effort to advance the science of medicine.

The scale model of the fur company store was exhibited at the Michigan Clinical Institute. The exhibit was staffed by members of the Woman's Auxiliary to the Michigan State Medical Society and of the Michigan State Medical Assistants Society, who distributed literature about the project and supplied information on the campaign.

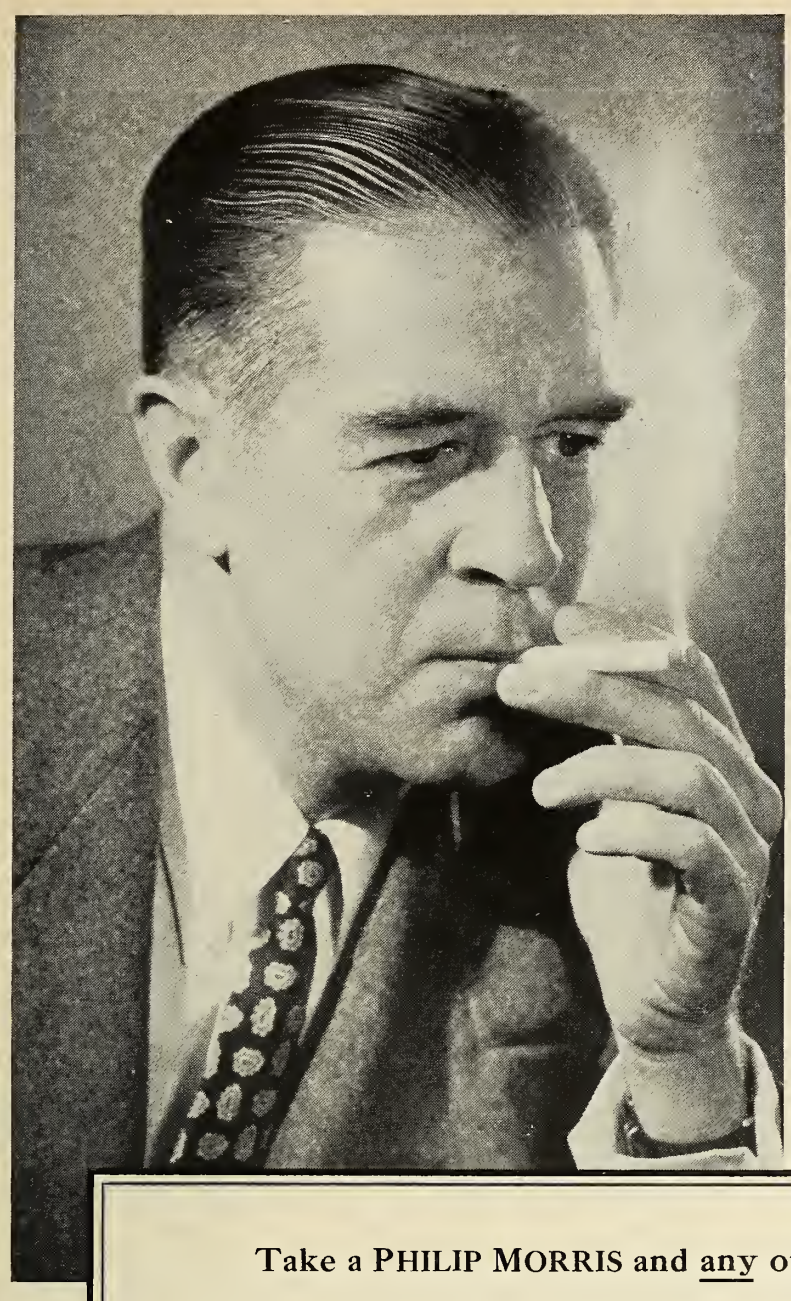
Those who saw the scale model in Detroit were impressed with the dignity of the memorial which will stand as a perpetual reminder of Michigan's part in significant and inspiring medical pioneering.

In Lansing

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1. Light up either one first. Take a puff—get a good mouthful of smoke —and s-l-o-w-l-y let the smoke come *directly* through your nose.

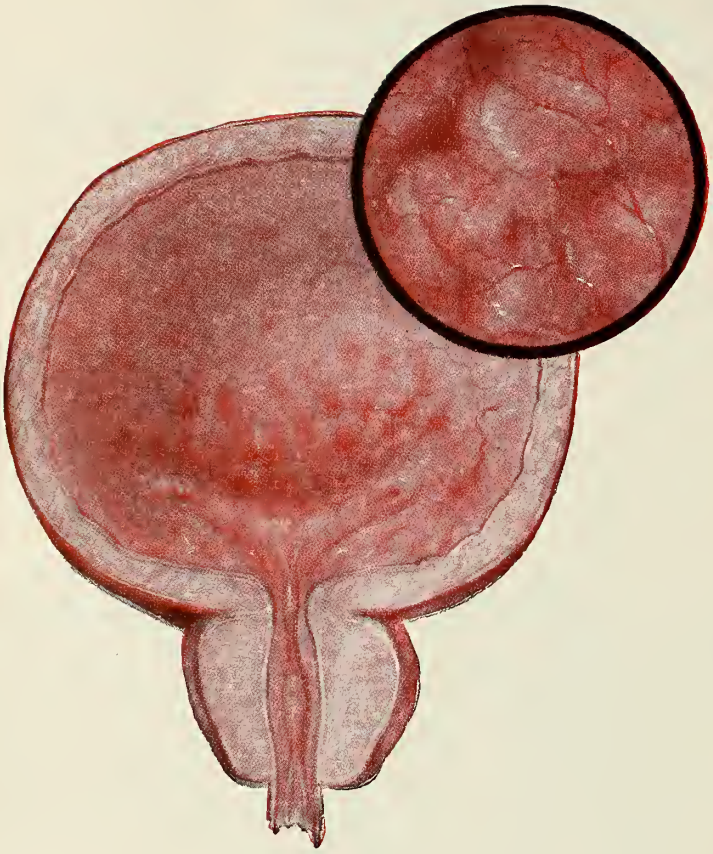
2. Now, do exactly the same thing with the other cigarette.

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Blahey, P. R.: Canad. M.A.J. 66:151 (Feb.) 1952.

ANTIBIOTIC DIVISION Pfizer

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Lobar pneumonia • Mixed bacterial pneumonias
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Acute and chronic otitis media
Acute bronchitis • Laryngotracheitis
Tracheobronchitis • Sinusitis
Chronic bronchiectasis
Pulmonary infections associated with pancreatic insufficiency
Scarlet fever • Urinary tract infections
Acute and subacute purulent conjunctivitis
Acute catarrhal conjunctivitis
Chronic blepharoconjunctivitis not involving the meibomian gland
Abscesses • Cellulitis
Furunculosis • Impetigo
Infections secondary to Acne vulgaris
Erysipelas • Peritonitis

Gram-negative Bacterial Infections

Gonorrhea • Brucellosis
Bacteremia and septicemia
Friedländer's pneumonia
Mixed bacterial pneumonias
Pertussis • Diffuse bronchopneumonia
Post-partum endometritis • Granuloma inguinale
Dysentery • Urinary tract infections
Respiratory tract infections
Cellulitis • Peritonitis • Tularemia

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Cancer Comment

THE CANCER COMMITTEE OF THE COUNTY MEDICAL SOCIETY

From the inception of the cancer control program throughout the country, the responsibility of the county medical society in all local programs has been stressed repeatedly. Both the American Medical Association and the American Cancer Society have insisted that all cancer programs be approved by the respective medical society before they are placed in operation. Wherever county medical societies have cancer committees—and there should be such a committee in every county medical organization—these committees have definite responsibilities to the community health organizations, public and private, as well as to their own society.

In too many instances, local medical societies have neglected to appoint cancer committees or those appointed have not taken their responsibilities and duties in the serious manner their appointment calls for. Local cancer programs have had the tacit approval of this medical committee without serious examination of their objectives or practical organization.

To overcome these objections, to point out their responsibilities to all local health organizations, and to co-ordinate more closely the local cancer program for the greatest community good, the Cancer Control Committee of the Michigan State Medical Society is issuing a pamphlet entitled "The Role of the Cancer Committee of the County Medical Society in Cancer Control." The pamphlet is patterned after a similar publication of the California Cancer Commission and points out the opportunities as well as the responsibilities of local medical cancer committees in co-operation with local public and private health agencies in the general cancer control program.

Professional education is discussed in detail and the opportunities offered by medical society and hospital staff meetings, cancer conferences of different types, cancer films and cancer literature as educational media are emphasized.

Cancer reference panels for the purpose of seeing that no cancer patient, regardless of financial or other difficulty, is denied the best service the community affords, are recommended as desirable medical services when they function in keeping with approved local medical plans.

Cancer diagnostic and/or treatment clinics are discussed and the organization of such additional clinics in strategic hospital centers to augment the fifteen clinics now in operation in Michigan is recommended.

Cancer detection examinations are being stressed more and more as the best means for finding early and curable cancer and this brochure urges that every doctor's office should be a cancer detection center. The Hillsdale Plan for Tumor Detection is offered as an outstanding example of a successful cancer detection program initiated and carried out by a county medical society in co-operation with the local health department.

The relation of the County Cancer Committee to the local health department is stressed as is the relationship to the local unit of the American Cancer Society. It is in this latter relationship that the Cancer Committee finds some of its most important responsibilities. The interest of lay workers in this program needs to be evaluated carefully and, when necessary, their emotional enthusiasm closely supervised and controlled to prevent undue emphasis being placed on the cancer problem that will increase rather than dispel fears of this disease. The Cancer Committee can assist greatly in interesting influential laymen in the local program, thus giving it leadership and stability.

Education of the laity is a prime responsibility of the medical profession and the local Cancer Committee is urged to provide leadership in this field. A speakers bureau is recommended, so that all speaking engagements will not fall on the few members of the committee. There is a place in this control program for every physician and it is the local Cancer Committee's responsibility to see that each physician makes his contribution in the most effective manner.

The text of this pamphlet closes with this summary:

"With these duties and responsibilities, the Cancer Committee becomes one of the most important committies in any County Medical Society. This committee is charged with the leadership of one of the

(Continued on Page 554)

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Federal Medicine

ANOTHER STEP IN SOCIALIZED MEDICINE

Hospitalization for insured persons over sixty-five, their dependents and survivor beneficiaries is recommended by the Social Security Administration in its 1951 annual report. The report cited as an example of need that only one of twelve aged couples receiving hospitalization have hospital insurance. This information was obtained from a recent survey made in two large cities by the Social Security Administration.

The report also recommended a program of disability and sickness insurance, estimating that a full social insurance program including such benefits could be financed by a compulsory 6 per cent payroll deduction tax. The report indicates that in 1951 about 77 per cent of the working population were under the old-age and survivors insurance program. Another 9 per cent were covered by the railroad retirement system and by separate programs of federal, state and local governments. Benefit payments of the survivors insurance program during the fiscal year ending in June, 1951, amounted to $1,498,000,000. The administrative expenses were $70,000,000. Contributions amounted to more than $3 billion.

Recipients of public assistance (federal-state programs on a matching basis) number more than five million persons. Public assistance includes programs of: old-age assistance, aid to dependent children, aid to the blind, aid to the permanently and totally disabled, and general assistance. Largest of these programs is old-age assistance, which reached a peak of 2.8 million recipients in September, 1950. The latest amendment to the social security program permits federal participation in the cost of state-provided medical care for needy individuals. Commenting on the advantages of the recent amendment, the report said, "Experience under this amendment, although limited in scope, will help point the way to further developments in provisions of needed medical care to low-income groups."

It was recommended that the insurance program be extended to protect members of the armed forces, and suggested that military personnel be credited with a free contribution based on an assumed $160 monthly wage.

The same report covered the operation of the Children's Bureau. Some major highlights are: (1) 171,000 mothers attended prenatal clinics operated by states with federal assistance; (2) more than 59,000 women were given postpartum medical examinations; (3) more than 258,000 expectant mothers received nursing services; (4) there were 723,000 infants and pre-school children who attended medical conferences; (5) 1,100,000 children received public health nursing services; (6) 2,894,000 children were under the program of nursing visits in behalf of school children; (7) 215,000 crippled children received physician and related services during the year; and (8) 40,000 children received hospital-patient care—the average length of stay was about thirty-six days.

The Children's Bureau recommended that an emergency maternity and infant care program for wives and infants of enlisted men of the Armed Forces be inaugurated. It suggested that the program be somewhat similar to the program conducted during World War II.—*AMA Washington Bulletin*, April 10, 1952.

GOVERNOR WARREN AND SOCIALIZED MEDICINE

Governor Earl Warren of California appeared over television, following a speech he made in Boston, on Wednesday, February 6, 1952. He was interviewed by Donald I. Rogers, editorial staff, *New York Herald Tribune*, and William Bradford Huie, editor of the *American Mercury*, with particular respect to his views on Socialized Medicine, State Socialism and the Welfare State.

HUIE: Now, sir, as the first question, it's often said our Eastern and Middle Western Republicans wonder how it is that you get so many Democratic votes. Now, do you think that you are the same kind of Republican that people are in the East and in the Middle West?

WARREN: I think that I am. I think our people perhaps are a little less party-minded out in the West than they are in the East and the Middle West, but Republicans in our part of the country think the same and act very much the same as they do in other parts of the country.

* * *

ROGERS: Would you describe yourself as a socialist?

WARREN: Oh, in no sense of the word. I have an abomination for socialism. I believe that our system is the greatest system that's ever been devised by man. But I believe that some of these people who use the word socialism very lightly these days and very often are unable to distinguish between socialism and social progress. You spoke of the speech that I made last night at Boston. In preparing that speech I found a little expression of Abraham Lincoln who—that reminded me of such people. He spoke of the type of thinking that could not distinguish between a horse chestnut and a chestnut horse.

ROGERS: To be specific, sir, would you say that, for instance, socialized medicine is social progress or socialism?

WARREN: No, I would think socialized medicine is socialism, but I don't believe in socialized medicine. I do believe that there can be social progress made so far as medical care is concerned. I believe that the cost of medical care has become so high that it is moving away from the person of average income, and I believe it is

(Continued on Page 620)



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POLICIES AND PROCEDURES ADOPTED BY THE DEPARTMENT OF DEFENSE IN IMPLEMENTING PUBLIC LAW 779, 81st CONGRESS

At the outbreak of the Korean incident, the only source of physicians and dentists available to the military services, other than those already on duty, was the reserve components. At that time the rolls of the active and inactive reserve components of the Army could not supply sufficient medical and dental officers, particularly in the junior grades. Only a very small number of medical and dental ASTP participants had enrolled in the Army Reserve. The Navy, on the other hand, was in a much better position because the majority of the medical and dental participants in the V-12 Program were members of the Naval Reserve. The Air Force was in a position similar to that of the Army, with the exception that it was not an independent department during World War II and, therefore, had not sponsored an educational program.

To insure an adequate number of physicians and dentists to meet military requirements, Public Law 779 (the Doctor Draft Act) was enacted. Under its provisions members of reserve components were specifically exempted from registration by the following:

> "Section 4i(1) . . . No such person who is a member of a reserve component of the Armed Forces shall, as long as he remains a member thereof, be liable for registration and induction under this subsection, but nothing in this subsection shall be construed to affect the authority of the President under any other provision of law to call to active duty members and units of the Reserve Components."

The effect of relieving members of reserve components from the obligation to register exempted all participants of the Navy V-12 Program, who were members of the Navy reserve component. This comprised a large group of physicians and dentists who would have been members of the Priority I group if they had not been so exempted. Further, in the Section quoted, specific authorization to call reserve personnel to active duty is reaffirmed and this is interpreted as indicating the intent of Congress that members of reserve components be so utilized at the discretion of the President.

Extensive and earnest study was given to the most equitable and satisfactory method of bringing physicians and dentists to active duty from the increased sources that became available after the enactment of Public Law 779. It was believed, and it still is believed, that the interests of all concerned are best served by the program which was adopted and which has been followed. It consists of assigning a priority classification, paralleling that of Selective Service, to all reserve medical and dental officers which they would have had under Selective Service had they not been exempt from registration and then calling them to active duty in accordance therewith. Thus, Priority I type reserves which includes Priority I registrants who have indicated a willingness to accept commissions are called up before Priority II's are called. It permits the Navy to utilize its reserves who were obligated to serve and it insures that the Army and the Air Force will have sufficient personnel. It also has the advantage of reducing to a minimum the necessity of actually drafting doctors by affording those who are vulnerable the opportunity of accepting commissions rather than having to face the stigma of being inducted involuntarily.

At the plan has operated, the Navy up to the present time has filled its requirements from its reserve components. The Air Force, with few exceptions, has had a sufficient number of requests for commissions and voluntary applications for extended active duty from Priority I registrants to meet its needs. Except for one month, July, 1951, the Armed Forces has been able to fill its requirements for physicians by involuntarily ordering to duty Priority I registrants who have indicated a willingness to accept commissions.

You are well aware of the advantages to the interests of the national welfare in having the local and State Advisory Committees of the Selective Service System advise the military departments on the essentiality of reserves destined for calls to duty. This arrangement has proved its merit and the departments have co-operated with it in a satisfactory manner even though the obligation to do so in the cases of reserve personnel is not prescribed under the provisions of Public Law 779.

It is true that there are some recalcitrant Priority I registrants who refuse to accept commissions and are escaping duty as long as a sufficient number to meet the requirement do volunteer. Their number, however, is relatively small. According to Selective Service statistics for January 31, 1952, of an original 10,785 Priority I living registrant physicians, 1,094 remain immediately available; and of an original 3,928 Priority I registrant dentists, 620 remain immediately available. Since January 31, 1952, the available Priority I dentist pool has been reduced by the induction calls for 335 dentists in April, 1952, and 175 dentists in May, 1952.

(Continued on Page 552)



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Formula For Freedom Nights

At County Medical Societies

Date	Place	Speakers
Dec. 18, 1951	Kalamazoo Kalamazoo Academy of Medicine	R. J. Hubbell, M.D., Kalamazoo Otto O. Beck, M.D., Birmingham L. Fernald Foster, M.D., Bay City D. Hale Brake, Lansing State Treasurer Hugh W. Brenneman, Lansing
Jan. 15, 1952	Grand Rapids Kent County Medical Society	L. Fernald Foster, M.D., Bay City Senator Carlton H. Morris, Kalamazoo Hugh W. Brenneman, Lansing
Jan. 22, 1952	Saginaw Saginaw County Medical Society n	L. Fernald Foster, M.D., Bay City J. E. Livesay, M.D., Flint H. B. Zemmer, M.D., Lapeer L. C. Harvie, M.D., Saginaw Hugh W. Brenneman, Lansing
Feb. 5, 1952	Big Rapids Mecosta-Osceola-Lake County Medical Society	L. Fernald Foster, M.D., Bay City Senator Milo A. Johnson, Greenville Hugh W. Brenneman, Lansing
Feb. 12, 1952	Owosso Shiawassee & Clinton County Medical Societies	L. Fernald Foster, M.D., Bay City Senator James M. Teahen, Jr., Owosso Hugh W. Brenneman, Lansing
Feb. 14, 1952	Ann Arbor Washtenaw County Medical Society	L. Fernald Foster, M.D., Bay City Bradley M. Harris, M.D., Ypsilanti D. Hale Brake, Lansing State Treasurer Hugh W. Brenneman, Lansing
Feb. 15, 1952	Muskegon Muskegon County Medical Society	L. Fernald Foster, M.D., Bay City William C. Vandenberg, Lansing Lt. Gov., State of Michigan Hugh W. Brenneman, Lansing
Feb. 19, 1952	Mt. Pleasant Gratiot-Isabella-Clare County Medical Society	L. Fernald Foster, M.D., Bay City Hugh W. Brenneman, Lansing
March 4, 1952	Battle Creek Calhoun County Medical Society	L. Fernald Foster, M.D., Bay City Senator Creighton R. Coleman, Marshall Hugh W. Brenneman, Lansing
March 7, 1952	Holland Ottawa County Medical Society	L. Fernald Foster, M.D., Bay City Senator C. H. Geerlings, Holland Hugh W. Brenneman, Lansing
March 18, 1952	Port Huron St. Clair and Sanilac County Medical Society	L. Fernald Foster, M.D., Bay City John B. Martin, Jr., Lansing Auditor-General, State of Michigan Hugh W. Brenneman, Lansing
March 19, 1952	Bay City Bay-Arenac-Iosco County Medical Society	D. Hale Brake, Lansing State Treasurer J. E. Livesay, M.D., Flint Hugh W. Brenneman, Lansing
April 1, 1952	Monroe Monroe County Medical Society	Bradley M. Harris, M.D., Ypsilanti D. Hale Brake, Lansing, State Treasurer Hugh W. Brenneman, Lansing
April 15, 1952	Flint Genesee County Medical Society	L. Fernald Foster, M.D., Bay City John B. Martin, Jr., Lansing Auditor-General, State of Michigan Joseph R. Hainline, Detroit
April 24, 1952	Hastings Barry County Medical Society	L. Fernald Foster, M.D., Bay City
April 24, 1952	South Haven Van Buren County Medical Society	L. Fernald Foster, M.D., Bay City Senator G. Elwood Bonine, Vandalia

(Continued on Page 552)

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At County Medical Societies

(Continued from Page 550)

Date	Place	Speakers
May 6, 1952	Traverse City Grand Traverse-Leelanau-Benzie County Medical Societies	D. B. Wiley, M.D., Utica D. Hale Brake, Lansing, State Treasurer Hugh W. Brenneman, Lansing
May 27, 1952	Genesee County Medical Society Woman's Auxiliary	L. Fernald Foster, M.D., Bay City
May 29, 1952	Dowagiac Cass County Medical Society	L. Fernald Foster, M.D., Bay City Senator G. Elwood Bonine, Vandalia Hugh W. Brenneman, Lansing
June 5, 1952	Ann Arbor Michigan Tuberculosis Association Annual Meeting	L. Fernald Foster, M.D., Bay City D. Hale Brake, Lansing, State Treasurer Hugh W. Brenneman, Lansing
June 17, 1952	Lansing Ingham County Medical Society	To be announced in June Journal
June 27, 1952	Iron Mountain Annual Meeting, Upper Peninsula Medical Society	To be announced in June Journal

POLICIES AND PROCEDURES ADOPTED BY THE DEPARTMENT OF DEFENSE

(Continued from Page 548)

When all Priority I type reserves have been called to active duty, or deferred for acceptable reasons, the Selective Service System will be requested to bring the remaining Priority I registrants into service before any Priority II type reserves are called up. It is anticipated that this will occur within the next six months; hence, the recalcitrant ones are only delaying their service until all the Priority I registrants who have accepted commissions are called up. It is a matter of opinion whether this is to their advantage. If the military emergency should cease to exist before they are inducted, they will have escaped military duty. On the other hand, if the emergency continues, they will be forced to come into service at a later date and will have to serve after their more willing contemporaries are returned to civilian life and become re-established in their practices.

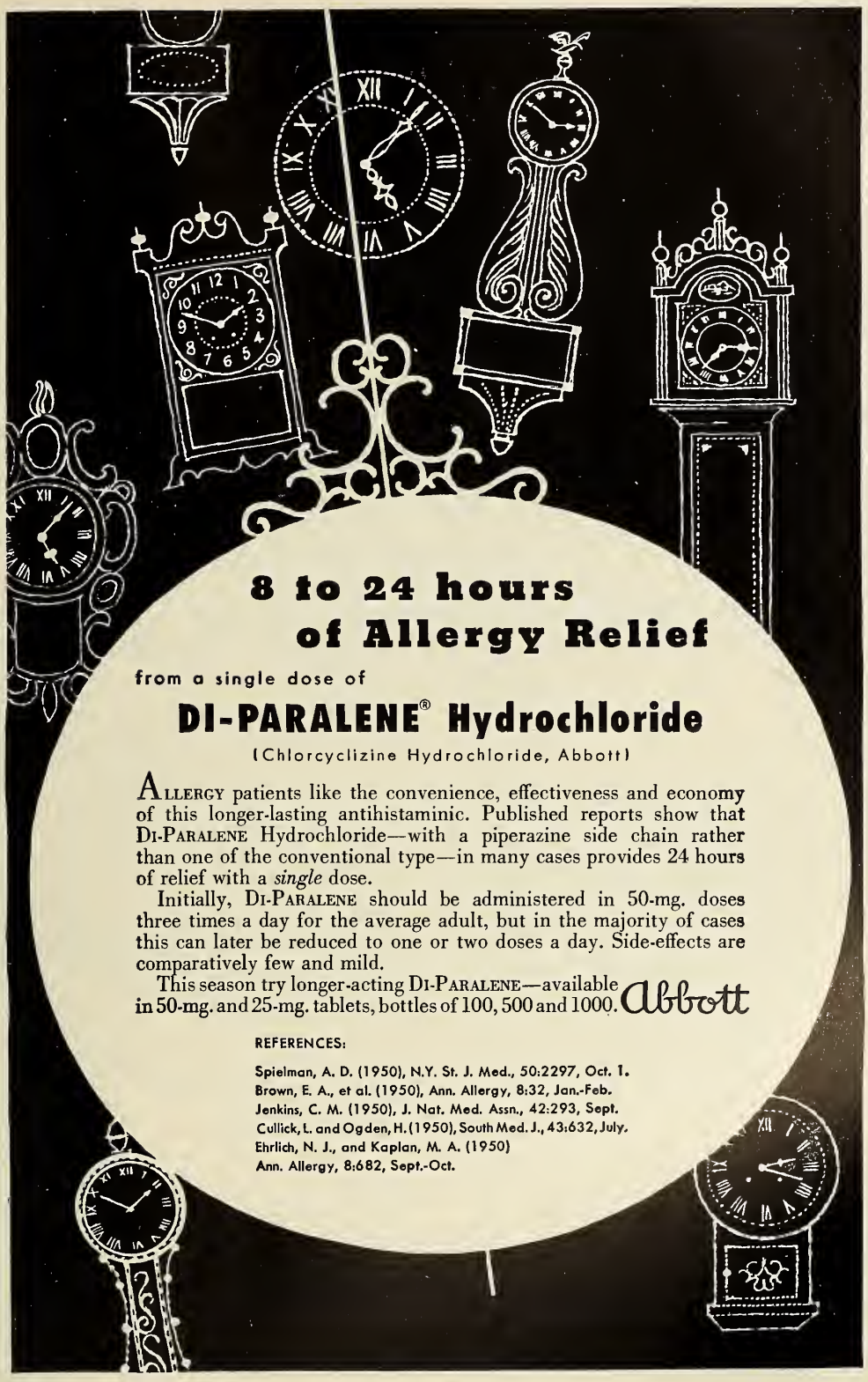
It has been the desire of the Department of Defense to comply with the intent of Public Law 779. It is believed that as far as practicable this has been done to the best interests of the individuals and of the Armed Forces.

NEW CRITICAL DEFENSE AREAS

Most recently designated "critical defense areas," eligible for special federal assistance for hospitals and other community facilities, include the following: Troma, Calif.; Barstow, Calif.; Orlando, Fla; Cobalt, Idaho; Gary-Hammond, East Chicago, Ind.; Parsons, Kan.; Lawrence-Olathe, Kan.; Indian Head, Md.; Bedford, Mass.; Oscoda, Mich.; Altus, Okla.; Umatilla-Hermiston, Ore.; Newport, R. I.; Charleston, S. C.; Smyrna, Tenn.; Rockdale, Tex.; Del Rio, Tex.; Arlington, Wash.

HOUSE INCLUDES HOSPITAL FUNDS IN DEFENSE AREAS APPROPRIATIONS

In passing a supplemental appropriations bill, the House reduced the request for defense community facilities from $25.7 million to $4 million, and specified that none of the money could be used for recreational purposes, for day care functions or for additional administrative expenses. Under certain conditions, funds could be used for construction and operation of hospitals in defense-impacted areas. The Committee report made no suggestions as to division of the money. However, in testimony at the hearings, spokesmen for Division of Hospital Facilities (PHS) asked that about half of the then proposed figure of $25.7 million be allocated for hospitals and health centers. Already approximately 160 areas have been officially designated as "critical." Of these, six have submitted evidence to show hospital facilities are urgently needed. However, the PHS does not have complete information on hospital needs in defense areas, and does not plan to issue application forms until funds actually have been appropriated.



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Model Code for M. D. Announcements

Comments by D. B. Wiley, M.D., Utica, Chairman of the MSMS Committee on Development of Model Code for M.D. Announcements.

The Council of the Michigan State Medical Society, at its September 23 meeting in Grand Rapids, was asked for an opinion on the matter of ethical practices in advertising by doctors of medicine, particularly as it pertained to the use of neon signs and bowling teams with the name of the doctor or clinic on the shirts of the bowling team.

The Council took the following action on the matter: "The Council of the Michigan State Medical Society disapproves of publicity of any type by any member which is not in keeping with the dignity of the profession." The Council authorized the creation of a committee to compile a model code covering recommended practices in reference to physicians' signs, newspaper, mail and radio announcements and other forms of advertising of any type.

The Committee on Development of a Model Code for M.D. Announcements found that many of the county medical societies have established regulations governing the type and size of physician's signs, and the type of other forms of announcements which may be used. It was the consensus of the committee that problems of ethics in the last analysis are decided upon according to the principles of Medical Ethics of the American Medical Association.

The Principles of Medical Ethics of the American Medical Association provided the following quotations which answered the questions under discussion.

1. In section 3, on page 4:
"The ethical principles actuating and governing a group or clinic are exactly the same as those applicable to the individual."

2. In section 4, on pages 4 and 5:
"Solicitation of patients, directly or indirectly, by a physician, by groups of physicians or by institutions or organizations is unethical."

3. In section 5, on page 6:
"The publication or circulation of simple professional cards is approved in some localities but is disapproved in others. Disregard of local customs and offenses against recognized ideals are unethical."

The Committee on Development of a Model Code for M.D. Announcements at its meeting of January 26, 1952, formulated the following report as given in the minutes of that meeting, which have been approved by the Executive Committee of MSMS.

From Minutes of Meeting of Committee on Development of Model Code for M.D. Announcements, January 26, 1952.

Neon Signs.—The item of clinics with neon signs and bowling teams with names of the clinic on the shirts was discussed by all present. Portions of the Principles of Medical Ethics of the American Medical Association were read. After discussion, it was the sense of the committee that the sponsoring of a bowling team or any other athletic team for the purposes of advertising is unethical. Donations to support athletic teams or events is ethical, and this applies equally to individuals and clinics as set forth in the Principles of Medical Ethics of the American Medical Association.

A neon sign or any other type of advertising of the name of a doctor or a clinic must conform with regulations of the local County Medical Society. "Disregard of local customs and offenses against recognized ideals are unethical." (AMA Code of Ethics).

It is the sense of the Committee that the problem of advertising of physicians or clinics is a local one, and no hard and fast regulations can be set down on a State-Wide basis.

This report is published upon instruction of the Executive Committee of The Council MSMS, February 20, 1952.

THE CANCER COMMITTEE OF THE COUNTY MEDICAL SOCIETY

(Continued from Page 544)

most important health programs in the county. While service on the Cancer Committee entails a large amount of effort and responsibility, it offers the finest opportunity of service to the public and to the County Medical Society."

The pamphlet is being placed in the hands of all local medical society officers and their cancer committees, all local health officers and commanders of local units of the American Cancer Society. In limited numbers, copies will be available to others interested.

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ACCEPTED COUNCIL ON PHARMACY AND CHEMISTRY AMERICAN MEDICAL ASSOCIATION

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The JOURNAL

of the Michigan State Medical Society

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The Best of Life

By A. M. Smith

Detroit, Michigan

Grow old along with me!
The best is yet to be,
The last of life, for
which the first was made.

—Browning

HOW MANY of the more than 20,000,000 elderly people in this land of freedom and abundance feel that they are enjoying the best part of lifetime?

How many past the busy years of careers, jobs and home-making feel that there is still a place in the world for them?

Past the days of routine work, either because of feebleness or just laid aside because they cannot, like Joshua, command the sun to stand still when they reach the age of three score and ten, how many look to the sunset of life with happy calm, and how many live in daily dread of tomorrow?

How many find themselves—or believe they are—an added burden on the families of their sons and daughters and wish they might have homes of their own where the thought of being a burden to others would not plague them by day and cause sleepless nights when old folks should have peaceful sleep and happy dreams—if any!

Thousands of court records and family histories compiled by medical men indicate beyond doubt that the mental borderline of a large proportion of elderly people is due to their anxiety while trying to adjust their old age to family life. In millions of cases, happy adjustment of elderly folk to continued living in their children's homes is impossible because of economic and other factors, though grandmother and grandfather are loved and revered by sons and daughters and grandchildren. The elders need, and richly deserve, the comfort, peace and happiness of home life as they approach the "valley of the shadow."

No such homey existence awaits the old folk in the general type of institution to which millions are committed, however arduously the management may strive to create "home atmosphere" in a beehive structure nearly in the pattern of a county jail. In such institutions, restraint of activity, confinement to single rooms or wards, and restriction to scheduled visits to recreation rooms of limited space are necessarily the rule for care of large numbers of "inmates." Freedom is denied them to wander about as they did in the homes they left.

This is not to condemn outright the thousands of public hospitals spotting this land of plenty. In a way, it is a blessing that there are provided at public expense the institutions where the feeble aged and the borderline, or over-the-line, mental cases may be kept with reasonable safety to themselves and their families. On entering, they become "cases," not personalities. At home, grandmother was the grand personality!

It is admitted that with the limited financial support and kind of physical facilities provided by legislatures, virtually all of these institutions do the best they can to give the millions of inmates good physical care and mental rehabilitation. But the general concept of public care of the ailing or feeble, whose families are unable to care for them, is basically wrong. It is lagging only a step in advance of the old insane asylum and poor house. These hospitals are not *homes.* Unless the elderly

A. M. Smith is an honorary member of the Wayne County Medical Society (1933). For twenty-four years he was a medical writer for the *Detroit News.*

patient is incurably insane, what is needed is a real home, home care, home atmosphere, home happiness and surcease of gnawing anxiety about being a burden on the family.

There are hundreds of "convalescent" and "rest" domiciles (attractively advertised as "homes") established as money-making enterprises where the ailing and aged may get board, lodging and what emergency medical care is needed. In most of them, real home conditions are either wholly lacking or of minimal resemblance.

There are hundreds of private and sectarian mental hospitals open to the psychopathic and to others who need prolonged rest or convalescence, or separation from their families. The fact that many of them are accredited by states and medical societies augurs well for the professional care inmates may have as needed. But few of them are capable of providing the home feeling which the feeble aged need more than any other medicine. The physical lay-out of these "hospitals" and "retreats," whether privately or publicly sustained, and the label "mental hospital," even if the institution were named "Angels' Rest," cast a pall over the mind of anyone sane enough to think about buildings to live in and human contacts.

Elderly people who have reasonable possibility of being cured of psychoses, and the clear-minded elderly folk whose family conditions offer no promise of happiness, comfort and adequate care, need the nearest possible duplicate of home life they created and sustained when they were happy, busy, young fathers and mothers. No other kind of residence is worthy of the concept, "home for the aged."

Until legislatures provide means of establishing as many homes of this character as may be needed, to supplement the very few privately owned which conform to this type, there will be a wide gap between what is and what ought to be in sound public welfare, and no reduction in rate of mental undoing of the aged and of their untimely death.

How many approaching old age in the frame of society today feel that "the best is yet to be"? Many have lost their loved mates with whom they worked, laughed, sorrowed and rejoiced through the long years. But that is a contingency faced by mates and lovers, young and old, and it needs be—and is natural—that faith wreathed by happy memories should brighten the way ahead.

Do the social planners, the welfare engineers, the sponsors of homes for the aged realize that the years of the old folk should be the "best . . . the last of life, for which the first was made"? The millions of the aged in institutions where they are regimented like robots, cut off from the atmosphere and happiness of real homes, provide the answer: "No!"

The social doctrine by which care of the aged is generally directed in institutions is that old people are useless, a burden to their families and society; that they have finished "real life," have had their share of usefulness and happiness, and henceforth have a right only to food, to medical care if they are actually suffering, to sedatives instead of a calm and happy mind to give them sleep, to a room to fend against the weather and to prevent them, in their longing for real companionship, from molesting other "inmates," and to a bed to sleep in—until the good angel puts them under the sod.

The poet was not dreaming or painting rainbows when he declared that old age is the best of life, for the years gone by have built wisdom, have stored up knowledge, rich memories, long retrospect with its prophetic vision for the guidance of the young generations still just experimenting with Life.

"The best . . . the last of life, for which the first was made" is a profound psychological axiom to which social planners and lawmakers give scant attention. Politicians are concerned with the community, state and national pocketbooks—as they should be, if they are good bookkeepers. But their attention has not been directed to the full-grown soul of humanity, the hearts and minds of the aged.

No, the politicians and legislators are not heartless. They have not yet reached the high level of including efficient guardianship of the potential beauty, happiness and usefulness of old age in the agenda of legislative action. Someday they will meet the challenge to clear the way for normal peace and contentment of the very best of society, the old folk—the best, for these have gathered years of wisdom, learned the pitfalls to avoid, tasted and thrived on the sweet companionship of home. They have grown to full stature in gentleness and kindliness. Yet, by the thousands and for whatever reasons, they need to be transplanted, but without pruning away the tendrils that bind their hearts to "home."

Dynamic Therapeutics in Chronic Disease

By Howard A. Rusk, M.D.
New York, New York

MEDICINE'S number one problem is no longer the acute, communicable diseases which claimed their victims with dramatic swiftness, but is the slow and insidious processes of the chronic diseases and the disabilities which they leave in their wake. Here, as in the battle against infectious disease, the first line of defense is the general practitioner.

One of the principal causes of the increasing prevalence of chronic disease has been the great advances in medical and surgical care which have prevented death and produced an aging population. Two thousand years ago the average length of life was 25 years; at the turn of the century, it was 49; recently compiled 1948 mortality statistics of the National Office of Vital Statistics show the average length of life in the United States has increased to 67.2. The average length of life of white women has now reached 71 years —that of white men, 65.5. As our population becomes older, it can be expected that the incidence of chronic disease and its resultant physical disability will increase correspondingly; studies indicate the higher the age group, the greater the percentage of chronic disease and disability. In the National Health Survey 1935 to 1936, the following incidence rates per 1,000 persons were found of persons with a chronic disease or impairment on a given day: over 65 years of age, 515; aged 45 to 64, 309; aged 20 to 44, 177; aged 5 to 19, 70; and under age 5, 34. Rates for total and permanent disability per 1,000 population were: over age 65, 75; aged 45 to 64, 22; aged 20 to 44, 8; aged 5 to 9, 4; and under age 5, 1.6.

In the twenty-five-year study that the U. S. Public Health Service has conducted among 2,000 white families in the town of Hagerstown, Maryland, it was found that at 25, about 35 of every 1,000 persons have some chronic illness or some major disability; at 45, the rate gradually rises to about 100 chronic cases in 1,000 men and women. After that, there is a much steeper climb, with nearly 250 out of 1,000 chronically ill at 60. At 80, more than half of the group needs regular medical care; and at 90, the rate is more than 900 per 1,000.

Lacking specific measures in the cure of many of the chronic diseases, medicine must look to rehabilitation to teach those afflicted by disability to live and to work as effectively as possible. Until medicine finds the specific answers to the problems of the diseases of the heart and circulation, rheumatic fever and arthritis, cerebral palsy, multiple sclerosis, poliomyelitis, and the other crippling diseases, we must utilize the techniques of physical rehabilitation, psychology, social service, vocational counseling, and the auxiliary specialties to teach the disabled to live within the limits of their disabilities but to the full extent of their capacities.

Although we have in this country the finest institutions in the world for medical care and for vocational training, outside of the military services and the Veterans Administration there are but a small handful of civilian agencies and organizations equipped to provide for the patient with a physical disability the necessary retraining in physical skills which is a requisite for later vocational training. In the past, the physician has thought too much about the physiologic and clinical aspects of the patient's disability. The vocational counselor too frequently has thought only in terms of physical skills which could be utilized vocationally. Between the two, however, there is a wide area through which most physically handicapped persons must go when their medical care is completed but before they are ready to undergo vocational training. In this area lies the physical retraining in skills necessary for the carrying on of the activities inherent in daily living and common to all types of work.

Except in a few isolated instances, the physically handicapped person must be retrained to walk and travel, to care for his daily needs, to use normal methods of transportation, to use ordinary toilet facilities, to apply and remove his own prosthetic devices, and to communicate either orally or in writing. These are such simple things that they

(Continued on Page 610)

Dr. Rusk is professor and chairman, Department of Physical Medicine and Rehabilitation, New York University College of Medicine; chairman, Health Resources Advisory Committee, Office of Defense Mobilization.

Presented at the sixth annual Michigan Clinical Institute, Detroit, March 12, 1952.

EDITOR'S NOTE: Dr. Rusk spoke extemporaneously. We are glad to publish this condensation of his remarks.

Health Requirements of the Aging Population

By Warren B. Cooksey, M.D.
Detroit, Michigan

SO MUCH IS BEING written these days regarding the many aspects of health care as it relates to an ever increasing number of aged persons in our population that it is not easy to choose any one aspect of this rather complex situation for review and discussion. In fact, I have found myself considering, for the purpose of this paper, several interesting aspects of illness in older people. While on the whole there is little medical difference whether we are dealing with a forty-year-old patient as contrasted to a sixty-five-year-old, nevertheless one does see a few somewhat unusual features of illness as they relate to older people. Some years ago, I was very much intrigued by a group of cases I was able to collect in which there was a considerable masking of unmistakable hyperthyroidism in older people[3] who came to me largely because of gastrointestinal manifestations. Since the incidence of hyperthyroidism in Michigan has been decidedly less in recent years, I have seen very few of these cases, and so such a discussion at this particular time would certainly not be profitable. I note in a recent issue of the *Journal of the American Geriatrics Society* an article by Kimble and Stieglitz[4] on the rather frequent occurrence of mild cases of hypothyroidism that had been discovered by searching carefully for such a condition in a group of older people. This could well be an important feature of the chronic illness and lack of vigor in the aged that is sometimes overlooked and may well have an important bearing on the progressive problems of arteriosclerosis in this group. I am sure that we have all seen conditions in which mild nutritional deficiency or relative degrees of avitaminosis have been shown to be present when more careful attention is taken to diet or supplementary vitamin feedings have been instituted. I have had several experiences in which lethargic and even confused older people have been rendered much more alert and mentally clear by a more careful attention to diet, and especially where administration of adequate vitamin B complex supplements had been started. The problem of diabetes in older people also presents some features not altogether common to diabetes in younger people. For the most part, however, diabetes in the elderly person is apt to be of the more mild type, and if one can obtain good dietary regulation and insulin is properly administered when needed, the elderly diabetic is not a difficult or complicated problem. In other words, as I have reviewed the various diseases as they relate to older persons, it has seemed to me that it might not be nearly so profitable for our consideration here to discuss the purely medical aspects of care as it would be to discuss the wider aspects of this problem to which we physicians can contribute so much and for which we are so largely responsible in extending life expectancy to its present high level. There are, in fact, extremely important and controversial issues which have arisen because of the new vast numbers of older persons in our society. We physicians must not fail to take our part in necessary adjustments that need to be made.

A very important consideration that I would like to discuss briefly is the concept that geriatrics is something set apart in the field of medicine; that possibly even a specialty of geriatrics should be created for the benefit of those who might devote their lives exclusively to this field of medical endeavor. There is nothing concerning the problems in the direct care of the aged, from the medical viewpoint, that I would feel more dogmatic about, than the idea that there should be geriatricians as medical practitioners. The care of the aged population, it seems to me, is the responsibility of all of us in the healing arts and positively must not be confined to any narrow group of persons who have set themselves up as specialists in this field. I was delighted to hear a junior medical student in the Wayne University Medical School recently, when discussing his major interests for the future, state that he really believed he was more interested in the field of internal medicine than any other. However, he said he would so much prefer being an internist who would care for his patients from the cradle to the grave. If every single one of us in medicine does not share the responsibility of caring for our older people in a thoughtful and comprehensive way, I can see no hope that these older people will have the care they need. The greater burden of responsibility at present rests upon the general practitioner who is able to know his people and see them in their homes, and thus be able to advise

most intelligently regarding the problems of older patients. Certainly the internist is seeing increasingly larger numbers of old people in his practice, so that very often 50 per cent of his hospital patients are older people. Few physicians indeed are likely to want to care only for the elderly patient because of the exacting and time-consuming nature of such a practice, not to mention the lack of tangible results from one's efforts. All of us therefore must bear this responsibility.

It is my belief that we physicians have a special and tremendous responsibility in giving advice to our individual communities on the many problems involved in the care of the aged. In this community, and I am sure it is not much different in any of the other communities of our state, a major problem involves the care of the bedridden aged. Certainly not a week passes but that I am confronted in one way or another with the problem of helping to place some bedridden older person in facilities where good care can be provided at a cost the patient can afford. Many approaches have been made to this problem, as we physicians well know. Sheer necessity has created the so-called nursing home, and because they are relatively small institutions and not fully economic, the cost of care in these homes has been relatively high. We have fifty-six such homes in metropolitan Detroit, and they need all the co-operation we physicians can give them. It is most encouraging that there is an association of nursing homes in the state, and this association has raised the standards of care significantly. In the average older persons' home, and we have eleven fairly good-sized ones in Detroit, no bedridden aged person can usually be given care. Most of these homes simply do not have the facilities and are undoubtedly afraid of the expense incurred in attempting to provide such care. We have two exceptions to this rule in Detroit: the Jewish Home for the Aged, and the Arnold Home. In the city of Detroit, I am sure that we could easily make use of four or five more homes such as these two, where ambulatory old people are given custody and completely bedridden old people are also cared for. In my judgment, the fully integrated and complete care of an older person such as is given at the Jewish Home for the Aged is not excelled by anything anywhere in the United States. Here those older people who can be around and contribute to the maintenance of the institution and to their own care, are given every opportunity for so doing. Numerous kinds of occupational and diversional activity is provided, and should the older person become bedridden, or should he be admitted as a bedridden patient, a fully equipped nursing service is provided which does not attempt to duplicate the general hospital, but is entirely adequate for the care of these sick old people. At the Jewish Home where a total of 200 beds are available, there are often 75 to 100 beds occupied by the non-ambulatory persons. The nursing care in these two institutions has been simplified and yet is entirely adequate. It has been astonishing to me how fine the care has been and how low the relative cost per person has continued to be over the years in these two homes. I understand at the present time that the average cost per person in the Jewish Home for the Aged is in the neighborhood of $125 per month, while at the Arnold Home it averages about $105 per month. It would be most desirable if every major community in this state could have a standard of care that covers the whole problem, as these two institutions have covered it, and I think it sets a pattern for the future that should be duplicated on a broad scale.

There has been discussion of recent years concerning an annex for the care of bedridden aged persons, as a separate wing of the general hospital. There is much to recommend this procedure, because if an integrated and complete approach to the care of the bedridden aged is given, many older people can be restored to some degree of activity who might not otherwise be rehabilitated in other types of facilities. I think this has been very well borne out by the experience in our institution here in Wayne County known as Eloise. Here, many hundreds of older people are cared for in a way that is not excelled anywhere in the country. A fine general hospital is available on the grounds for any and all kinds of medical and surgical attention, and this is indeed a fortunate circumstance. The shortage of general hospital beds, combined with inadequate personnel, does not make very likely, however, a duplication of this type of service for the private patient as an annex to private general hospitals. Such an arrangement has been worked out in England, and has proven most satisfactory, as it has been reported by Dr. Cosins[1] and others from the Oxford group in England.

Another activity which we physicians can certainly help promote concerns the rehabilitation of handicapped older people. I do not have the

slightest doubt, in spite of the fact that this is a period in which the sentiment of early ambulation is strong, that there still are thousands of older people who are permitted to remain in bed for weeks, months, or years. When some degree of activity is insisted upon at an early date after cerebrovascular accidents, cardiac failure, fractures, et cetera, many of these patients can be restored to unbelievable degrees of activity. We older physicans easily remember many of our patients who had severe hemiplegia that for weeks or months seemed utterly hopeless, and who a year or two afterwards were able to go up and down stairs and do a good deal toward their own care. I can never forget one such patient who was not only hemiplegic but whose speech center was so badly involved that for many months he could only say "yes" or "no." This patient, by the application of patient re-training, through orthopedic measures, and through speech training devices, was actually able to return to his business and carry on a successful advertising agency. I can never forget one of my fine old patients, a judge, who suffered a similar type of hemiplegia, but who for several years now has been able to be about his home and actually go up and down stairs and carry on a reasonably good conversation. And what is especially important is that he is able to enjoy hearing about the doings of his community and can visit with his old friends and associates. Yes, massage, correction of toe drop, early manipulation, and the use of every single adjunct to rehabilitative care can do much for these older people, to make their remaining days enjoyable and not a burden to themselves and others. How often it is, if this is not done, that it can be said of the older person that he died at fifty or sixty but he was not buried until sixty or seventy. This none of us desire, and it is our obligation to see that our patients can avoid this kind of disaster, if it is possible.

In the same connection, I have been very much heartened by some work that has been done by the Institute of Human Adjustment at the University of Michigan,[2] whose staff members have been working in the Detroit area for the past year on what they call their Activities Program. Using scientific measurements and a scientific approach to the problem of care in an average old persons' home, they have compared the well-being and the spirit of the residents in the home before and after certain activities were instituted in the institution. When co-operative endeavors, self-help, recreational and occupational provisions were properly made that had not been possible before, it is reported by this group of workers that a measurable good could be shown to have occurred in the individual persons in this home after such activity was instituted. Unless such a program is well organized and on an economic basis, such as has been carried out especially at the Jewish Home for the Aged, as I have previously mentioned, it is not easily feasible in the average custodial home for the aged. In other words, it is desirable to have very forthright planning at the onset.

As some of you know, we have recently had a visitor to the Detroit area from New York City, a Miss Olive Crandall, who has urged that a return be made to having old people cared for in individual homes—a return, in other words, to the family circle or foster home, where the grandparents are made an integral part of family life. Undoubtedly there are many situations where this kind of relationship is indeed quite ideal. I am sure it is desirable, wherever possible, to preserve the old person's interest in living things, as exemplified in the activity of the family circle. However, in modern urban life, this is many times totally impossible and is often made more difficult because the older person has no preparation whatsoever for the later years and cannot cultivate hobbies or outside interests of any kind. Such an arrangement can be very difficult indeed for younger people who are struggling to adjust to a complex society, when their lives are dominated by a selfish and unreasonable old person. Certainly it is the cause of many family disruptions, and from my own personal observation as a physician, I would strongly favor provision for the various types of care, where under some circumstances the individual family can be used, and in other circumstances congenial housing with people of their own age and interests is provided.

Another subject I wish to mention, which is very much in the minds of some of us in the state of Michigan, concerns the care of the mentally disturbed older person. As most of you probably know, at the present time we are forced to commit these old people to our mental institutions. It is true they are segregated more or less, but usually in quarters not at all designed for economic and completely adequate management of this specific type of mental illness. There are several groups in the state who are promoting the idea that

separate institutions of not too large a size should be provided for the mentally incompetent old person where a different type of institution can be created for this specific purpose. It is hoped that several institutions of this type can be eventually built, to serve the various parts of the state. It would indeed be a great saving, rather than having them housed in an expensive psychiatric institution as at present. We physicians, who all too frequently see this problem in our practice, need to be alert to this movement, and lend our aid wherever possible.

The final social economic matter I wish to discuss relates to the medical care of old age assistance cases which are not in institutions, and to the medical care of persons who have been arbitrarily retired at sixty-five from industry. Under the present arrangement, we have 22,000 recipients of old age assistance in Metropolitan Detroit. These persons receive a total of $60 per month if ambulatory, and $80 per month if they are in nursing homes. For the most part, these people are cared for medically by our free clinics and the city physician's office. In some cities of Michigan, experiments are being made where a modest fee is paid by the county on an individual fee basis and payment is made direct to the county medical society, while care is given by the old person's family physician. This arrangement for the most part has been popular where it is well organized. Preservation of old family physician relationships is so desirable it is hoped we physicians can do everything possible to co-operate in solving this problem satisfactorily throughout the state.

A much more difficult situation exists however when one considers the retired worker. There has recently been organized in Detroit a UAW-CIO Retired Workers Club. I understand 1,000 members have already been listed, and several meetings of the group have been held with as high as 500 in attendance. It is reported to me that a very strong clamor has arisen in this group for some form of government-supplied medical care. When one considers that the retirement pay in our auto factories at present varies between $80 and $125 per month, it is understandable that these families may indeed be hard pressed to provide living necessities and very extensive medical care unless they have considerable reserve savings. Blue Cross-Blue Shield insurance, of course, can be continued on an individual basis after retirement at a slightly higher rate, but apparently not too many workers have continued such coverage. That this ever-increasing group of older citizens provides a fertile field for radical government-controlled medical care goes without saying. Why could not organized labor, organized medicine, and industry sit down together now to discuss proper means of solving this difficult problem. If, in addition, we individual physicians do everything we possibly can to care for and help retired workers, we may indeed avoid undesirable effects.

In summary, may I suggest that we family physicians bear a very real responsibility in not only being alert to the sometimes different diagnostic and therapeutic problems presented by older persons, but that the vast social and economic problems presented by an aging population is also a responsibility which we must share. The provision of adequate facilities for housing, bed care, rehabilitation and preservation of the spirit for older persons is a necessity which is not always being met in every community.

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MSMS

PENSION PLANS

Pension plans begun in more recent years, such as those negotiated in the auto industry, have not felt the full impact of inflation.

But UAW (CIO) officials point out they are keeping close tab on how their 12,500 members who have retired since April, 1950, are getting along. Most of the pensions are limited to a maximum of $125 a month, including social security.

Another group whose retirement plans have come in for revision are persons who took out annuity policies before prices began spiraling.

Insurance spokesmen estimate it takes $180 today to equal the purchasing power of $100 received from such a policy in 1939.—*Detroit Free Press,* April 6, 1952.

Arteriosclerosis

By Chas. F. Wilkinson, Jr., M.D.
New York, New York

OF THE SEVERAL types of arteriosclerosis, atherosclerosis is by far the most important. It is not only the leading cause of death but many of the serious disabilities of later life are secondary to it. This talk will deal with atherosclerosis or atheromatosis. It is a disease of the intima and is most commonly seen in the aorta, but is also found with distressing frequency in the cerebral, coronary and renal arteries.

Certain characteristics of the atheromatous lesion should be emphasized so that we may be better oriented in the subsequent discussion. It is well to point out that it is not an inevitable result of aging. Ophulus[35] has shown that about 10 per cent of individuals above the age of seventy that come to necropsy do not have a significant degree of atherosclerosis. Furthermore, atheromatosis is not a process that is necessarily associated with old or middle age. It does occur in younger individuals. My associates and I[55] have reported a case of a girl, nine years old, with angina pectoris which presumably was due to advanced atherosclerosis. We must remember that all of the experimental methods for producing atheromatosis work as well in the young and middle-aged animals as they do in the older animal. Holman[17] has shown that even in very old and far-advanced atheromatous lesions, one can pick out lesions of very recent origin. We then come to the conclusion that the development of atheromata is an episodic process. The fact that it occurs more commonly in older than in younger people may be the result of an accumulation of lesions over a period of years rather than being due to a process that is associated with old or middle age.

The atheromatous lesion is largely composed of cholesterol,[28,36] and the tremendous amount of evidence that atheromatosis is in some way related to cholesterol metabolism may be regarded as conclusive. However, there is equally good evidence that a metabolic abnormality of this sterol cannot account for all the phenomena observed in this disease.[15] For example, the well-known patchiness of the disease makes it necessary to postulate the operation of local factors in addition to the general metabolic "predisposition." Despite these reservations, the importance of cholesterol metabolism in the genesis of atherosclerosis must still be conceded.

The histology of the atheromatous plaque is so well known that we need not dwell on its description. It is a subintimal collection of lipid-laden foam cells. This lesion may enlarge by the accumulation of more foam cells, may become necrotic and ulcerate through the overlying intima, or may slowly regress, the foam cells being replaced by varying amounts of connective tissue. Though the life history of the characteristic fatty-plaque is known with reasonable certainty, the exact mode of genesis is still obscure. Leary[27] has proposed a theory that the atheromatous process is the result of a direct invasion of the intima by macrophages containing lipid material. These cells he called lipophages, and he states that he has demonstrated all stages of this intimal invasion. This theory has been questioned by some who feel that the lipid, whether as lipophages or not, enters the intima by way of the vasa vasora. On the other hand, Duff[7,8,9] has brought forth evidence that the primary lesion is an alteration of the ground substance of the subintima, which is followed by the appearance of lipid material and finally the local accumulation of phagocytic cells.

Wilens[51] has recently demonstrated that the lipids do pass directly through the intima.

There are many apparently controversial statements in the literature. Some of these are not so controversial on second thought but appear to fit into some sort of a pattern. The picture is far from complete but the outlines seem to be forming. There are however still many points of controversy that only the accumulation of more data will settle. Time does not permit a detailed review of the subject, and reference to many excellent papers will have to be omitted.

Bloch and Rittenberg[3] have shown that in the rat most of the cholesterol is formed from acetate and water. Their work indicates that it is unlikely that fatty acids are directly involved in cholesterol synthesis.

The exact mechanism of cholesterol formation in the human is not known, but we do know that it can be synthesized. In 1920 Gamble and Black-

Based on a talk given at the Michigan Clinical Institute, March 14, 1952, Detroit, Michigan.

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fan[12] showed that there was a greater output than intake of cholesterol in the infant and concluded that it was synthesized in the body. This has been confirmed by other investigators in the adult.

It has also been shown that many tissues in the body can synthesize cholesterol. Among these are the liver, adrenal cortex, kidney, testes, small intestine and skin.[4,43,44] Siperstein[41] and his colleagues have now shown that even the aorta can carry out this synthesis *in vitro*. The relative importance of this ability of different tissues to synthesize cholesterol cannot be evaluated at this time.

There is good evidence[46] that the rate of synthesis in the body is to some extent dependent upon the amount of cholesterol in the diet. Thus if excessive cholesterol is added, the amount of endogenous cholesterol produced is decreased. If the dietary cholesterol is reduced, endogenous synthesis is increased.

It has also been shown that diets in which cholesterol is low or almost absent do not have any effect on the blood cholesterol of normal people. Even in certain types of hypercholesterolemia, diets in which cholesterol is low or almost absent have no effect on the ability of the body to maintain elevated levels of cholesterol in the blood.[42,53]

It appears certain, therefore, that the human organism can synthesize cholesterol, and except in certain highly artificial situations, can maintain normal or even elevated plasma levels.

One cannot discuss the synthesis of cholesterol without discussing its absorption, destruction and excretion.

Cholesterol can be absorbed from the gut by either the herbivorous or carnivorous animal, and the ability to absorb cholesterol is enhanced by the presence of fat in the gastrointestinal tract.[5]

Keys[25] has shown that the blood cholesterol is lowered even in the face of large amounts of cholesterol in the diet if the other fats in the diet are reduced to less than 20 grams per day. This would indicate a decreased absorption of ingested cholesterol as well as the cholesterol from the bile, to such a degree that endogenous synthesis could not maintain normal blood levels. Mellinkoff's data[29] would appear to be open to the same interpretation. He used a diet completely devoid of fat and obtained a decrease in the blood cholesterol of most of his subjects.

The herbivorous animal certainly handles cholesterol with more difficulty than does the carnivorous one. In fact, it can be shown that herbivora excrete very little cholesterol.[17] This

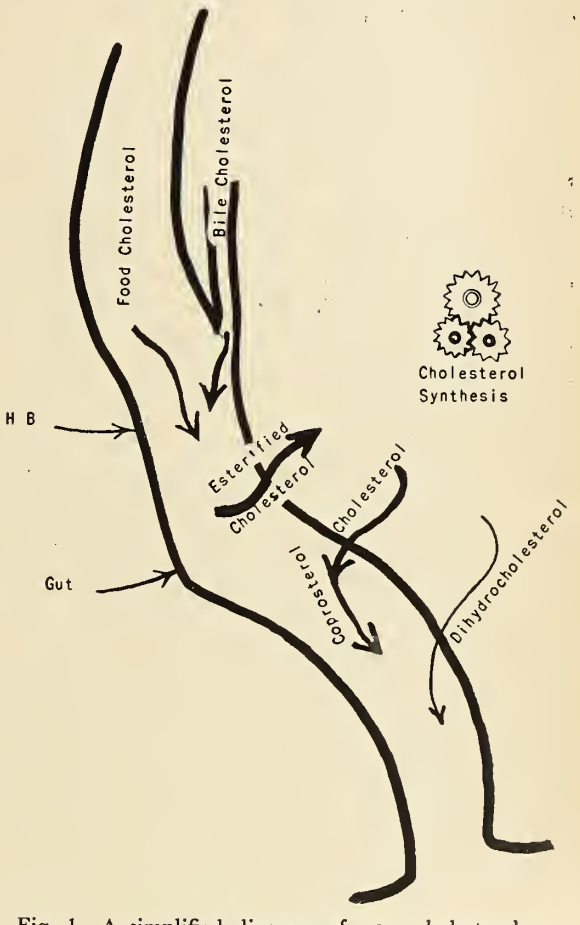


Fig. 1. A simplified diagram of ways cholesterol may be introduced and removed from the gut.

inability to excrete cholesterol after it has been absorbed explains why the blood cholesterol in rabbits can be raised so rapidly by adding it to the diet. From this we must conclude that there are at least two different ways in which cholesterol is metabolized by various animal species.

Neither dihydrocholesterol nor coprosterol can be reabsorbed from the gut. Coprosterol can be formed from cholesterol in the gut. This would be one way in which cholesterol, formed in the body and excreted into the gut, could be made unavailable for reabsorption by the organism. Dihydrocholesterol can be formed in the body and excreted into the gut. The inability of the herbivora to do this as readily as the carnivora may explain many species differences in cholesterol tolerance. Figure 1 illustrates in a diagrammatic

manner the many ways cholesterol is introduced and removed from the gut.

All of this emphasizes the difficulty one has in translating conclusions derived from animal experimentation in cholesterol metabolism to man until more is known about fundamental cholesterol metabolism in man.

The controversy between those who would restrict fat and cholesterol from the diet of an ordinary individual, and those who would not, has achieved so much space in the literature that it would seem profitable to go into this in some detail. It would appear best to approach it first from the point of view of what practical variations in the normal diet do, then, the results of extreme variations in the diet. My colleagues and myself have shown in a recent study[54] that when individuals eat a diet of choice, the individual variations in their dietary fat and cholesterol have no effect on the level of blood cholesterol in normal or hypercholesterolemic individuals. Within the tested range, the percentage of total calories due to fat and cholesterol did not affect the total blood cholesterol (Fig. 2). It should be emphasized, however, that this was a diet of choice and was not a severely restricted diet. A similar piece of work was carried out by Moses[34] and his associates when they added large amounts of cholesterol to the diet of pregnant females. Here, they had a situation where the blood cholesterol would ordinarily increase during the course of pregnancy and they found that even with the added cholesterol there was no greater increase than in their controls.

What happens when fat is totally absent or markedly reduced in the diet? The studies of Keys[25] and Mellinkoff,[29] mentioned above, demonstrated that it is possible to reduce the blood cholesterol by severe restriction. However, few of us would care to eat the completely synthetic diet that Mellinkoff used, or a diet containing 20 grams or less of extractable fat such as Keys employed.

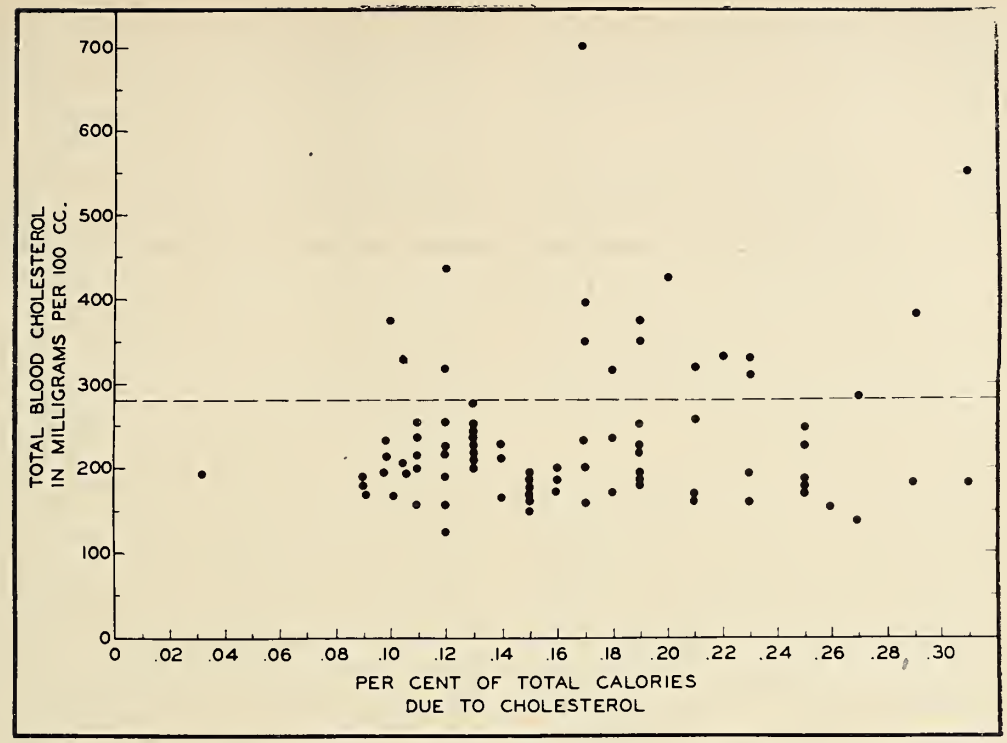
Is it possible to raise the blood cholesterol by variations in the diet? Here again it is possible in very abnormal circumstances to raise the level of the blood cholesterol. Steele[30] and his coworkers have fed dried egg yolk in large amounts to patients and found that it was possible to elevate the blood cholesterol. It is of interest to note that when cholesterol in its pure form was added in even greater amounts than the amount present in egg yolk, no elevation was effected. In addition, pure cholesterol plus added fat did not increase the blood cholesterol as did the dried egg yolk. The amount of egg yolk administered was well above that consumed in the ordinary diet, being equivalent to between 25 and 30 eggs per day, and while the increases in blood cholesterol were very definite, they were not excessive.

From the above illustrations it would appear that normal variations in a diet such as the average person would choose, will not bring about changes in that person's blood cholesterol level. However, with radical restriction of the dietary fat, it is possible to decrease the level of the blood cholesterol and with equally radical changes in the other direction, by the addition of large amounts of egg yolk, it is possible to increase the blood cholesterol. For the present, therefore, it hardly seems reasonable to use dietary regimes in the prevention or treatment of arteriosclerosis unless we are going to advocate an extreme type of diet.

Even if we were able to convince our patients to eat this bizarre diet, have we any proof that a low blood cholesterol will prevent or cure atheromatosis? Shaffer[40] has reported some interesting data after analyzing the autopsy findings of 100 persons between forty-seven and sixty-five years of age who had been on diets abnormally high in cholesterol and fat for the treatment of peptic ulcer. He found that the incidence of coronary arteriosclerosis was no greater than in 100 control persons who had been on diets much lower in cholesterol and fat.

Wilens[50] has shown that the substitution of alcohol for a large portion of ordinary foods in the diet does not have, in itself, an appreciable effect on the development of atherosclerotic lesions. He also emphasizes that the materials deposited in atheromatous lesions are not necessarily derived as such from ingested food. He points out that in excessive alcoholism average body weight is usually maintained and the liver contains large amounts of fat, suggesting that much of the alcohol consumed was converted into fat.

We know that any group of atheromatous individuals, as manifested by coronary occlusion, will have a higher average blood cholesterol than will a corresponding group of normals. It is, however, prudent to point out that many of those with coronary occlusion will have lower blood cholesterols than many of the normals, and some



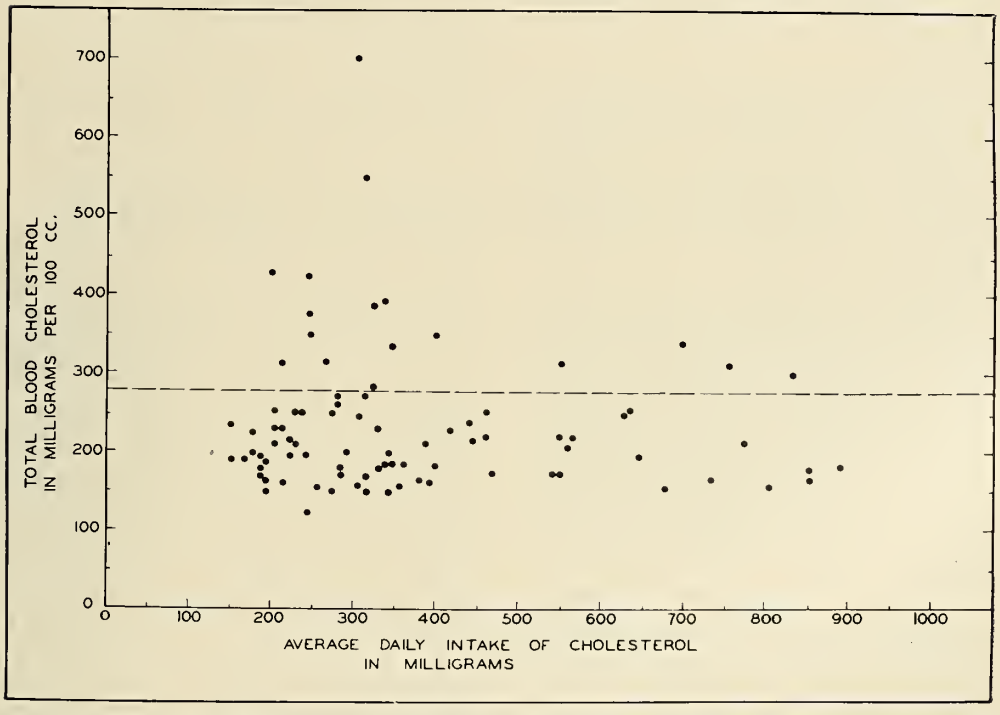


Fig. 2. These two graphs show that there was no relation between total cholesterol intake or per cent of total calories due to cholesterol and the blood cholesterol. Similar graphs were constructed for carbohydrate, fat, and protein.

of the normals may have higher blood cholesterols than those with coronary occlusion. There is, then, no very definite correlation as far as the individual patient is concerned between his blood cholesterol level and whether he will or will not have atheromata.

The demonstration by Hueper[18] that injection of macromolecular colloids others than cholesterol

could produce the histologic picture of atheromatosis naturally excited the suspicion that the stimulus to atheroma formation lay not in the chemical structure of cholesterol but rather in its physical state.

Moreton[31,32] has advanced a theory that the physical state of the blood lipids is the cause of arteriosclerosis. He has reported that people with nephrosis, myxedema, xanthomatosis and other diseases which predispose to arteriosclerosis have an increased number of "chylomicrons," even in the fasting state, and that polyvinyl alcohol and the other substances used by Hueper are also in large particles or "chylomicrons."

His theory is that large lipid particles which pass with the lymph into the intima incite the foreign body response which is a characteristic histological feature in early experimental atheromatosis. He believes the triglycerides and fatty acids are rapidly resorbed or metabolized, and cholesterol, being more inert, remains behind, and accumulation of lipids in the arterial intima is a local mechanical problem and is unrelated to general body balance or over-all metabolism of the body lipids.

Bevans, Kendall and Abell[2] have produced atheromata by repeated injections intravenously of cholesterol suspensions. They noted microscopic evidence of lipid within the intima of the aorta three hours after a single injection. They did not, however, report the particle size of their cholesterol suspensions.

Pollack[37] showed that subintimal cholesterol deposits could be demonstrated immediately upon the completion of injection of cholesterol suspensions and that the number of lesions were larger upon injecting coarse suspensions than finely dispersed cholesterol. He also reported that the number of atheroma-like lesions decreased if the experimental animal were allowed to survive after a single injection.

Still more recently, Gofman[13,14,21] has demonstrated an increase in a certain class of lipoprotein molecules in many cases of experimental and human arteriosclerosis. These molecules are characterized by their rate of flotation in the gravitational field of the ultracentrifuge. These data, while extremely impressive, by no means give an absolute correlation between the incidence of arteriosclerosis and the presence of these particular lipoprotein molecules.

Keys[24] has criticized Gofman's interpretation of his data and believes that the presence of large molecules is no better as an index of the degree of arteriosclerosis present than is the level of the total blood cholesterol. Gofman[21] has also stated that these large molecules could be reduced by restricting the dietary intake of fat. Other workers have not been able to confirm this,[16,33] and at the present we must await clarification of the importance of these large molecules both in the genesis as well as the diagnosis of atheromatosis.

Recently Barr[38] has brought forward new evidence that the physical state of the lipid is important. He has shown that the ratio between the alpha and beta liproproteins is definitely shifted in diabetics who are presumably predisposed to arteriosclerosis. It should be pointed out that the level of the blood cholesterol did not necessarily correlate with the altered physical state of the blood lipids as measured by the method of Barr.

Since the ratios of the various blood lipids are altered in certain disease states and normally change after meals, it is not surprising that some investigators have studied these variations in relation to the formation of atheromata. This led to inquiries into the mechanisms which maintain the normally finely-dispersed colloidal suspension of this hydrophobic lipid in serum. At least two factors would seem to be of importance in this respect: (1) plasma proteins, which have been discussed, and (2) plasma phospholipids.

The major phospholipid of plasma is lecithin, which is hydrophyllic in contrast to the other plasma lipids and is capable of stabilizing oil-in-water emulsions.[39] In 1949, Ahrens and Kunkel[1] were able to show that the concentration of phospholipid was an important factor in determining the particle size of serum lipids.

Kellner and his associates have reported that the repeated intravenous injection of either Tween 80 or Trition A-20 into rabbits fed a high cholesterol diet, retarded or prevented the development of atherosclerosis.[23] This was in spite of the fact that rabbits given the intravenous detergents had far higher mean levels of the blood cholesterol than the control animals, which were also fed cholesterol but did not receive the detergents.

The critical factor in this experiment was thought to be not the level of the blood cholesterol, but its proportionate relationship to the phospholipids in the blood. When the phospholipids were elevated to the same degree as the cholesterol, the incidence and severity of atherosclerosis was de-

creased. If, however, the phospholipid did not parallel the rise in cholesterol, there was rapid production of atheromata. No such protection was noted if the detergents were given by mouth, and process. No such relationship could be demonstrated between phospholipid and total or esterified cholesterol.

With elevation of the free cholesterol, there is a

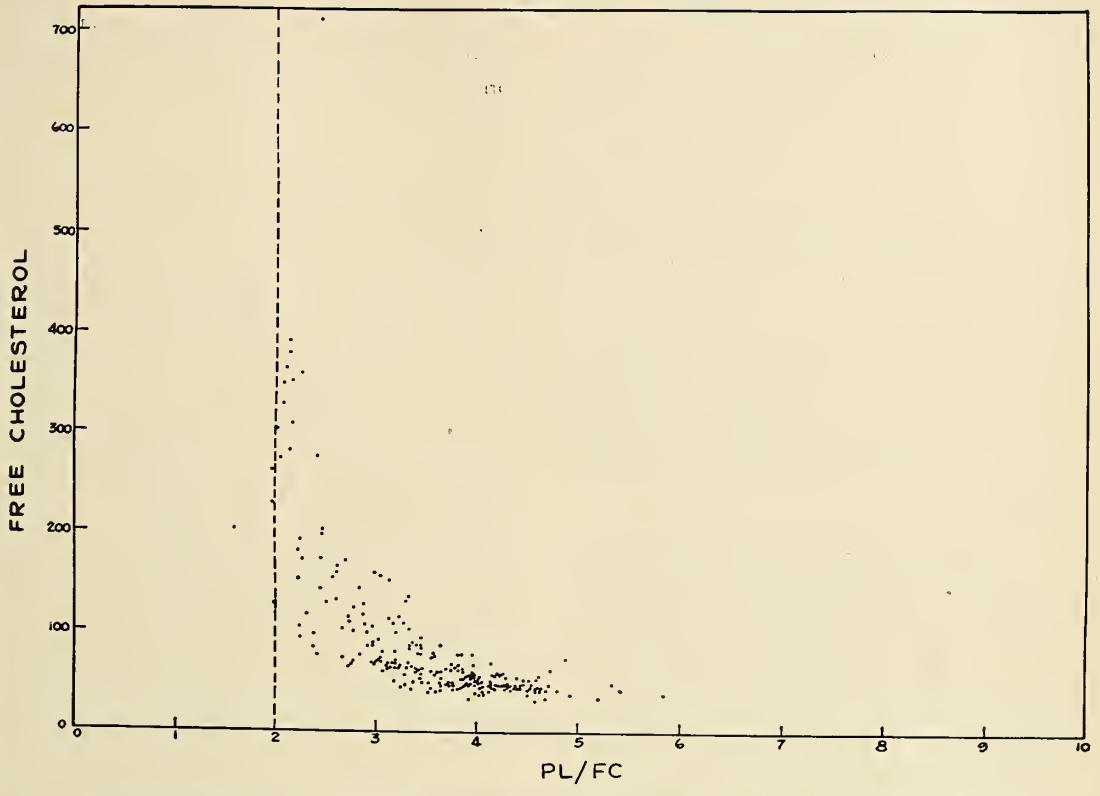


Fig. 3. This illustrates the limiting value of a PL/FC ratio of 2.00. This value represents an equimolar concentration of phospholipid and free cholesterol.

intravenous detergents were ineffective in the resorption of atheromata previously produced by cholesterol feeding.

Duff and his co-workers[10] have shown that diabetes produced in rabbits by alloxan actually inhibits the formation of atheromata. This, of course, is directly opposite to the commonly accepted idea that human diabetes causes an increase in the incidence of atherosclerosis. The neutral fat in the diabetic rabbits showed a much greater rise in proportion to the increase in total cholesterol than it did in the control rabbits.

In 1950 and 1951 a group of us[19,20] reported on the relationship between the phospholipids and the cholesterols in plasma on the basis of the examination of 242 human subjects, including both normal controls and a variety of disease states. A most consistent relationship was found to exist between the phospholipids and free cholesterol which appeared to be independent of the disease decrease in the proportionate amount of phospholipid. The rate of decrease, rapid at first, approaches zero when the PL/FC ratio has declined to the point where equimolar quantities of phospholipid and free cholesterol exist. Further increases in free cholesterol do not disturb this equimolar relationship (Fig. 3).

Since the ratio of free cholesterol and phospholipid can be predicted on the basis of the total cholesterol level, in the absence of liver cell failure, neither this ratio nor the total cholesterol-phospholipid ratio seem to be of any more value than the height of the blood cholesterol in determining whether a patient is likely to have atheromatosis or not. It has been pointed out[26] that the heights of the blood cholesterol cannot be used to separate individuals with atheromatosis from those without it. We do feel, however, that this limiting factor of the unimolar ratio may be important in

intimal metabolism of lipids and the sequestration of cholesterol in the formation of plaques.

More recently, Kellner and his group[22] have emphasized the interrelations of the blood lipids in the lymph and have shown that many of the changes in the circulating plasma are not always reflected in the lipids of the lymph.

With this evidence in front of us it appears reasonable to say that the interrelationship of the blood lipids is important in experimental atheromatosis and possibly in human atheromatosis; and through an understanding of this and the physical state of the blood lipids, we may finally arrive at our goal, which is the prevention and treatment of arteriosclerosis.

There can be no doubt that the state of the body metabolism and mechanics has a great deal to do with the development of atheromata. It would not be practical to cover all the material available on this subject, and I shall, therefore, select only a few examples.

Wilens[49] has shown that atherosclerosis is more likely to develop in obese than in underweight people. He has also shown that the process can be reversed to some extent by a reduction in weight.[52]

Diabetes and myxedema are known to be associated with an increased incidence of atherosclerosis. Stearns[45] and his co-workers have reported that 75 per cent of fifty diabetics at autopsy showed significant coronary artery disease and one third of them died of acute coronary occlusion. They feel that diabetic women over forty are as likely to have coronary atherosclerosis as are men and that diabetics have coronary artery occlusions twice as often as non-diabetic men and eight times as often as non-diabetic women.

On the other hand, Underdahl and Smith,[48] in reviewing the records of 95,000 women under forty seen at the Mayo Clinic over a ten-year period, found only twenty-seven with unequivocal evidence of coronary artery disease, and of these only one had diabetes. They felt that obesity, hypertension and hyperlipemia were the conditions nearly always associated with coronary atheromatosis in women under forty.

Bruger and Chassin[6] in 1940 reported that the hypertensive state leads to an increased deposition of cholesterol in the renal arteries. Faber[11] has demonstrated the same phenomenon in the aorta.

Ophuls[35] has shown the extreme importance of the existence of nephritis in young individuals who have atherosclerosis. In his series of those who had arteriosclerosis below the age of thirty, more than one half of them were nephritic.

The recent brilliant researches by Wilen[51] have shown the extreme importance of intra-arterial pressures upon the rate with which the blood lipids are filtered through the intima. It has also been shown that trauma can predispose to the formation of atheromatous lesions in the experimental animal.

Summary and Conclusions

1. Cholesterol can be manufactured by the body in large amounts.

2. Except in certain metabolic disorders, the level of the blood cholesterol is affected only by extreme changes in the diet.

3. Hypercholesterolemia, *per se,* is probably not the cause of atheromatosis.

4. The physical state of cholesterol and the other blood lipids seems to be an important factor in the production of atheromata.

5. Experimentally, the interrelation of all the blood lipids appears more important than the concentration of any single one.

6. Atheromatosis should be thought of as an episodic, intermittent and cumulative disease. The fundamental underlying process can occur at any age.

7. As yet we have no laboratory procedure which can predict atheromatosis, either present or impending, with any degree of accuracy, except the typical electrocardiogram of coronary occlusion.

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Meniere's Disease

Medical Treatment

By Henry L. Williams, M.D.

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DIFFICULTIES in the therapeutic management of Ménière's disease appear to stem from two sources. The first is the confusion in the differential diagnosis which has been produced by the introduction of the term "Ménière's syndrome" and the broadening of the term to include any condition which produces true vertigo, even aural suppuration, and such diverse symptoms as dizziness, in-co-ordination, unsteadiness, syncope and lightheadedness as well as true rotatory vertigo. This broadening resulted from misreading and misquoting Ménière's original papers both in respect to the symptom complex he described and to the pathologic basis which, it is falsely alleged, he suggested for the condition.[27] A proper conception of the meaning of the terms used, and with this as a basis, proper differential diagnosis is the first requisite in the treatment of this disorder.[26] If this prerequisite to treatment is not met, many therapeutic failures may be expected from attempts to treat as Ménière's disease diverse conditions, which are not in fact Ménière's disease. A careful and detailed history with proper attention to meanings should be considered the basic first step in successful treatment.[25,29]

The second factor which has been productive of therapeutic failure has been the lack of a unifying concept to explain the etiology of this condition. It is considered that this lack has been supplied by the hypothesis of physical allergy.[28] Ménière's disease then is a localized type of autonomic dysfunction producing spasm in the arterioles supplying the macula and crista of the equilibrial labyrinth or those supplying the stria vascularis or both at once. One may thus conceive of Ménière's disease with or without endolymphatic hydrops, a conception which is quite valid on an anatomic basis as was originally pointed out by Lermoyez.

In the localized type of autonomic dysfunction of physical allergy the underlying lesion has been shown to be, by biomicroscopic methods, an arteriolar spasm with secondary dilatation often amounting to varicosity of the conjoined capillary and venule. This results in anoxia, injury to the tissues of the capillary wall and to wandering cells contained in the lumen of the capillary loop. The result of such injury is the release of toxic substances such as the necrosin, leukotaxin, and histamine, depending on the cell injured. Both the anoxia and the released histamine tend to produce an increase in the permeability of the capillary wall with a consequent increase in the interstitial fluid which will result in typical allergic wheal. Other types of allergic lesions may occur if there is a preponderance of substances producing tissue injury.

If such a disorder of function affects the inner ear, it may involve the crista and macula and will result in the characteristic vertiginous crises, falling attacks or persistent unsteadiness. On the other hand, if this arteriolar-capillary disorder affected the stria vascularis, endolymph of increased volume and increased protein content will result. The Donnan effect ought to be particularly active in a situation such as the endolymphatic system, which is virtually an enlarged lymph sac. This, by increasing osmotic pressure in the cochlear duct, should produce an increased volume of endolymph and a squeezing effect on the organ of Corti resulting in the characteristic auditory changes of Ménière's disease.[5,10]

If both areas (the crista and macula, and the stria) are affected simultaneously, the complete triad of Ménière will be produced. Reactions in these different areas result in various symptoms and signs with which we are all familiar,[7] such as the so-called cochlear deafness preceding vertigo by many years, and also the converse. We also recognize that the vertiginous crises and variations of cochlear function in a typical instance of Ménière's disease may occur independently of one another.

In treatment for Ménière's disease three principal factors must be taken into consideration: (1) the dysfunction of the vascular portion of the autonomic system, the arteriole and capillary loop and (2) the collection of an increased amount of interstitial fluid in the endolymph system which is a result of the increased capillary permeability and (3) the dysfunction of the autonomic system. It has been found more effective clinically to treat

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these factors synchronously rather than to direct treatment first against one and then against another aspect of the disorder as is often done.

Vasodilatation to relieve arteriolar spasm was probably the first method employed in the treatment of Ménière's disease. Before the symptom complex was described by Prosper Ménière or its etiology understood, physical therapy was employed in many vertiginous conditions. Müller pointed out that a greater vasodilating effect can be produced by contrast baths than can be produced by the intravenous use of the nitrites and he recommended such therapy in Ménière's disease. Dederding and Mygind and Dederding advocated, in addition, massage, not too vigorously applied. They found that massage mobilized the interstitial collections of fluid in other parts of the body, which in their opinion frequently are associated with Ménière's disease, and tended to correct the disordered splanchnoperipheral balance due to the autonomic dysfunction.

Apparently papaverine was used next.[17] This produced vasodilatation by its effect on smooth muscle, releasing in this manner the arteriolar spasm present. Papaverine hydrochloride, ¼ grain (0.016 gm.) given intravenously, was originally recommended. Later investigators found this dosage too low to be effective in similar conditions. In cerebral angiospasm, for instance, a related condition, Russek and Zohman advocated from 4¼ to 18 grains (0.28 to 1.2 gm.) of papaverine hydrochloride per day by mouth. They found the toxicity of papaverine so low that ten times the maximal therapeutic dose would not result in untoward effects. Combination of papaverine with phenobarbital (¼ to ½ grain; 0.016 to 0.032 gm.) appeared to reduce the dosage of the latter required for clinical improvement. Conversely the use of coffee and tea in excess tended to vitiate the effectiveness of papaverine.

Papaverine, 2 grains (0.13 gm.), can be combined with ¼ grain of phenobarbital and given at intervals of four to six hours throughout the twenty-four. This tends to relieve the arteriolar spasm and at the same time diminishes the emotional perturbation which often seems to be a major factor in precipitating attacks of Ménière's disease.

Histamine has been recommended as a vasodilator in many conditions, especially in Ménière's disease. According to Weiss, Robb and Ellis, the effectiveness of histamine in releasing arteriolar spasm varies in different individuals and some of the failures in histamine therapy may be attributed to this fact. The effectiveness of histamine appears to be due to its speed of administration rather than the total dose received, as it is almost immediately metabolized in the blood stream. For this reason histamine given intramuscularly in small doses is of doubtful effectiveness as a vasodilator.

It is recommended[30] that 2.75 mg. of histamine diphosphate be dissolved in 250 cc. of 5 per cent solution of glucose and administered by intravenous drip. The rate of administration is usually 25 drops per minute at first and gradually increased during the course of administration to 50 drops per minute or more. The rate of administration should be so regulated that no headache or other reaction is produced, and infusion should never be continued longer than one hour. If an untoward reaction is produced, the rate of injection should be immediately slowed. Because histamine produces an increase in the secretion of gastric acid, patients receiving it should either have the stomach full of food or should be given protective antacids during its administration. Best results are secured by daily repetition of the intravenous injections over an extended period. In Ménière's disease with endolymphatic hydrops improvement in the hearing has sometimes not appeared until after two to four weeks of vigorous intravenous histamine therapy although vertigo may disappear in two to three days.

The disadvantages of treatment with histamine are that the constant attention of a physician or of other thoroughly trained persons is required during administration, and relatively elaborate preparations must be made for its use. In this respect it has the same disadvantages as procaine solution used intravenously recommended recently by Hilger except that histamine appears to be a more effective vasodilator.

Nicotinic acid and its pyridine compounds such as sodium, ammonium and monoethanolamine salts containing the free nicotinic acid radical are vasodilators and have a physiologic effect nearly identical to that of histamine.[4] It should be noted that nicotinic acid amide and other compounds having a fixed nicotinic acid radical are not vasodilators but may even have a slight vasoconstricting effect. Their use should be avoided in Ménière's disease.[1]

Nicotinic acid may be given intravenously but when so used has many of the disadvantages of

histamine and in addition is relatively insoluble, 100 mg. requires 10 cc. of water as solvent. Monoethanolamine nicotinate (nicamin)[25] has proved the most convenient vasodilator to use in office practice. It may be secured in vials of 2 cc. containing 100 mg. of the salt. This can be given intramuscularly with no danger of a serious reaction and little danger of any reaction and its administration may therefore be entrusted to the office nurse.

Therapy is started in the average patient with Ménière's disease with intramuscular administration of 25 mg. of monoethanolamine nicotinate. This amount is increased by a like amount at daily or twice daily injections until the dose begins to give relief of symptoms. The dose is then usually 100 mg. Administration of 100 mg. daily is then continued for an extended period. Patients at high altitudes (5,000 feet or more) may require a larger dose to secure comparable therapeutic results, sometimes as much as 400 mg. daily.

Dizziness and vertigo are usually relieved in two or three days and if Ménière's disease is without the cochlear signs of endolymphatic hydrops, the dosage may be decreased at the end of two weeks. This is best done by increasing the interval between doses to every other day for a week, three times a week for another week and then stopping injections. If symptoms tend to return at a later date, "booster" injections may be given. From an initial dose of 25 mg. the dosage may be increased to 100 mg. and given at this level for a week. Administration then may be abruptly stopped. Such "booster shots" given two or three times a year may be found necessary to keep patients with Ménière's disease relatively free of symptoms.

If, on the other hand, endolymphatic hydrops with its associated cochlear symptoms is present, a delay of good results as far as a return of the hearing is concerned should be expected. This delay appears to be owing to the fact that in the endolymphatic system of the human animal nature has prevented those factors such as pulsation of vessels and other structures,[19] which usually operate in the elimination of lymphatic fluid, from producing much effect. Meurman has indicated that in man there is no free communication between the perilymph and the cerebrospinal fluid so that pulsations of the brain and cerebrospinal fluid are prevented from affecting the humors of the ear. Both for this reason and because the endolymphatic (otic) sac and duct are constructed to be effective

Maximum in 24 Hours	Basic Ash Foods	Acid Ash Foods	Minimum in 24 Hours
1 pint	Milk	Eggs	2
2 servings	Vegetables	Meat, fish and fowl	1 serving
		Bread and cereals	5 slices or servings
2 servings	Fruits, except ⟶	Prunes, plums and cranberries	As desired

dampeners of pulsation, secretion as suggested by Guild, by Bast and Anson and by Arnvig, and osmosis are the only forces by which endolymphatic fluid can be eliminated. Therefore the absorption of an excess of endolymphatic fluid, especially if it contains a higher percentage of protein, may take considerable time.

When endolymphatic hydrops is present, therefore, improvement in the hearing may not appear before two or four weeks of active treatment. Active treatment should be continued until improvement in the cochlear function reaches a standstill.

It has been suggested that the use of vasodilators without at the same time paying attention to elimination of interstitial fluid will delay resolution of edema such as is present in endolymphatic hydrops. It is thought that the increased filtration pressure produced by the vasodilator will produce a temporary increase in the volume of the endolymph.

Schemm has stated that retention of sodium is the primary factor in the persistence of edema. In each liter of edema fluid Schemm found 10 gm. of an alkaline mixture of sodium salts, consisting of five parts of sodium chloride to one part of sodium bicarbonate at a pH of 7.4. The alkaline edema fluid remains inert and is retained indefinitely unless the bicarbonate fraction is used up by the metabolic acids or by ingested acids. Acidification mobilizes the sodium. As the sodium leaves the body via the kidneys, its water of solution is free to leave the body as urine, as water vapor or to remain in the body to remedy decreased concentrations of body fluid and cellular dehydration.

Since Rössle has shown that allergic edema fluid differs from ordinary edema fluid only by its higher protein content, elimination of the sodium seems an important goal in endolymphatic hydrops.

Schemm has suggested a low sodium diet which yields a neutral or slightly acid ash, to prevent neutralization of the metabolic acids. He pointed

out that the construction of such a diet depends on knowledge that milk, all vegetables, and all fruits except plums, prunes and cranberries yield an excess of alkaline ash.

Patients with Ménière's disease with endolymphatic hydrops therefore should be put on a diet modified from Schemm as shown in the accompanying table.

Precautions recommended are:

1. Use no salt or soda in or on food (soda biscuits).
2. Take no prepared foods containing salt (sauerkraut).
3. Take no salty broth, soup, extra juice or milk.
4. Take no vegetable salt, no soda bicarbonate for "gas," et cetera.

Schemm stated that the neutral or acid reaction of the diet is, within limits, more relatively important than the total sodium or salt.

Since it is difficult for ambulatory patients to maintain an extremely low sodium diet, patients with Ménière's disease are advised not to add any salt to the diet, except that used in seasoning in the kitchen. Provision is made to get rid of the excess sodium by diuresis and at the same time produce relative acidity, by the use of ammonium chloride. Keith and associates have pointed out that ammonium chloride will have a greater effect toward producing an acid pH than mineral acids. They advised the use of from 6 to 9 gm. per twenty-four hours.

My patients, therefore, are given six enteric-coated tablets of ammonium chloride of 7½ grains (0.48 gm.) each during meals three times a day. Patients also are advised to avoid overloading themselves with fluid, especially beer and soda drinks.

Stoesser and Cook and Kern have shown that sodium tends to lower the threshold above which allergic reaction tends to take place. Furstenberg, Lashmet and Lathrop confirmed this effect of sodium in Ménière's disease. This constitutes an additional important reason why the intake of sodium should be controlled in Ménière's disease.

The third factor to be considered in the relief of Ménière's disease is the autonomic dysfunction consisting of overactivity of the cholinergic portion of the autonomic nervous system. Several autonomic blocking drugs have been presented but the one apparently having the greatest anticholinergic effect at present appears to be beta-diethylaminoethyl xanthene-9-carboxylate (banthine). This interrupts transmission of impulses not only at the autonomic ganglia but also at the end-plates of the cholinergic nerves, thus its activity in therapeutic doses is largely anticholinergic.

In Ménière's disease patients in the active stage are given either 100 mg. of banthine every six hours (night and day), or 50 mg. every four hours. Some patients protest against the night doses, but unless these are given, much of the effect appears to be lost. When the maximal improvement has been obtained, use of this medicament is stopped but patients are advised to resume its use whenever they are to be faced with stress whether environmental or emotional.

Patients should be told of the unpleasant side effects of this drug, the most annoying of which is the dryness of the mouth and nose. Other unpleasant effects are interference with accommodation of the lens and slight difficulty with urination.

Other drugs which may be found useful in Ménière's disease are phenobarbital or Cyclopal.® These may relieve an anxiety tension state which is often present. Both dimenhydrinate (Dramamine®) and diphenhydramine hydrochloride (Benadryl®) have been recommended in Ménière's disease and appear to be about equally effective. Their sedative side action rather than any other may produce the symptomatic relief.

For the acute crisis of Ménière's disease drugs which stimulate the adrenergic and depress the cholinergic fibers of the autonomic nervous system have been found effective. Epinephrine given slowly intravenously will often cause rapid relief to symptoms.

A total of 3 to 5 minims of 1 to 1,000 epinephrine injection is given slowly to relieve the severe vertigo and nausea. Injection should be stopped as soon as the severe symptoms have decreased. Administration by mouth of 3 grains (0.2 gm.) of ephedrine repeated in one-half hour if necessary also has proved effective in the acute attack, as has 10 mg. of amphetamine sulfate. The most effective remedy, however, appears to be atropine sulfate 1/75 grain (0.00086 gm.) given intramuscularly. Patients can be taught to administer this dose to themselves and the fact that they can control and prevent these embarrassing

attacks of vertigo, nausea and vomiting at will goes far to relieve the feeling of insecurity with which many of these patients are afflicted.

Summary

Ménière's disease is considered to be a localized type of overactivity of the cholinergic fibers of the autonomic nervous system acting on the arterioles, capillaries and venules of the peripheral-vascular bed, in other words a physical allergy.

Treatment based on this hypothesis is directed at three principal factors, first, the arteriolar spasm, second, the excess of interstitial fluid, and third, the overaction of the cholinergic fibers. It has been found that if measures directed against these three factors are used concurrently, better results will be obtained than if they are used alone or in tandem.

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Varicose Veins

Evaluation and Treatment

By Charles R. Doyle, M.D.

St. Louis, Missouri

VARICOSE VEINS of the lower extremities and the ulcers of the legs they often cause continue to be one of the most distressing common conditions which confront the physician. This pathological condition has been recognized since the earliest times and many great practitioners have concerned themselves with it. Each has advocated his own form of treatment; and as is the case when so many different therapeutic measures have been and still are advocated, none is completely satisfactory by itself.

The basic trouble in this condition is incompetence of the valves of the veins of the lower extremities. This results in retrograde flow of the blood in these veins, increased pressure on the walls of the veins with resultant dilatation and tortuosity. Thus there is a vicious cycle produced since incompetence of the valves causes increased pressure which, in turn, causes dilatation of the veins and a greater degree of incompetence of the valves. The color changes, thickening of the skin, and frequently ulceration are the result of improper nutrition of the tissues due to stasis and retrograde flow.

Many theories have been advanced as to the cause of varicose veins, such as congenital absence of valves and structural defects in the vein walls. However, it is well known that these cannot be the only causes. They occur most frequently in individuals who are required to stand for long periods of time; barbers, banktellers, cooks, workmen who stand at machines, and clerks are most commonly affected.

During pregnancy minimal varicose veins are likely to become pronounced, and the condition becomes progressively worse with each succeeding pregnancy. Many women come for treatment during the fourth and fifth pregnancy who give a history of trouble during the earlier pregnancies with complete remission of symptoms during the interval between them. As the varicosities become more pronounced with each succeeding pregnancy, the remissions do not occur and the symptoms become more severe.

The most common complaints are pain, tiredness of the legs, full bursting sensation, nonulcerative skin changes and ulcers. Some patients, usually women, come for cosmetic reasons alone. The pain is usually aching in character and becomes worse toward the latter part of the day, and not uncommonly there may be cramp-like pains for an hour or two after going to bed. The full bursting sensation in the legs is present in the more severe cases, particularly those individuals who must stand in one position for long periods of time. The muscular action of walking helps to empty the veins so there is much less stasis even though there is marked retrograde flow. The nonulcerative skin changes vary from mild discoloration to thick brawny induration, most frequently seen in the inner lower aspect of the leg, but may completely encircle the leg just above the ankle.

More than 50 per cent of the patients seen already have ulcers which vary from multiple small, denuded areas in a thickened pigmented skin to large, deep, dirty ulcers, some of which involve the complete circumference of the leg. It is common to find patients who finally present themselves for treatment who have been dressing ulcers daily for two to three years. In several instances the time was as long as eight to fifteen years.

The evaluation of the severity of the condition begins with a complete history and physical examination. The history should be particularly specific regarding any possible previous deep thrombophlebitis. The presence of a post-phlebitic syndrone is usually quite apparent from the examination and definitely does not contra-indicate surgical treatment for incompetent superficial veins in which there is retrograde flow of blood. The post-phlebitic syndrome with its complications is too large a subject to include in this discussion. However, it is true that the two conditions frequently are related; and that once there has been a major thrombophlebitis of the deep veins of the lower extremity, that extremity will never again be normal. The severity of the post-phlebitic syndrome probably will become progressively worse beginning from three to five years after the original thrombophlebitis when recanalization of the organized thrombus has progressed significantly.

The history and general physical examination should also determine the presence of pelvic dis-

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ease or tumor, which might cause pressure, or of any general constitutional disease such as diabetes.

In the examination of the lower extremity the arterial circulation should be evaluated, but even though there is impaired arterial flow with marked decrease or absence of the pedal pulses, this is not a contraindication to the treatment of the varicose veins. On the other hand, it may be a definite indication for instituting proper therapy to remove at least one factor producing stasis and contributing to any existing ulceration, in an extremity where the nutrition is borderline.

Numerous tests have been devised to facilitate the diagnosis and to determine the pathological significance of varicose veins. The most common of these are the Brodie-Trendelenburg, the comparative tourniquet of Ochsner and Mahorner, the Perthes' test, the compression test, the Schwartz percussion test, and more recently phlebograms. The Brodie-Trendelenburg test, commonly referred to as the Trendelenburg test, is the only one needed for the complete evaluation of varicose veins. It provides all the information necessary, is the simplest, the quickest, the easiest to perform. It does not require any great skill, and the interpretation of the findings is quite obvious.

The Perthes' and the compression tests are supposed to evaluate the adequacy of the deep venous system; however, the application and interpretation of these tests is not always easy and often fallacious. The Schwartz test is dependent on the transmission of a percussion impulse from a varix in the leg to the sapheno-femoral juncture as a positive indication of an incompetent long saphenous vein. This has been shown to be incorrect and that it is possible for the impulse to be transmitted through the column of blood in a normal vein. The comparative tourniquet test gives no information that is not easily obtainable from the Trendelenburg test, except that it is supposed to indicate the presence of deep vein thrombosis. Theoretically, the latter may be true but its application is highly impracticable.

There are as many methods of producing phlebograms for the evaluation of varicose veins as there are authors advocating their use. The procedure is cumbersome, it is not without some danger (although slight), and the interpretation is difficult and frequently doubtful. However, the most valid argument against their use is that no information is obtained by phlebograms which cannot be more readily and even more accurately obtained by careful clinical examination. Lastly, the results of phlebograms have no bearing whatever on the treatment instituted if there are incompetent varicose veins in which there is retrograde flow.

The Trendelenburg test is accomplished in the following manner: The patient stands so that the entire lower extremity may be inspected. The prominence of the veins and their tension to digital pressure are noted. The patient then lies down and the lower extremity is elevated so that the blood drains from the superficial venous system. Without tourniquet or pressure, he stands again and the rapidity with which the veins fill is noted. It will be immediately apparent where the veins are prominent, whether they fill rapidly or slowly from below. If they fill slowly from below so that forty to fifty seconds elapse before the veins are filled to the level of the knee, then there is no incompetence of the valves at that particular time. If the superficial veins have filled rapidly, there is incompetence.

The patient is asked to lie down and the lower extremities again elevated for a few seconds. Pressure is applied over the sapheno-femoral juncture either digitally or with a tourniquet around the upper thigh, and the patient stands up. With the upper end of this saphenous vein occluded by pressure, if the veins do not fill rapidly as they did without the pressure, then it is apparent that the only incompetence is in the long saphenous vein and that there are no incompetent communicating veins. If, however, when the patient stands the veins in the leg still fill rapidly, even though there is occlusion of the upper end of the saphenous vein by pressure, this is definite evidence of incompetence of one or more communicating veins or incompetence of the short saphenous system; and that blood is pouring out into the superficial veins from the deep system causing them to fill rapidly even though there is a tourniquet around the upper thigh.

It is not always possible, but sometimes the incompetence of the short saphenous system can be demonstrated by digital pressure over the short saphenous vein in the popliteal area with simultaneous occlusion of the long saphenous vein above the knee. The Trendelenburg test can thus be applied to the short saphenous system as it was to the long saphenous system. It is apparent that if there are incompetent communicating veins, the

competence of the short saphenous system cannot be determined as the veins in the leg will fill rapidly when the patient stands whether or not the short saphenous vein is occluded.

There have been many variations and multiple new expressions introduced to further refine the Trendelenburg test. Almost without exception they have confused the interpretation so that it is difficult to tell from the written record just what the examination revealed. It must be borne in mind that the competence of the valves of the veins may change from time to time, so that a patient who is examined early in the day may appear to have competent saphenous systems; while if that same individual is examined later in the day after standing in the kitchen or at a machine, there may be found markedly incompetent veins.

As was stated above, the status of the deep circulation has no bearing on the treatment of incompetent superficial veins except that the results will be much less satisfactory where there is a post-phlebitic syndrome.

The question often arises as to the treatment of varicose veins during pregnancy. There is no reason why women should endure the discomfort of varicose veins for several months during pregnancy. It is perfectly safe, particularly after the third month, to treat the varicose veins as at any other time. Surgical treatment is not ordinarily instituted during the first trimester because of the somewhat increased irritability of the uterus during this time, and also there are usually few complaints until after the third month of gestation.

Many forms of treatment have been advocated. It is not necessary to review the history of the treatment of the varicose veins which goes back to the earliest writings. The most significant advance was the result of the work of Homans, who in 1916 described ligation of the long saphenous vein at the sapheno-femoral juncture with individual ligation of all the tributaries to the upper end of the vein. This procedure has stood the test of time; but multiple ligations, ligations of the individual incompetent communicating veins, high ligation combined with injection therapy, all have been found wanting to a more or less degree. All of these methods may give seemingly good results temporarily, but too often, within one to two years, the patient returns with the same trouble and complaints he had originally.

Multiple ligations and ligations of the individual incompetent communicating veins are impracticable because in only certain patients is it possible to determine the exact location of incompetent communicating veins. In obese individuals, who frequently are troubled with varicose veins, it is impossible to locate the course of the long saphenous vein, let alone determine the site of incompetent communicating veins. Furthermore, granting that it might be possible, often the treatment is incomplete because the competency of veins varies from time to time depending upon the pressure exerted on the walls of the vein from within. This accounts for the fact that patients whose conditions are markedly improved or apparently cured following one of these procedures, may return soon afterwards because segments of the vein which were left and communicating veins which were competent at the time of the first examination, and therefore not ligated, have subsequently become incompetent and produced the same symptom complex as before.

High ligation combined with retrograde or subsequent injection of sclerosing solutions gives much better results than the above procedures. However, there is almost always a severe painful phlebitis if adequate obliteration is obtained. It has been shown also that massive retrograde injection is not without danger not only from possible involvement of the deep veins, but also from allergic sensitivity to the sclerosing solution. Another reason for failure of this method is recanalization of obliterated veins with re-establishment of uncontrolled channels which again give rise to the previous symptoms.

The most complete, the most permanent, the least traumatic and the most easily accomplished adequate procedure for the treatment of varicose veins is the combination of the high ligation at the sapheno-femoral juncture and stripping of the long saphenous vein from the groin to the ankle; and also the ligation of the short saphenous vein in the popliteal space and stripping it from the back of the knee to the lower calf. The incidence of simultaneous incompetence of both saphenous systems is so great, that the long and short systems should be ligated and stripped routinely at the same operation. If the short saphenous system is not incompetent, it usually becomes so before long.

The operation of high ligation and stripping is not a formidable procedure, even though it is

frequently time-consuming. The patient is given adequate sedation, depending upon the age and weight. The lower extremities are shaved completely including the pubic and groin areas. They are then suspended from an overhead screen frame by towels around the heels, while the skin is prepared in the usual manner. A sterile sheet is placed on the table, the feet lowered onto sterile wrappings, and the patient is draped, with either one or both lower extremities exposed (depending upon whether the operation is to be unilateral or bilateral).

The high ligation is accomplished using local infiltration anesthesia of 1 per cent novocain (without adrenalin). The incision is in the crease of the groin centered over the femoral vein. When all the tributaries have been individually ligated and the long saphenous vein ligated flush with the femoral vein, an intraluminal stripper is introduced into the distal segment of the vein. Frequently it passes to the ankle without difficulty, where it can be palpated within the vein.

With local infiltration anesthesia again, the vein is exposed through a small transverse incision where it lies over the internal malleolus. It is picked up and divided between clamps, the distal segment ligated and the stripper brought out through the lower wound. The vein is tied to the stripper cable about one inch from the end and the proper size stripping head threaded onto the cable.

If difficulty is experienced in passing the stripper downward through the saphenous vein (and this frequently occurs), no time is wasted trying to coax it or push it one way or the other trying to introduce it from above downward. Instead the saphenous vein is immediately exposed over the internal malleolus and the stripper introduced from below upwards. With very few exceptions unless there have been extensive injections or previous ligations, the intraluminal cable will readily pass from the ankle to the groin.

If the procedure is a bilateral one, another team has been carrying out the same procedure on the opposite side; or if only one team is working, the procedure accomplished thus far is repeated on the other extremity.

When the stripper or strippers is in place, a general anesthetic (usually gas) is given while the actual stripping is done. The patient is placed in moderate Trendelenburg position and the strippers pulled through, removing the main channels of the long saphenous system and segments of the communicating veins along with them. Only rarely is it necessary to ligate the communicating vessels individually.

As the veins are stripped, pressure is applied over the tracts to help control the bleeding from the avulsed tributaries. There is remarkably little bleeding. (No case has ever required special treatment because of bleeding.)

The patient is allowed to awaken as soon as the veins have been stripped, the wounds are closed with interrupted cotton sutures, dressings are placed on the wounds in the groin, and the patient turned on his abdomen.

Again with local infiltration anesthesia a transverse incision is made just below the popliteal crease. The deep fascia is incised and any significant short saphenous vein will be visualized lying about midway between the condyles of the femur. If there is a significant short saphenous vein, it is ligated as high as possible in the popliteal space, and the lower segment is stripped to the lowest muscular portion of the calf with only short anesthesia for the actual stripping.

Frequently the short saphenous vein appears as a very small structure, but if the stripper can be introduced it should be stripped, because very often, while it appears small in the popliteal area, it is much larger in the calf after it has received incompetent communicating veins or tributaries from the incompetent long saphenous system.

Again the patient is allowed to awaken and the wounds are closed with interrupted cotton.

Occasionally it is impossible to introduce the intraluminal stripper the full length of either the long or short saphenous veins from either direction. Sometimes this difficulty can be overcome by introducing a cable from each direction to the point of obstruction; or it may be necessary to make one or two additional incisions and strip these segments either by the intraluminal or the extraluminal (Mayo) stripper. Also it may be necessary to use the extraluminal stripper where the vein is a thick, heavy, recanulated, thrombosed vein. It is the usual experience that in these relatively infrequent instances, only a combination of intraluminal and extraluminal strippers permits accomplishment of a complete operation.

Elastic bandages are applied from the base of the toes to the upper thigh. The patient is returned to the ward where he is instructed to move

(Continued on Page 591)

Some Effects of Electric Shock on Brain Cortex

By Stanley K. Ellis, Ph.D.,
and
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WORTIS, SHASKAN, Impastato and Almansi[10] have shown that shock lasting 0.1 seconds of 50 to 100 milliamperes and 120 to 145 volts produces a 25 per cent decrease in oxygen consumption of rat brain tissue compared to controls. Their method consisted of shocking the intact rat, excising the brain and determining the rate of oxygen uptake in Ringer's dextrose solution by the Barcroft-Warburg procedure.

In this investigation, a study is made of the effect of electric shock on oxygen consumption rates of mouse brain homogenate and diced brain, respectively, supported in regular and modified Krebs-Ringer's solution. An attempt has been made to demonstrate the behaviorism of brain metabolism before, during and following electrical stimulus. Measurements by polarography permit observation of these phases, which may be recorded graphically. The effect of electric shock on cellular potassium leakage from the whole brain of the mouse is also treated in this communication.

Instrumentation

1. *Heyrovsky Recording Polarograph.*—Model XXI. E. H. Sargent Company, Chicago, Illinois. This instrument was used to study the rate of oxygen consumption of nervous tissue supported in Krebs-Ringer's phosphate buffer solution.

2. *Rectangular Wave Impulse Generator.*—(Shock Instrument). The shock instrument used in this work was custom built by the Detroit Edison Company, Detroit, Michigan. It is a line-operated A.C.-D.C. source unit, capable of delivering 0 to 50 milliamperes at 110 volts, 0 to 70 impulses per second with a cycle duration of 0 to 100 per cent.

3. *Beckman Flame Spectrophotometer.*—All metal balance studies on potassium were made spectroscopically.[6] Because of the very small amounts of potassium to be measured, a physicochemical method appeared desirable.

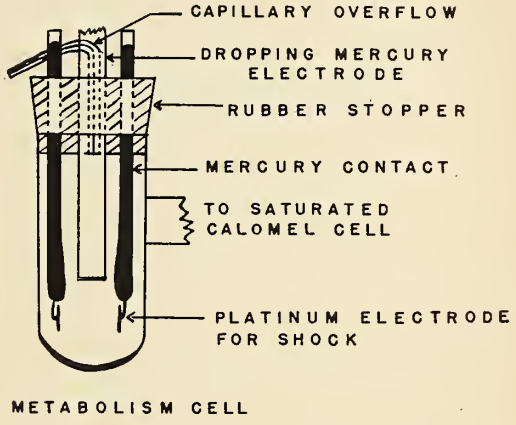


Fig. 1

Fig. 1.

4. *Metabolism Cell.*—The cell[5] used in this experimental study is shown in Figure 1. It is composed of a metabolism chamber (approximately 25 milliliters in volume) joined to a calomel half-cell through a saturated potassium chloride agar bridge. The chamber contains two platinum shock electrodes, a dropping mercury cathode and an overflow tip. The tissue preparations and supporting electrolyte are placed in this cell for study. Magnetic stirring was provided to insure uniform diffusion of available oxygen throughout the chamber. The same dropping mercury electrode was used throughout the entire study maintaining a drop rate of approximately four seconds per drop.

5. *Magnetic Stirrer.*

Solutions

The Krebs-Ringer's phosphate buffer solution was prepared according to the following formula:[9]

100 parts of 0.154 M NaCl
4 parts of 0.154 M KCl
3 parts of 0.11 M $CaCl_2$
1 part of 0.154 M KH_2PO_4
1 part of 0.154 M $MgSO_4$
24 parts of 0.1 N phosphate buffer, pH 7.4 (17.8 g. $Na_2HPO_4 \cdot 2H_2O$ and 20 ml. 1 N HCl diluted to 1 liter.)

Technique

Method for Oxygen Consumption Rate Studies.—The tissue preparation was placed in the metabolism cell filled with normal or modified Krebs-

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Dr. Ellis is now associated with the Institute of Biology, University of California, Berkeley.

Ringer's solution. The rubber stopper with accessories was put in place sealing the system from air. The oxygen concentration was then measured polarographically using the calomel cell as a reference anode. Oxygen concentration of the media was determined at a constant voltage of 0.45. A short polarogram recording was made at 0.0 volts before each oxygen concentration measurement to serve as a base or reference point. Less than one minute is required to complete this cycle. Magnetic stirring was continuous except for the time required to record oxygen concentration. No attempt was made to assign quantitative values for oxygen to each polarogram measurement; therefore, these points may be referred to as relative oxygen concentrations as indicated on the accompanying graphs.

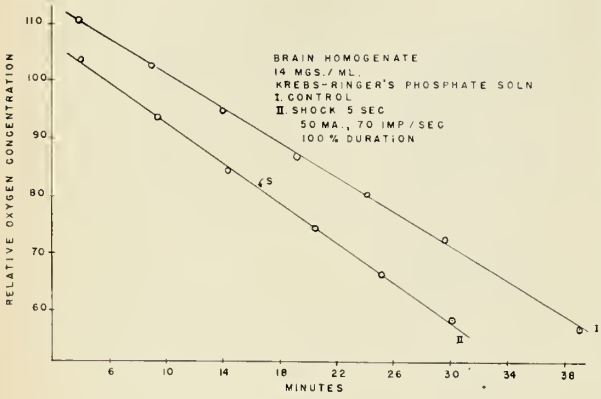


Fig. 2.

Method for Potassium Migration Study.—The investigation of the effect of electrical stimulus on intracellular potassium of nervous tissue was carried out in potassium-free Krebs-Ringer's solution. The whole brain was removed from an etherized mouse, washed in potassium-free Krebs-Ringer's solution several times, suspended between and in contact with the shock electrodes in a simple glass cell. The supporting electrolyte was stirred for various periods of time prior and subsequent to shock stimulus. Samples were taken at intervals to establish the rate of potassium escape from cell to supporting electrolyte. Controls paralleling the conditions of time without shock were made to determine the rate of escape of intracellular potassium from the whole brain by simple diffusion.

Experimentation

Oxygen Consumption.—Petering and Daniels[7] have reported the rate of oxygen consumption of liver homogenates by the polarographic method. Several experiments were performed on this type preparation preliminary to the study of brain tissue. These samples were prepared by using the procedure of Potter and Elvehjem.[8] It was apparent that in order to obtain uniform rates of oxygen consumption stirring was an essential factor. Homogenates of this type eventually settle and carry enough tissue to the bottom of the cell to cause irregularities in the continuous polarogram. Fifty milliampere current, 70 impulses per second of 100 per cent duration at 110 volts made no significant alterations in the rate of oxygen consumption of the liver preparations tested.

In the study of brain homogenates, the forebrain was removed from a live, etherized mouse and washed free of blood. This tissue was thoroughly homogenized in 6 milliliters of Krebs-Ringer's solution. The homogenate was divided into equal portions and each portion diluted to 25 milliliters with Krebs-Ringer's solution. Relative oxygen consumption rates of the two preparations were determined polarographically at room temperature. The results are shown in Figure 2. Alternating current shock imposed for five seconds on one of the samples (Curve II) produced no effect on the oxygen consumption rate. This was anticipated since similar results were obtained with liver homogenates. It will be noted that the initial oxygen concentration of the first sample, represented by Curve I of Figure 2, is somewhat greater than that of the second aliquot, represented by Curve II. This is due in part to the fact that both samples could not be run simultaneously, and even though the sample represented by Curve II was permitted to stand open to the air while the first preparation was being measured, some decrease in initial oxygen concentration resulted due to metabolism of the system.

Holmes[4] has shown that the rate of respiration of chopped or diced cortex is approximately the same as that of slices. Because of ease of preparation, diced samples were used in this investigation. Approximately 0.20 gram of mouse forebrain was diced, washed free of blood with Krebs-Ringer's solution, and transferred to the metabolism cell, which was filled with this electrolyte. The system was sealed and agitated with magnetic stirring. The relative oxygen consumption rate was determined by recording intermittent polarograms at 22° C.

A similar preparation was shocked for five sec-

onds with 110 volts 70 cycle current of 100 per cent duration at 50 milliamperes. The results of this experiment are shown in Figure 3 and are

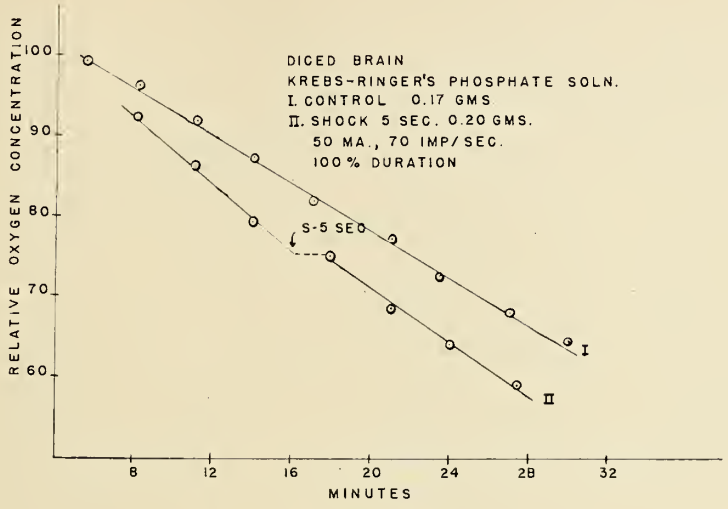


Fig. 3.

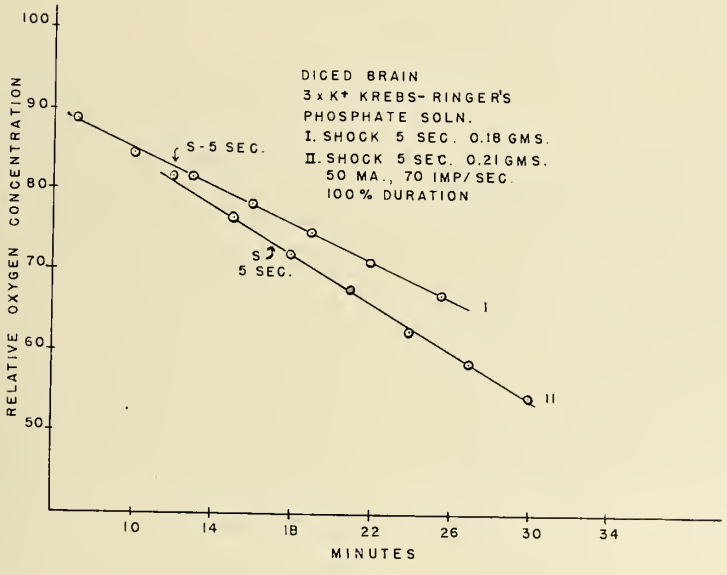


Fig. 4.

technique of dicing brain only approximates equal surface areas. This factor as well as sample size influences the rate of oxygen consumption.

typical of numerous preparations measured which were treated in this manner. It may be seen that the shocked sample (Curve II) underwent an apparent cessation of oxygen consumption and thereafter consumed oxygen at a rate somewhat less (approximately 22 per cent) than the period before shock. The relative rate shown in Curve I is somewhat below that of the relative rate exhibited in Curve II (Fig. 3). Oxygen consumption is in part dependent upon surface area. The

Effect of Shock in Modified Ionic Environment.—In this series of experiments, diced brain was shocked in Krebs-Ringer's solution with altered concentrations of potassium and calcium. These modified electrolyte solutions were prepared by adjusting the final volumes with 0.154 M NaCl to approximate the ionic concentrations called for in the original solution formula. For instance, it will be seen that the formula initially requires 4 parts of 0.154 M KCl and 1 part of 0.154

M KH_2PO_4. If all the potassium is removed, 5 parts or volumes must be compensated for to make a total of 133 parts or volumes as indicated, such preparations, however, the rate of oxygen uptake per milligram of tissue appeared to be less than that studied using the regular Krebs-Ringer's electrolyte. Figure 6 illustrates the effect of shock on brain tissue supported in calcium-free Krebs-Ringer's solution. There appears to be some decrease in metabolism after shock, though this is not as apparent as in the case of electric shock on brain tissue supported by unmodified Krebs-Ringer's solution (Fig. 3).

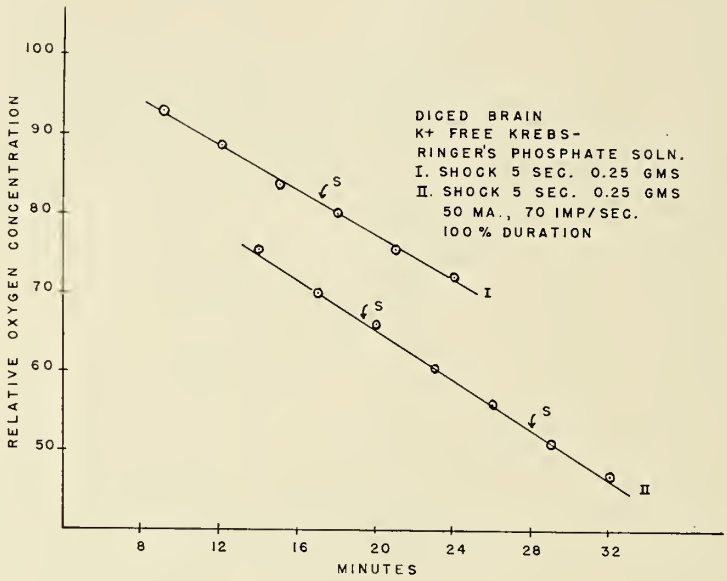


Fig. 5.

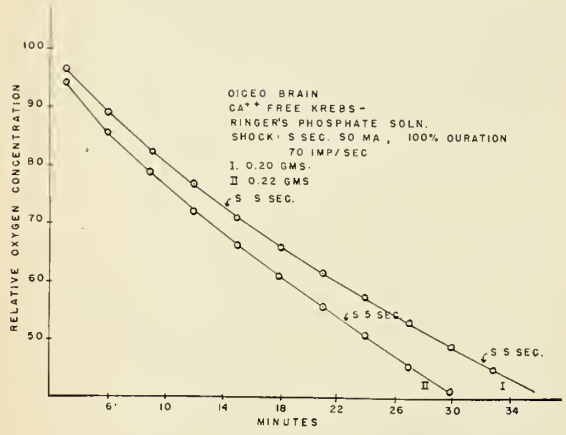


Fig. 6.

originally. By adding 105 parts of 0.154 M NaCl instead of 100, the required amount when potassium is present, the total ionic concentrations remain the same. If more than the normal amount of a specific electrolyte is desired, it is compensated for by adding less 0.154 M NaCl.

The preparations containing the potassium excess (Fig. 4) effectively resisted the normal influence of electric shock. No change in metabolism following shock was demonstrable. This was also shown to be the case when potassium was completely removed from the system (Fig. 5). In

The Effect of Electric Shock on Potassium Migration.—Cowan[2] has reported a twentyfold increase in potassium migration from the unmyelinaed nerve of the crab, Maia squinado, after continuous electric shock of five minutes (14 to 18 18 volts, 40 to 140 impulses per second). More recently, Young[11] has confirmed these results, using the leg nerve of the Limulus. However, Fenn[3] has found that continuous electrical stimulation for thirty minutes (50 to 100 impulses per second) produces no consistent loss or gain of potassium from myelinated nerve of the cat. He attributes this to the presence of the myelin sheath which acts as a barrier preventing the escape of potassium. Cicardo[1] claims that potassium is released from the brain of a dog on electric shock; however, he gives no quantitative data.

Whole forebrain of a mouse, washed free of adherent blood, was fixed between two shock electrodes of platinum and immersed in a 30 ml. cy-

lindrical glass cell containing 15 ml. of potassium-free Krebs-Ringer's solution. Agitation of the electrolyte was obtained by magnetic stirring. One-

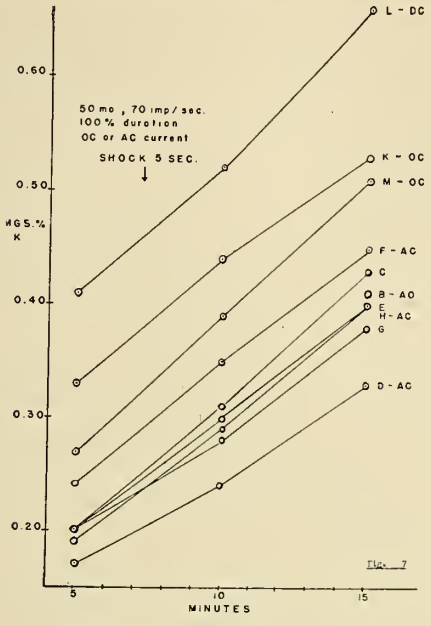


Fig. 7.

milliliter samples were withdrawn at five, ten and fifteen-minute intervals. One minute after the first sample of electrolyte was taken, the preparation was shocked at 100 volts, 70 cycle, 50 milliampere current of 100 per cent duration. The three samples of Krebs-Ringer's solution removed were diluted with five milliliters of distilled water and analyzed for potassium with the Beckman flame spectrophotometer. The results for the controls (G, C, E), A.C. shock (D, H, B, F) and D.C. shock (L, K, M) are shown in Figure 7. It is evident that there is no greater leakage of potassium in preparations which were shocked than in the controls in which potassium was released by simple diffusion. In another series, forebrain specimens were shocked continuously for four minutes (5 milliamperes, 70 impulses per second, 100 per cent duration, 110 volts) in 10 milliliters of Krebs-Ringer's solution. The results were also negative with respect to accelerated potassium migration from cortical tissue.

Summary

1. Electric shock, as used in this investigation, has no apparent effect on the rate of oxygen consumption of mouse brain homogenate.

2. Electric shock stimulus has a definite and immediate effect on the metabolism of diced mouse brain cortex, which is manifested by a cessation of oxygen consumption for measurable periods of time. The rate of metabolism thereafter is approximately 25 per cent slower than that of controls.

3. Modifications in the potassium and calcium ion concentrations of the Krebs-Ringer's solution used to support diced brain during and after shock resulted in behavior markedly different from that observed when these ions were present in normal concentrations.

4. It is suggested that electric shock stimulus produces cellular polarization which prevents the utilization of oxygen by the cell. The mechanism of this polarization is not clear but appears to be related to the cell membrane, since experimentation with homogenates shows clearly that electric shock in no way disturbs the oxidative enzyme systems.

5. Under the conditions of this experimentation, intracellular potassium does not migrate in measurable amounts from mouse brain under electric shock stimuli of varying quality and periods of time.

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Hypertensive Complications of Pregnancy

Experimental Use of Various Drugs

By N. S. Assali, M.D.

Cincinnati, Ohio

IN THE thirty minutes allocated to me, I shall attempt to give a brief summary of the use of several drugs which have served not only as therapeutic agents but also as physiologic tools in the study of hypertensive diseases of pregnancy, particularly pre-eclampsia and eclampsia.

For better understanding of the subject, it would be appropriate to say a few words about the actual concept of toxemia of pregnancy. Although the primary cause of this disease is as yet unknown, it is generally accepted that the main underlying pathophysiologic phenomenon is a widespread arteriolar vasoconstriction. The constriction of this part of the vascular bed, which has also been called the "stopcock" of the circulation, results in hypertension and a decrease in the blood flow to organs and tissues. Edema, albuminuria and other manifestations of toxemia of pregnancy might also be explained on the basis of arteriolar vasoconstriction.

Now, what are the mechanisms through which arteriolar vasoconstriction can be produced? The mechanisms are two:

(a) Increased neurogenic impulses from the autonomic nervous system

(b) Humoral mechanisms such as that produced by epinephrine or epinephrine-like substances.

How did we arrive at this concept and what is the practical application of these findings in obstetrics? That is what I am going to discuss with you.

Figure 1 shows the effect of a standard dose of Tetraethylammonium Chloride (Etamon) on the blood pressure of different groups of patients. As you may know, this drug blocks the autonomic nervous system at the ganglionic level. After the injection of this drug, the blood pressure which remains is supported presumably by humoral agents. The thin line represents the mean control blood pressure. The thick line represents the TEAC "floor." This is defined as the lowest blood pressure reading within the first 10 minutes after the injection of the drug. As you can see, the normotensive non-pregnant subjects respond to the blocking action of TEAC with a slight fall in blood pressure. On the contrary, the normal pregnant group at term responds with a dramatic fall in blood pressure. Toxemic patients show very little response to the blocking action of TEAC.

The conclusions to be drawn from this preliminary set of experiments is that the blood pressure in normal pregnancy is supported by increased neurogenic tone, while in toxemia of pregnancy the neurogenic tone is negligible. Concomitantly, TEAC is of no value in the treatment of toxemia of pregnancy.

Figure 2 shows the effect of another type of autonomic blockade which is very commonly used in practice—that of spinal anesthesia as compared to TEAC. High spinal anesthesia blocks the neurogenic impulses in the subarachnoid space. As you can see, the effect of high spinal anesthesia on the blood pressure of a normotensive non-pregnant female is negligible, and it parallels that of TEAC. On the other hand, the effect of the same agent on the blood pressure of a normal pregnant woman results in a severe fall reaching shock levels (Fig. 3). The same patient submitted to the same procedure following delivery shows a negligible response to both spinal anesthesia and TEAC. In toxemia of pregnancy, high spinal anesthesia to C^4 results in a negligible fall in the blood pressure despite the large quantity of procaine given to the patient.

Patients who present essential hypertension associated with pregnancy very often respond with a marked fall in blood pressure to both spinal anesthesia and TEAC (Fig. 2). This shock-like state can be corrected immediately by raising the legs 90 degrees. This indicates that the fall in blood pressure following spinal anesthesia is caused by pooling of blood in the lower extremities. The mechanism which produces this pooling is the following:

(a) Spinal anesthesia and TEAC produce blockade of the neurogenic impulses which control both arteries and veins.

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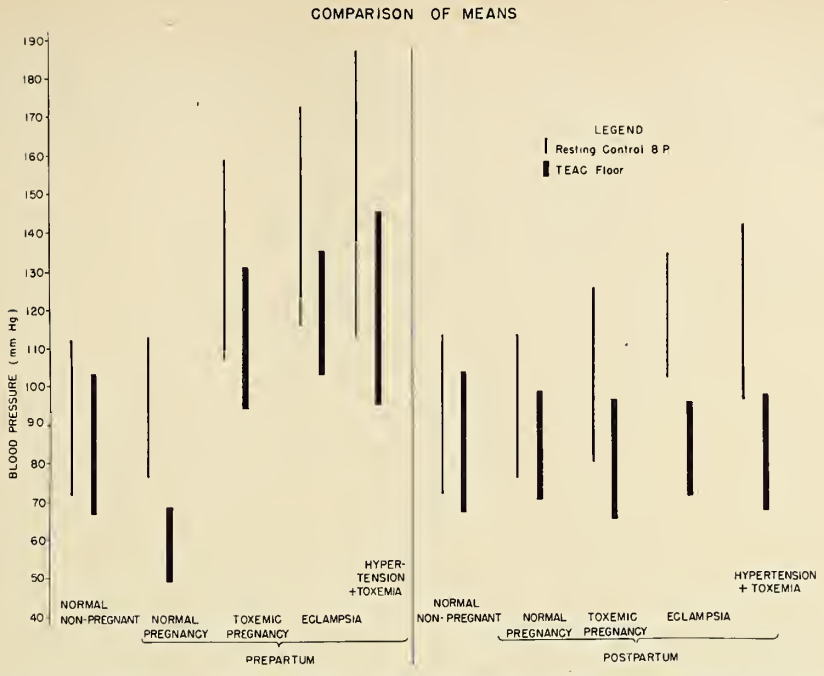


Fig. 1. The effect of a standard test of tetraethylammonium chloride (TEAC) on groups of normal non-pregnant subjects, normal pregnant patients and patients with pre-eclampsia, eclampsia and pre-eclampsia superimposed on essential hypertension in the prepartum and postpartum periods. The thin line is the mean control blood pressure at rest. The thick line is the TEAC "floor" as defined in the text. The upper end of the line is the systolic and the lower end is the diastolic level. Note the marked fall in the blood pressure of normal pregnancy after the blockade as compared to the negligible fall in normal non-pregnant and toxemic patients. In the postpartum period all patients respond in the same manner. These findings indicate increased neurogenic tone in normal pregnancy.

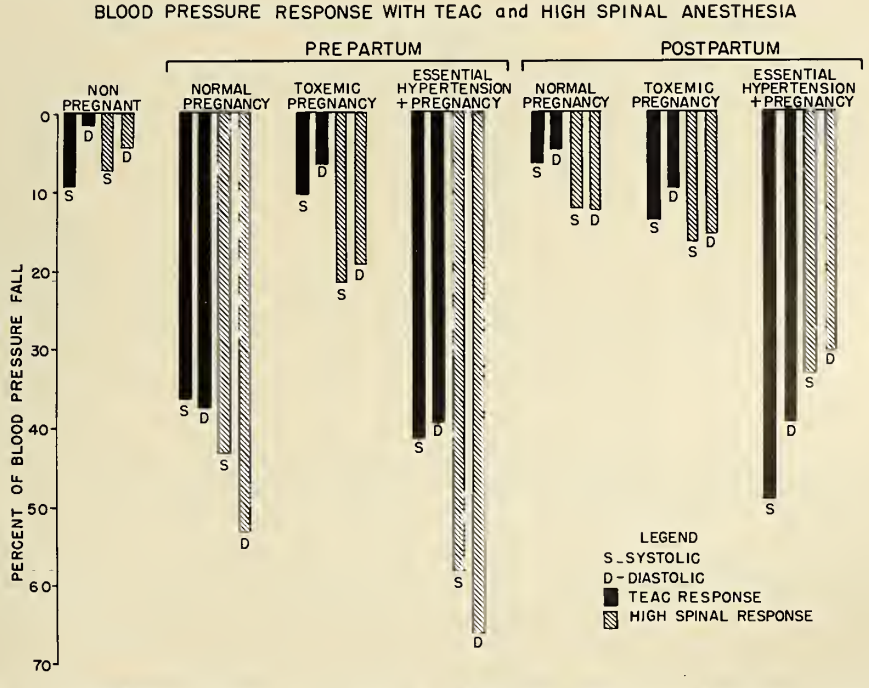


Fig. 2. Comparison between the effects of TEAC and high spinal anesthesia in similar groups of patients as in Figure 1. Note the parallel effects of TEAC and spinal anesthesia in all groups. Once more the contrast between normal and abnormal pregnancies is illustrated. The blood pressure response to TEAC and spinal anesthesia is plotted as per cent of the blood pressure control.

(b) There is dilatation of both arteries and veins.

(c) The arteries regain their tone because they possess intrinsic tone.

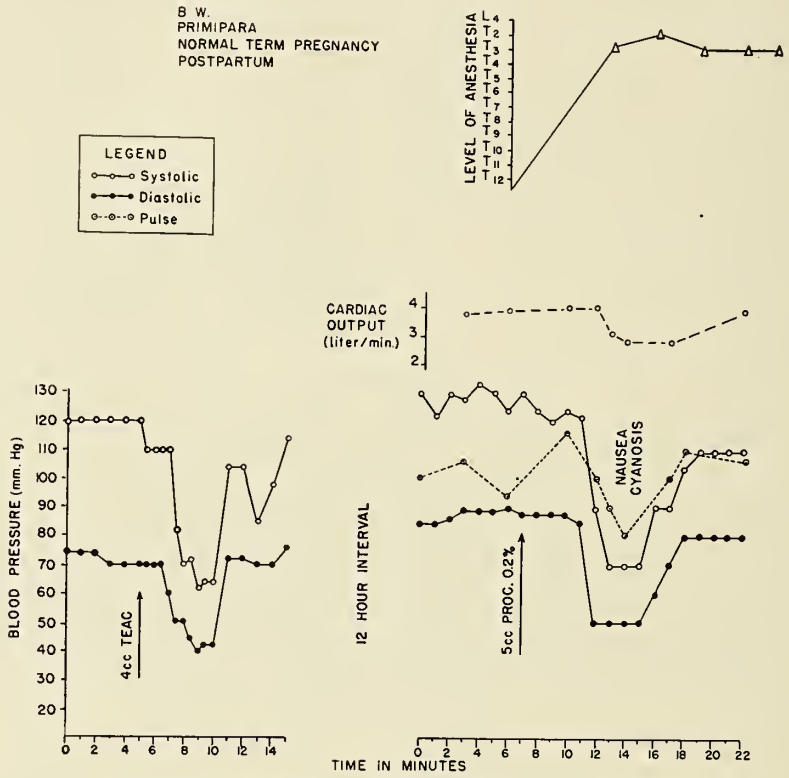


Fig. 3. Cardiac output determinations during spinal anesthesia in a normal pregnant woman. In this case, the cardiac output decreased about 1200 cc. at the height of the blood pressure fall. This decrease is caused by the pooling of blood in the lower extremities and impairment of venous return to the heart.

(d) The veins remain atonic and collapsed because they lack intrinsic tone.

(e) A large amount of blood is pooled in the veins of the lower extremities. This leads to impairment of venous return to the heart and a decrease in the cardiac output. Figure 3 shows that the cardiac output is markedly decreased at the height of fall in blood pressure with spinal anesthesia. Our study shows that the blood flow to the kidneys and the urine volume also drop when the blood pressure falls with spinal anesthesia.

These studies on the effect of spinal anesthesia and TEAC confirmed our previous conclusion that in normal pregnancy at term there is an increased neurogenic tone which maintains the blood pressure. When this tone is blocked, the blood pressure falls to shock levels. This explains the old observation that pregnant patients are very sensitive to spinal anesthesia. It also explains the tendency of these patients for fainting and for other vasomotor disturbances. These experiments also confirm the idea that the hypertension of toxemia of pregnancy is not caused by increased neurogenic tone. The impression is that humoral agents are the cause of such a hypertension.

Further studies were carried out on the action of a drug which counteracts the effect of epinephrine and nor epinephrine. It is called Benzodioxane. When it is given to a toxemic patient, there is no change in the blood pressure. This indicates that the hypertension of toxemic patients is not caused by epinephrine or nor epinephrine and that the drug has no place in the treatment of this disease.

Figure 4 shows the effect of Roniacol which is also supposed to be a vasodilator agent. You can see that the effect on toxemic hypertension is negligible.

Finally, we come to the drug which has been

used for many years in Cincinnati and now is creating a new enthusiasm around the country—Veratrum Viride. It has been recently demonstrated in man and animal that veratrum produces an integrated arteriolar dilatation without any postural hypotension or any change in the cardiac output.

Figure 5 shows a case of eclampsia treated with veratrum intravenously. An injection of 0.2 cc. of Veratrone was given after the patient was admitted to the hospital in coma. Thereafter, the drug was given in intravenous infusion in 5 per cent glucose and water in amounts regulated as to deliver 0.2 cc. every hour. You can see that the blood pressure is well stabilized within normal ranges. The urinary output was adequate.

It has been said repeatedly that veratrum decreases the urine volume. Our study leads us to believe that there is a slight decrease in the urine volume shortly after the first dose of the drug, but it is later compensated by a marked polyuria.

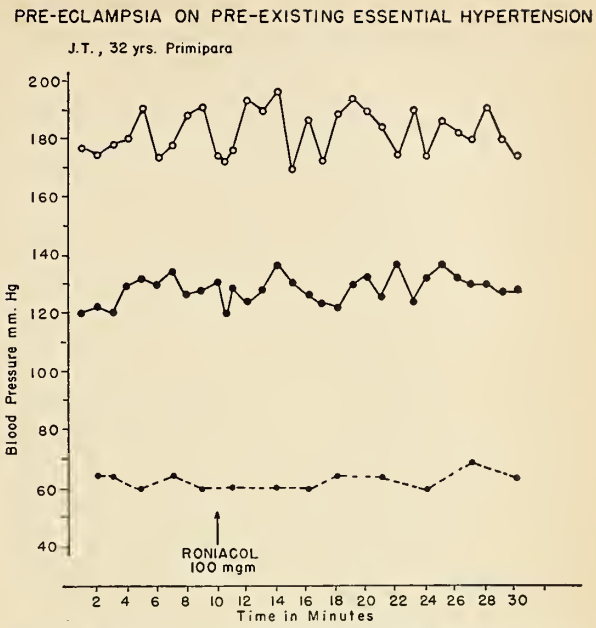


Fig. 4. The effect of Roniacol on the blood pressure and pulse rate of a patient with toxemia superimposed on essential hypertension. No vasodilator action was found.

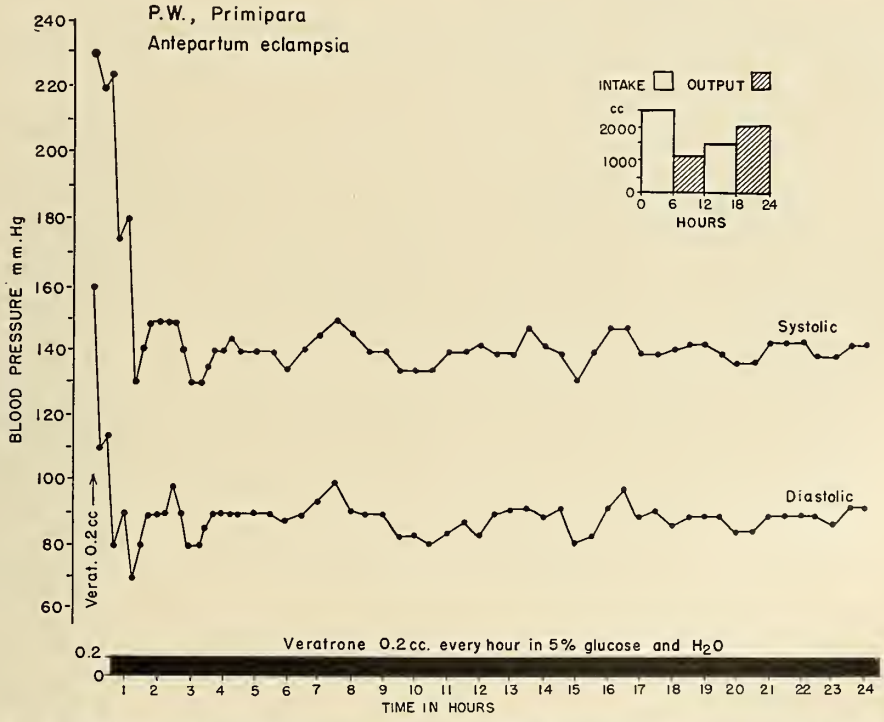


Fig. 5. Eclamptic patient who was seen with her fifth convulsion in progress. Veratrone in the dose of 0.2 cc. was given intravenously. Thereafter, the drug was given in intravenous drip mixed with 5 per cent glucose and water. The blood pressure was maintained within normal ranges with this treatment. Convulsions did not reoccur. The patient was completely controlled within one hour after the treatment. (Courtesy of *American Journal of Obstetrics and Gynecology*)

This temporary decrease is absolutely harmless to the patient.

If there is a serious drop in the blood pressure after veratrum administration, it can always be counteracted by ephedrine or atropine.

During the last year, we have been working with

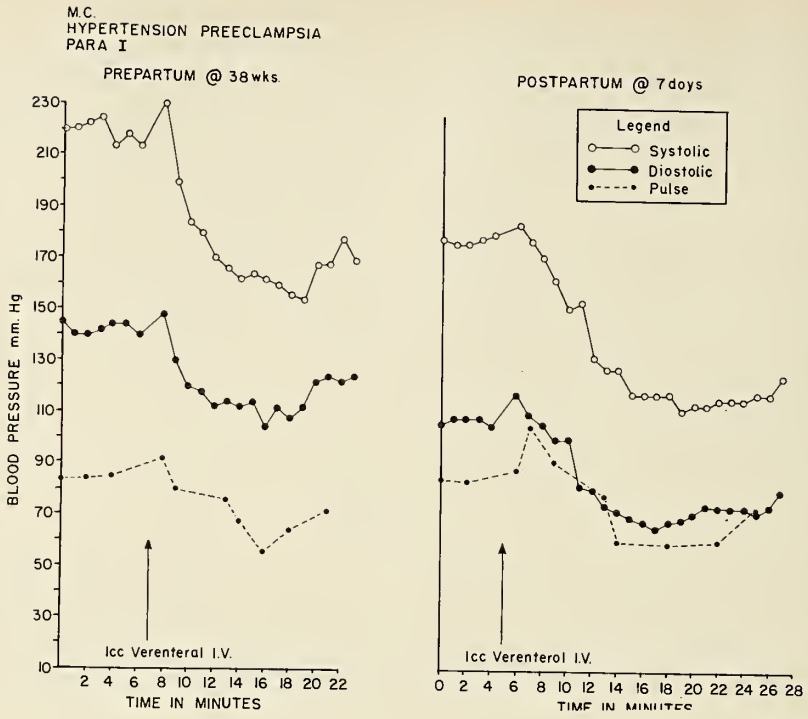


Fig. 6. Pre-eclamptic patient treated with intravenous Verenteral. One dose lasts for approximately one hour. In this figure the time was shortened purposely.

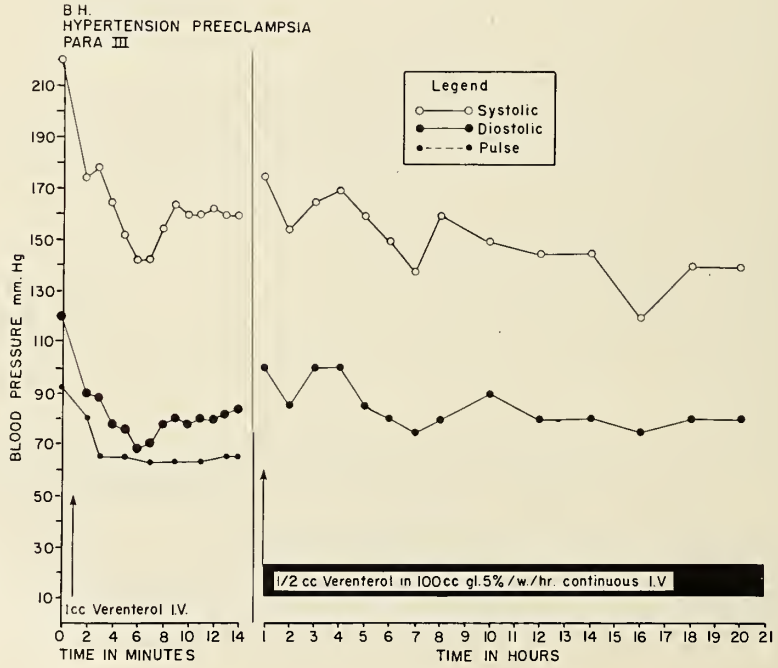


Fig. 7. Severe pre-eclamptic given 1 cc. of Verenteral on admission and later carried on intravenous drip of 0.5 cc./100 cc. of glucose and water hourly. Most patients are controlled quickly with this treatment. The intravenous infusion may last for four to seven days and sometimes longer. Thereafter the intramuscular route can be used.

a new veratrum preparation called Verenteral. It is a stable and a sterile preparation but less concentrated than the old Veratrone. The intravenous dose of Verenteral is from 0.5 cc. to 1 cc. while that of Veratrone is 0.2 cc.

Figure 6 shows a pre-eclamptic patient given 1 cc. of Verenteral. Note the marked drop in the blood pressure which lasts for approximately two hours. This patient was carried on intermittent injections.

Figure 7 shows a pre-eclamptic case treated successfully with intravenous Verenteral. The patient was under control for three to four days. Thereafter, labor was induced medically and the patient was delivered and discharged well from the hospital.

In summary, I would like to say that the real treatment of toxemia of pregnancy awaits the discovery of its cause. We have to continue treating these cases on a somewhat empirical basis.

Autonomic blocking agents of any kind have very little effect on toxemic hypertension. When they produce some effect, it is by venous pooling in the lower extremities and decrease in the cardiac output.

Adrenolytic substances are also of no value in the treatment of this disease.

Veratrum viride preparations, by their vasodilator action on the arteriolar system, by the lack of postural hypotension and by the lack of any effect on the cardiac output, are valuable adjunctive agents in the treatment of toxemia of pregnancy.

From the point of view of the greatest possible gain in early diagnosis, teaching women how to examine their own breasts is more important than teaching the examination technique of breast examination to physicians, for at least 98 per cent of women who have breast cancer discover their tumors themselves.

* * *

Most breast lumps must be biopsied to determine their exact nature, for even the most experienced surgeon will diagnose a breast tumor correctly only 70 per cent of the time.

* * *

In repeated studies it has been shown that the *first* physician to see the patient with breast cancer gives that patient wrong advice in almost 25 per cent of cases, his advice being to "forget it" or "let's watch it."

* * *

In case where a laparotomy and colotomy are performed to remove a polyp, a frozen section examination should be done so that definitive surgery can be carried out at once.

* * *

Painless hematuria indicates malignant disease of the urinary tract in 90 per cent of cases. It is usually the first, and often, for months, the only sign or symptom.

* * *

Many surveys have shown that length of survival after discovery of cancer is directly related to the stage of the disease at the time of diagnosis and treatment.

VARICOSE VEINS

(Continued from Page 580)

the extremities actively as soon as possible. He is gotten out of bed within two to three hours, and walks five minutes every hour for the remainder of the day, and is gotten up to walk five to ten minutes during the middle of the night.

If ulcers are present on the extremity, this is no contraindication to stripping. It is not only time-consuming but definitely unnecessary to wait for healing of an ulcer (if it could be accomplished) before the above treatment is carried out. Patients with ulcers are prepared with moist dressings and antibiotics for two to three days prior to operation, and the stripping is carried to a point distal to the ulcer if possible. If this is not possible, the vein is stripped to a point as close to the ulcer as is technically feasible. Ordinarily these patients leave the hospital on the third or fourth day and return to the physician's office or the clinic for subsequent dressing. The elastic support to the thigh is removed after twenty-four hours, but that on the leg remains for a few days or a few weeks depending on the severity of the condition, the rapidity with which any ulcer heals, and until there is little or no swelling when the elastic support is removed.

Ulcers which have been present for many years frequently heal in four to six weeks; ulcers which have been present only for a few weeks and, therefore, have produced only a moderate amount of scarring frequently heal in a week to ten days.

The results of this method of treatment have been more gratifying than any other. The patients have less discomfort; and, most important, the majority of the patients are cured by one operation. Occasionally subsequent strippings of accessory venous channels are necessary, or subsequent injections of superficial varicosities chiefly for cosmetic reasons are carried out as an office or out-patient clinic procedure.

Conclusions

1. The Trendelenburg test alone is completely satisfactory for the evaluation of varicose veins.

2. High ligation of the long saphenous and ligation of the short saphenous vein in the popliteal space with stripping of both the long and short saphenous veins is the most satisfactory method of treatment.

Civil Defense

By William Henry Gordon, M.D.
Detroit, Michigan

TONIGHT we discuss civil defense.

I do so not as a pessimist or an alarmist but as a realist. We Americans, because of the atomic bomb, which is not only in our hands but in the hands of our enemies, are confronted with a serious threat, a specific danger, which could, if not prepared for, result in the loss of our independence or our total existence as a free nation in a free world.

Today the world is divided into two parts: the free world and the shackled countries.

We of the free world are naive in our trust. We have permitted those who control the shackled countries to have our financial, industrial and military aid, to help them build up a belligerent group whose fundamental aim has been to destroy and conquer.

We are kind and trusting and respect the rights of individuals and nations. Our potential enemy is just the opposite. He has forgotten the Biblical rule: "Thou shalt not covet."

It is because I believe that "vigilance is the price of liberty," and preparation for the future must be today instead of tomorrow, that I wish to present a few phases of the subject for your consideration and action.

It is necessary to define civil defense, to suggest where it fits into our present economy and what is expected of the civilian population to protect itself individually and collectively from the effects of any disaster in the present or in the future.

The outcome of the past two world wars was decided by the weight of American industrial production in support of a determined fighting force.

In a future war, it is probable an enemy would attempt at the outset to destroy or cripple the productive capacity of the United States and to carry direct attack against civilian communities. This would disrupt the war effort.

This assumption constitutes the basic reasoning behind the necessity for civil defense. Attacks would be planned against points which would cause greatest strategic damage. These "target bombings" of our key cities would have four objectives:

1. To destroy production centers, such as Detroit, New York, Los Angeles, Pittsburgh, et cetera.

2. To destroy the nerve center of this country (Washington).

3. To destroy sea and rail centers (the Soo locks; the Chicago and St. Louis rail centers, et cetera).

4. By destroying one or more of the aforesaid, to destroy the psychologic attitude of the population.

If a bombing should occur, the dangers ahead for all of us are disease, flood, fire and hunger—consequently panic and pestilence.

After World War II, a large number of intelligent citizens realized the aforesaid dangers. They organized groups who pestered the federal government to produce a law which would protect them in case of disaster. Such a law was passed by the Congress on September 30, 1950. It is Public Law No. 875 of the 81st Congress.

I urge each and every one of you gentlemen to read that law and see its scope. By passing the law, Congress produced something that never had been part of our past history, that is, four lines of defense—the Army, Navy, Air Force and civil defense.

It legislated the state should be the unit of civil defense—all agencies within the state should be under the control at state level.

Congress also legislated cities, counties, and other units of the state should use the state plan as the master plan, and fit their plans into the jig saw puzzle.

As a result of this law, the majority of states of the United States have plans in different stages of development which are working efficiently.

Detroit and Sault Saint Marie are two of the "target areas" in the United States: Detroit, because it is the center of manufacturing of our armament, and the Soo, because it is the connecting unit of water traffic from the iron-bearing regions which feed our blast furnaces and armament plants.

Try to imagine a hundred sneak suicide long-distance bombers breaking through our air defense, and dropping eight to ten atomic bombs on Detroit, the Number 1 target, the Soo, New York

Delivered before the Scottish Rite Masons, Detroit, January 22, 1952.

City, Washington, Chicago, Los Angeles and other key centers.

Think of the destruction by radiation, fire, blast, tumbling buildings and other forces; consider our inadequate defense preparation. How would we care for the catastrophe?

Visualize each man for himself, not considering the whole. Imagine the panic, the fires—without equipment and trained fighters—the thousands and hundreds of thousands of injured, the lack of food, water and health facilities, the need for organized care of the casualties, the vandalism without a police system.

Take Woodward Avenue, so loaded with refugees on both sides of the street they interfered with the fire equipment, the ambulances and the trucks coming to the aid of the downtown section at the height of a calamity—all because we did not have a plan.

Remember when the Germans broke through in late 1917—the panic of the French people, how the civilians and their carts blocked the roads while the military were trying to come up—the mass panic in Poland when the Nazis invaded Poland in 1939.

All here know of the unorganized retreat of the South Korean civilian population in late 1950 and early 1951.

Civil defense is not new to America.

All of you have been trained in school fire drills. You were taught not to start a panic, but to remain cool and to march out quietly in an orderly manner.

Today, we adults concerned with civil defense can take a valuable lesson in the psychology of morale from school drills of young children.

The Detroit Board of Education has instituted an excellent school protection plan, including air-raid drills. Mr. John Pritchard, it's secretary for civil defense, recently stated:

"Fear, we have found, is not commonly generated when we explain why we have air-raid drills, in which the school participates as a unit, and there is fellowship and a feeling of mutual support. . . . But when we begin telling pupils how each one should provide for his personal safety in case he sees an atomic flash, we are putting each pupil strictly on his own. Psychologically that is different. And it may be dangerous. We know because we have tried it cautiously in a few places. No terror resulted—the 'guinea pigs' were bright sixth graders—but abruptly there were drawn eyebrows, and covert resistance was high.

". . . Our business is to build the man and woman of tomorrow; we are sending them, the boy and girl of today, diving into basement refuge areas. If we develop permanent attitudes of abject fear in this process—completely defensive attitudes, huddling and helpless attitudes—we are doing tomorrow's America a bad turn. But if we lay emphasis on coming up out of the basement afterward, fit for work and full of fight, we are doing our job the way it ought to be done in time of crisis."

This, it seems to me should be the attitude and the state of morale of our entire civilian population.

General Clyde E. Dougherty, director of the Office of Civil Defense for the City of Detroit, has suggested:

"While the public should be warned and informed of the actual hazard from atomic or other special weapons attack—and it is to be expected that the effects of such attacks would be horrible—the effects can be considerably mitigated by an informed people willing to help themselves and others.

"Sunday supplement writers, "General Dougherty warns, "have pictured the effects of atomic attack as something against which there is no defense. An uninformed public has been led to believe that no defense is available, save fleeing in panic from target areas. This reaction, of course, would serve a useful purpose to an enemy; a purpose which could be accomplished merely by threat of bombing."

The truth is, while atomic bombs hold more death and destruction than man ever before has wrapped up in a single package, their over-all power still has very definite limits. Not even hydrogen bombs will blow the earth apart or kill us all by radioactivity. Atomic weapons will not destroy the earth.

Radioactivity is not the bomb's greatest threat. In most atom raids, blast and heat are by far the greatest dangers that most people must face. Radioactivity alone would account for only a small percentage of all human deaths and injuries, except in underground or underwater explosions.

Radiation sickness is not always fatal. In small amounts, radioactivity seldom is harmful. Even when serious radiation sickness follows a heavy dosage, there is still a good chance for recovery.

Do not worry about high-level radioactive clouds. Regardless of all you may have heard or read concerning the dangers of radioactive clouds, after the first minute and a half there is actually little or nothing to fear from those produced by high-level bursts. While most of the radioactive materials swept up into the sky eventually fall back

to earth, they are so widely and so thinly spread that they are very unlikely to offer any real dangers to human beings.

Thousands of bombs would have to be set off in the air before serious ground contamination would be found over really large areas. There was no ground-level pollution of any importance following either of the two Japanese bombings. Not any of the Japanese at Hiroshima or Nagasaki were harmed by lingering radioactivity. Explosive radioactivity caused all the casualties.

Because the power of all bombs is limited, your chances of living through an atomic attack are much better than you may have thought. In the city of Hiroshima, slightly over half the people who were a mile from the atomic explosion are still alive. At Nagasaki, almost 70 per cent of the people, a mile from the bomb, lived to tell their experiences. Today thousands of survivors of these two atomic attacks live in new houses built right where their old ones once stood. The war may have changed their way of life, but they are not riddled with cancer. Their children are normal. Those who were temporarily unable to have children because of the radiation are now having children. Another myth that should be killed is the false belief that germ warfare, or biological warfare, as it is correctly called, will knock out entire cities. No kind of biological warfare could kill or sicken every person in a large area or city. Also, talk of poisons killing millions of people is nonsense. Toxins, which are special kinds of poisons, can be deadly. But there are definite, practical limits to distributing them. You might as well consider dividing one aspirin tablet evenly among the eleven million people in the greater New York area. Furthermore, no "mystery germs" can cause terrible epidemics. Epidemics are not likely to be caused by biological warfare. Even if one were caused, we probably could stamp it out quickly. The reason plagues used to sweep through whole populations is because our ancestors did not have the fine health safety systems we have today. Although disease can spread quickly, most outbreaks move quite slowly. The plague which swept over London in the seventeenth century began with a few cases in the fall of 1664. It took the disease six months to cross from one side of the city to the other. The peak of the epidemic did not come until August, 1665. While almost 70,000 people died of plague, it was not a lightning-quick disaster from which there was no escape. With the public health organizations which exist now, the London outbreak could have been stamped out with little or no loss of life.

Today the United States has a nationwide system set up to prevent and control disease outbreaks of all kinds. This safety network covers not only people but crops and livestock as well. In suggesting these terrifying myths be viewed in the clear light of reality—which still reveals them as bristling with inherent danger— may I present General Dougherty's challenging but calming conclusion: "The public must be re-educated to the facts necessary for survival under attack, so that casualties can be held to a minimum and the productivity of our cities maintained at the highest degree of efficiency." In short, we cannot prevent enemy attacks from happening, but we can keep them from knocking us out! There is no sure way of keeping enemy planes from breaking through our defenses. General Hoyt Vandenberg, chief-of-staff of the United States Air Force, has said that at most we could knock down only 30 out of each 100 enemy planes attacking America, but there is a sure way to save many thousands of lives if we are attacked. There are defenses against the atomic bombs. There are ways to save thousands of people from the effects of blast, heat and radioactivity. There are ways to take shelter, to rescue the trapped and injured, and to cut fire losses to a minimum. We have defenses against biological warfare and poison gases, but we must face facts. Civil defense takes planning, organization, and hard, hard work.

Consider the Medical Department:

1. Medical and Health Services
2. Public Health
3. Radiological Defense Division
4. Chemical Defense Division
5. Other Special Weapons Defense Division such as Biological Warfare
6. Education and Training
7. Medical Care Services
 - (a) Casualty Medical Services (First Aid and Hospital)
 - (b) Nursing Section
 - (c) Pharmacy
 - (d) Medical Practice
 - (e) Dental Services
 - (f) Physical Medicine
 - (g) Administration

Services which have been mentioned here also include milk and food sanitation, sanitary control

in disaster areas and supervision of general sanitation in emergency shelters, prevention of spread of communicable diseases, mass immunization of disaster victims, motor transport, hospitalization and a regulation center for control of the medical personnel who should be available in the vicinity of the bombed areas, the clergy—extremely important, for one of the greatest controls in panic is the knowledge one has his pastor available—and finally mortuary service, identification of the dead and wounded. The people in bombed England were less panicky when they knew the bodies of their loved ones would be identified and adequately cared for by the mortician. For the services suggested in just this one department—the medical—we need:

1. Physicians from every specialty
2. Dentists
3. Laboratory technicians
4. Nurses
5. Orderlies who are medically trained (there are thousands of male and female hospital orderlies and technicians from the Army, Navy and Air Force who should be available)
6. Ambulance drivers and stretcher bearers

These are only a few of the people needed in the medical setup. Now think of the whole setup from the state down. Governor Williams has made Brigadier-General Lester J. Maitland the director of civil defense for the State of Michigan. His office is at Lansing. General Maitland has appointed his subcommittees from the state level down and has divided his operations and services into many different departments. The major divisions are as follows:

1. Fire Fighters
2. Police
3. Wardens—down to the block and even the building floor level
4. Engineers—supervising blackout, dimouts, camouflage, protective construction, shelters, city planning and sanitary arrangements
5. Rescue
6. Transportation
7. Communications
8. Medical, Health and Welfare
9. Staff

To go into the necessity for these various and manifold classifications and divisions of duties and services and operations which must be set up well in advance of possible calamities and threatened dangers, I should like to go back to England to compare World Wars I and II. I was in London as a medical officer en route to France at the time of the first zeppelin bombing of London, and well remember the surprise and consternation of the British populace at this change in modern warfare: destruction from the air. I was in England again in 1944 and will never get over the precision of a well-trained group of civilians who cared for the destruction and injuries caused by the air, buzz bombing and long range guns. It was remarkable to note the calm and lack of panic of the British with whom I had the opportunity to work. I would like to tell you some other instances. I commanded a hospital between Bristol and Gloucester. It was six miles from our railhead. A call would come telling us we were to receive a convoy of wounded soldiers from France. The Motor Officer was immediately notified, he, in turn notified the Civil Defense Director of Bristol who was told the number of ambulatory and walking wounded to arrive. By the time the train pulled into the railhead, civilian ambulances and litter carriers, supplemented by Medical Corps men, made it possible to unload a convoy of 300 to 400 men from a hospital train and place them in wards in the hospital with the least delay. It is a matter of record—and is one of the fine traditions of England—how householders in Britain fought fire in World War II. In some cases bombs started fires in every house on a street, yet every house was saved. In one town, 150 small fires were started by one air raid. Only two grew large enough to call for the regular fire-fighting service.

I have tried to outline the reason for civil defense. I firmly believe in preparedness, we have safety, and in preparing for preparedness, we must do it *now*—not tomorrow. I suggest each and every one of you decide where you belong—be it with the police, fire fighters, motor transport, communications services, engineers, air plane spotters—there are many from which to choose. Report to General Dougherty's office in Detroit or to General Maitland in Lansing. You must have training in whatsoever duties you undertake. Enlist to do your part. Serve where you can do the most good—civil defense starts with personal and mutual responsibility. May I earnestly suggest you start a civil defense plan and program in your office, factory, church, club, your neighorhood, block and surely in your home. Remember we are a community. We are faced by a danger which

(Continued on Page 602)

Blood Typing Tags

By H. E. Cope, M.D.

Lansing, Michigan

MORE THAN 800,000 Michigan people now have or soon will have in their possession Civil Defense blood type identification tags. Therefore, it becomes highly desirable that the story behind these tags be told to the medical professions.

Immediately following the authorization of a Civil Defense blood typing program by the Michigan State Legislature, in March, 1950, a number of pilot studies were set up to determine the relative feasibility of certain proposed methods for large scale typing of civilian populations.

The first of these was conducted in Jackson under the immediate supervision of J. H. Ahronheim, M.D.* As a part of that project, metal identification tags were prepared and distributed to those typed. These tags were prepared by the same method as, and much resembled the charga-plates distributed by retail stores. They carried in reverse embossing, the individual's name, address, accession number, and, on the last line, symbols indicating the individual's religion, blood group and Rh type.

Because of the lack of public acceptance of this type of tag and the difficulty in reading the indented printing, further production of this type of tag was discontinued.

A second type of identification tag was prepared for those individuals in the study groups in Alma and selected pilot groups in the Detroit area. These tags were prepared by laminating typewritten copy between two sheets of plastic. The face of the tag carried the individual's accession number, name, address, religion, blood type and Rh factor. The reverse was color coded in standard international blood type colors.

Accurate typewritten transcriptions of blood typing results were difficult to obtain and in the interest of accuracy, this method of preparation

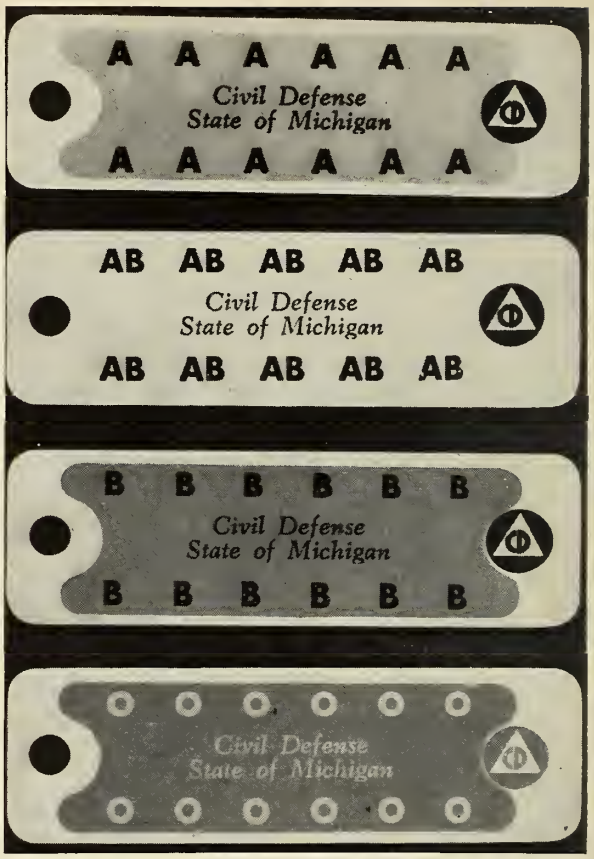
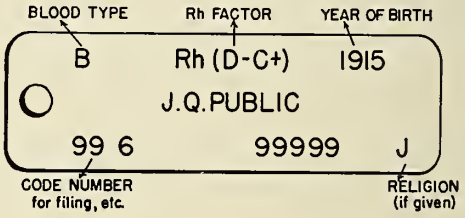


Fig. 1.



MICHIGAN
CIVIL DEFENSE IDENTIFICATION TAG
Fig. 2.

was abadoned in favor of mechanical IBM transcriptions.

Except for these first 108,356 typings, all other individuals have been issued a tag of the type illustrated in Figure 1.

These tags are in four colors—the standard international blood type colors: Blue for Group O; red for Group B; yellow for Group A and white with black lettering for Group AB.

The information on the face of this tag is

(Continued on Page 598)

Dr. Cope, clinical pathologist, Division of Laboratories, Michigan Department of Health, is consultant to the Blood Typing Division of the Michigan Office of Civil Defense.

*See Ahronheim, J. H.: The mass blood typing program of Jackson, Michigan. J. Michigan M. Soc., 50: 288 (March) 1951.

Detroit Physiological Society

MEETING OF MARCH 20, 1952

Maturing Chick Embryo

FRED L. RIGHTS

Wayne University College of Medicine
Department of Microbiology

The growth of several viruses was observed by *in vitro* and *in vivo* studies in the tissues of embryonated eggs. The viruses studied were influenza, vaccinia, pigeonosis and Newcastle disease (N.D.V.). The *in vitro* studies were performed in fluid tissue cultures by Simm's method without the use of serum ultra-filtrate.

Both *in vitro* and *in vivo* studies indicate that influenza virus grows well in young 10-day chorio allantoic membranes at both 35 and 40° C. However, virus growth is inhibited at 40° C. in 18-day membranes. A similar *in vitro* result was observed when the yield of virus from 18-day pulmonary tissues was compared with that obtained from 2- to 3-day-old chicks.

Such an *in vivo* effect was not observed with the N.D.V. agent. The growth *in vivo* of both pigeonosis virus and vaccinia virus was inhibited by increased temperature regardless of the physiological age of the embryonic membrane.

Factors Affecting the Growth of Virus in the AC-Globulin Changes in Placenta Abruptio

J. F. JOHNSON AND R. G. BRADEN
Wayne University College of Medicine.

In the coagulation of blood prothrombin is activated to thrombin by several activating agents, including thromboplastin. The thrombin formed converts fibrinogen to fibrin. A further action of the thrombin converts plasma Ac-globulin to serum Ac-globulin. The latter form is necessary for the accelerated activation of prothrombin. In time, thrombin also converts serum Ac-globulin to an inactive form, so that no serum Ac-globulin is found in serum older than several minutes.

According to the work of Schneider there exists, in placenta abruptio, the opportunity for the entrance of thromboplastin from the torn decidua into the circulating maternal blood. This initiates the blood-clotting mechanism. If intravascular coagulation then actually occurs, there should be a fall in the plasma level of the Ac-globulin, as well as a decrease in prothrombin and fibrinogen concentration.

Two cases of full-term pregnancies were studied in which there was separation of the placenta and the blood levels of the prothrombin, fibrinogen and Ac-globulin were measured by reliable quantitative techniques. There was a marked decrease in concentration of these factors immediately after placenta abruptio. These events were followed by a slow rise to normal plasma concentrations in the next two days. Ac-globulin values rose more slowly than either of the others, normal levels being attained only after five days.

Concepts of Plasma Antithrombin Activity

WALTER H. SEEGERS, M.D.

Wayne University College of Medicine

The capacity of plasma to neutralize thrombin activity can be ascribed to at least four mechanisms; namely, (1) Adsorption of a small amount of thrombin on fibrin, (2) Neutralization of thrombin by plasma antithrombin, (3) Interference with the thrombin-fibrinogen interaction by heparin and a plasma co-factor, and (4) The inactivation of thrombin by *antithrombin-accelerator.*

The activity of the natural antithrombin of plasma is destroyed by ether extraction. After such treatment, the antithrombin-accelerator reaction, recently discovered in this laboratory, can be demonstrated. It occurs during and shortly after the activation of prothrombin in plasma. Dicumarol plasma does not give the reaction as markedly as normal plasma does. Serum does not show the reaction at all; but if serum is treated with an adsorbent such as barium carbonate the antithrombin-accelerator reaction can again be

This investigation was supported by a research grant from the National Institutes of Health, Public Health Service.

demonstrated. This is done by dissolving purified prothrombin in ether-extracted-barium-carbonate-adsorbed serum. Upon activating the prothrombin the resultant thrombin is inactivated by the antithrombin-accelerator reaction. If the material adsorbed on barium carbonate is eluted with seven per cent sodium citrate solution an inhibitor of the antithrombin-accelerator reaction is obtained.

At the moment an unequivocal interpretation of these important findings is not possible. However, the following theory is proposed: The antithrombin-accelerator reaction is due to a substance which we may call *antithrombin-accelerator*. It arises during the activation of prothrombin, probably due to the action of calcium and thromboplastin. Antithrombin-accelerator can inactivate thrombin and is itself eventually destroyed by an inhibitor of the plasma. This inhibitor can be adsorbed from serum on barium carbonate, and thereby antithrombin-accelerator is set free.

The inhibitor which can be adsorbed on and eluted from barium carbonate can be prepared in concentrated form by the techniques used for preparing concentrates of proconvertin, SPCA, or factor VII, et cetera. Perhaps the inhibitor of antithrombin-accelerator and proconvertin are identical substances. If that be so, then we must consider that proconvertin is not an activator of prothrombin. It may have an indirect influence on the activation of prothrombin by suppressing the antithrombin-accelerator reaction. This would permit thrombin to accumulate rapidly, and this phenomenon could easily be mistaken for accelerated activation of prothrombin. This theory thus regards proconvertin as an inhibitor of an antithrombin reaction.

This investigation was supported by a research grant from the National Institutes of Health, U. S. Public Health Service.

BLOOD TYPING TAGS

(Continued from Page 596)

transcribed mechanically from the original punch card records on any given individual. The information is coded (Fig. 2).

Blood group is recorded by international classification as O, A, B or AB. The Rh type is recorded by the Fisher-Race classification as D+; D−C−; or D−C+. An individual whose Rh type is recorded as D+ is Rh_o positive; an individual whose type is recorded as D−C− is Rh'_o negative; and an individual whose type is recorded as D−C+ is Rh_o negative and rh′ positive.

The year of birth, in the upper left-hand corner, is recorded solely as a secondary means of identification in the case of duplication of names.

The code number on the lower line of the tag is made up of three components. The first two digits indicate the county of residence of the individual; the second group, the local group with which the particular individual was blood typed; and the last group, the serial accession number of the individual typed.

The symbol at the far right of the lower line indicates the religious preference of the individual typed if the individual wishes to have that information included on his tag. The space for the religious symbol was reserved at the request of the Michigan clergymen in order that a person gravely injured in accident, disaster or war might have a cleric of his preferred faith to minister to his spiritual needs. The code for symbols indicating religious preference follows: P for Protestant; C for Catholic; J for Jewish, and X if not given.

We have no doubt that the physicians of Michigan have a personal as well as a public interest in the accuracy of these blood types as distributed. Two per cent of all typings have been subjected to duplicate examinations in the local testing laboratories and in the Michigan Department of Health Laboratories. In the check specimens among the first 725,000 typings completed, we have found 23 discrepancies in blood group; fifty discrepancies in testing for D (Rh_o) factor and thirteen discrepancies in testing for the C (rh′) factor; for an overall accuracy 99.26 per cent. We believe that the Michigan Office of Civil Defense, and particularly the individuals in charge of blood typing and responsible for the testing in the local laboratories can be very proud that they have had a part in a project of this magnitude which has resulted in such a low percentage of error.

Editorial

GERIATRICS

A NEW CONCEPT in the practice of medicine, specifically the care of the aged, has become a major activity of the practicing profession. Geriatrics must consider specifically the changed effects of disease, and the reactions of the older patient to environment, illness and health measures. All these have a bearing on the good health, welfare and happiness of the patient.

The task of the medical profession is to alleviate the sufferings of our people—to make life happy, contented, and satisfying. During the formative periods of our nation this was no problem. Our older people were fewer in number, but most of them had accumulated a sufficiency to care for their less active later years, or their families had so established themselves that there was always a place for father, mother, or other elderly relative without disturbing the economy of the group.

The last one or two generations of Americans have witnessed a change so revolutionary it staggers belief. In general, industrialization of the nation has made for more wealth, much higher living standards, and assured work for those who wished to work. Industrialization, however, has left the older person hanging on a limb, with no place to light. The young and vigorous have demanded, and have secured to themselves the best jobs, the control of labor and employment, and through the machinations of labor organizations have set the age limit for working persons at sixty-five.

Old age security has been demanded, and the government has accepted the mandate. We have established by Federal law the policy of Social Security in old age, plus the compulsory retirement of the worker at age sixty-five. True, a person may work after sixty-five, but at a loss of his benefits, and at a serious disadvantage in securing employment. In fact, after age forty-five, or thereabouts, securing a job is oftimes a real problem.

These conditions of instability have increased the problem of the conscientious doctor, for his is the task to correct the effects of a disjointed life and sometimes mentality. In this number of THE JOURNAL, we are offering papers touching on the economic, social, or somatic reactions of our patients.

Recent articles in the metropolitan press admonish people with insufficient fixed incomes not to go to Florida hoping to find employment to eke out their funds.

OLD AGE SECURITY

THE GOVERNMENT passed its social security laws about seventeen years ago, and made them applicable to a large segment of our population, mostly employed persons. Two years ago, an extension of the act brought in about ten million more, but by request and to maintain an American principle of independent action, it exempted certain of the self-employed. The medical profession, law, dentistry, architecture, ministers, and others were exempt. Rates were raised, the wage limit was raised and the benefits were multiplied.

The laws which provided for old age benefits fixed the age of "old age," and provided the machinery for retirement which has been a boomerang. Little did Labor think it was planning a system to make securing of employment difficult during the fifties, and almost impossible in the sixties. To add to Social Security benefits, industry has been compelled to establish retirement plans for its employes. A few years of labor does not establish a backlog of sufficient size to finance these plans. Therefore, an older man out of work has difficulty. This uncertainty has its effect on the morale of the worker.

Recently, labor has been trying to set up a plan whereby a man who changes his employment does not lose his seniority, or his employment social benefits. Federal Social Security is so conducted. It is wholly inadequate and must be supplemented by industrial plans. This has been one of the important "fringe benefits" so universally demanded by labor-bargaining agents.

There are now bills in Congress to add the legal profession to those under the compulsory listing of Social Security, and to extend the listings to an indefinite number. Just recently, Ernest P. Boaz, M.D., and other members of the Physicians Forum, a New York group favoring compulsory

health insurance, have advocated that doctors of medicine be included under Social Security.

We, the medical profession, have believed that our best interests would be served if we were allowed to care for ourselves in the true American independent self-sufficient plan which has made America a nation of giants in the world.

WE ASK EQUALITY AND JUSTICE

FOR THE PAST seven years, this Editor has been advocating that the Federal tax laws be so changed that we as professional men, or self-employed persons, might have the same benefits now allowed to administrators in industry. We invited attention to this problem in September, 1945, page 1013; September, 1949, pages 1171-2; July, 1950, page 810; April, 1951, page 410; May, 1951, page 514; and January, 1952, page 71.

It has been our belief that some modification of the tax laws could be made, allowing self-employed persons of the professions to set aside a certain percentage of their income each year, not to exceed a certain specified amount, to be invested in specified securities (and we suggested low interest government special tax bonds designated for that purpose). The money invested in these securities would be tax-free until such time (after age sixty-five, or after necessary retirement disability) when they would be cashed as annuities, or periodic allowances. At this time they would be taxed as income. There would be an advantage to the Government in that this money reserved from taxes would be invested with the Government, the same as other financing bonds, plus the additional advantage of low interest.

Following our advocacy of this plan, a resolution of approval was passed by the House of Delegates of the American Medical Association in 1949 and 1951. Since that time, the American Medical Association has been active. Several years ago we mentioned that the architects were interested in such a plan, and some years later mentioned the American Bar Association.

We are happy to report that the weekly letter of the Secretary of the American Medical Association for March 21 contains the following paragraph:

"Instead of urging inclusion of doctors under Social Security, the American Medical Association is joining hands with the American Bar Association, the American Dental Association, architects, engineers, accountants, and other professional groups in support of the Reed-Keogh bills, which provide for the exclusion of certain portions of earned income from federal income taxation if those amounts are used to buy a pension. These bills have been approved in principle twice by the House of Delegates."

We firmly believe that some plan, as outlined, could be passed if members of the professions and other self-employed persons would make their belief known to their Congressmen. The bills are now under consideration. The benefit thus provided would be mere justice, placing us on the same benefit plane as is now enjoyed by thousands in industry and other employment.

Under the present Social Security laws of the Federal government, a man who now comes under the benefits (and this is compulsory) may pay a Social Security tax of $81.00 per year for a minimum of eighteen months, then if over sixty-five may retire on a monthly income of $120.00 (if married).

Under the plan we are proposing, we will not in any way be beneficiaries of the Government but will pay for our own benefits by buying them through bonds and annuities. Our demonstrable benefit from the government would be the saving temporarily of income taxes, and through that very savings we would be able to accumulate a security which we cannot do under present tax laws.

All of this points to a greater security in our advancing years, and a greater contentment, therefore a better health because we will have provided for our needs.

WHY DEMORALIZING INACTIVITY?

WE HAVE MENTIONED the provision of our Social Security laws requiring a beneficiary who has passed sixty-five to lose his benefits if he earns more than fifty dollars a month. His maximum benefits, if single, are eighty dollars, making a total of $130 for his support per month. If he earns one cent more, he will lose his Social Security payment, which is tax free, and every cent more than the fifty dollars of earning is taxable.

The law encourages indolence in some and compells indolence in others. The law is claimed by its sponsors to be insurance, the payments are not a dole but a right, yet the Government takes away that right for no good purpose, other than to keep the old man out of the labor market. We

(Continued on Page 616)

A True Country Doctor Named Michigan's Foremost Family Physician

Everyone loved it.

The story had great possibilities. It was the personification of a great American Ideal—the revered country doctor.

Clayton Willison, M.D., an 82-year-old Sault Ste. Marie country doctor, was named Michigan's Foremost Family Physician for 1951 by the Michigan State Medical Society House of Delegates. The choice was made during the MSMS 86th Annual Session in Grand Rapids last September. The award scroll was given at the Michigan Clinical Institute in March, 1952.

The selection of Dr. Willison, who has practiced medicine for sixty years, stirred the imagination and lifted the curtain on scores of memories of Michigan's citizenry. These memories, fanned to life by news stories, were tinged with the smell of hot, fresh-baked bread in an old-fashioned kitchen, the excitement of a square dance and the soft crunch of a horse's hoof on a country road.

The story even conjured up pictures of a lone figure driving a horse and buggy through a blinding snowstorm late at night to preside at the birth of a baby, or the long night vigil at the bedside of the patient approaching the crisis in pneumonia.

Those were the good old days—the good old days of the 100-cent dollar, the nickel cigar and the Saturday nights on Main Street. Those were the good old days before the complexities of living in 1952 and the new-fangled penicillin and the sulfonamides.

The good old days when life was worth living —if you managed to. The baby born in a four-poster bed at the neat farmhouse, while the wind-whipped snow raged in white fury outside, had a great future in this land of opportunity as long as his future wasn't cut short at the age of five by whooping cough or perhaps scarlet fever.

THE COVER

Michigan's Foremost Family Physician for 1951, Clayton Willison, M.D., Sault Ste. Marie, receiving scroll from MSMS President Otto O. Beck, M.D., Birmingham, during Michigan Clinical Institute ceremonies in Detroit, March 13, 1952.

What the patient with pneumonia really needed was thousands of units of penicillin. But those were the good old days of 1900 when Sir Alexander Fleming was only nineteen years old.

Without a doubt, Dr. Willison, as Michigan's Foremost Family Physician, fitted into the people's viewpoint of the dearly loved country doctor. The vision, swelled by countless memories, was standardized into a composite picture so that like Pavlov's dogs the stimulation by the phrase "country doctor" rang the bell and the same scene unfolded in a million minds: a kindly, respected man who at the first stab of pain or the first sniffle could be called day or night in rain or shine. He was the uncomplaining individual, who seemed duty-bound to travel the same roads at night which some patients found inconvenient to travel during office hours. And he was agreeable. His bills could be paid last or not at all. He understood.

The elements in the story of Dr. Willison's life meshed with the picture. But there was another element in the picture which was not so visible. Dr. Willison and his contemporaries were the vanguard in an era of medical advancement which is still moving forward.

In training for his role of the country doctor, Dr. Willison attended the University of Michigan for two years, then transferred to the Chicago Homeopathic Medical College where he received his medical degree in 1891. And in 1891 already the first strides in better medical education were being made. Dr. Willison became the first intern at Grace Hospital, Detroit.

The same year he was appointed Assistant House Surgeon at Grace Hospital; the next year he was named House Surgeon at the Hospital. In 1894 he entered private practice in Detroit.

Several years later he left the city and became part of the development of the giant lumbering industry. He served as a physician and surgeon in lumber camps of northern Michigan.

At the turn of the century, Dr. Willison began his medical practice in Sault Ste. Marie, Michigan. During a portion of his medical career, he represented the U. S. Public Health Service in Sault

Ste. Marie. When he left the Health Service he still continued in his practice which even today is still an active one.

The story of Dr. Willison further conforms to the picture of the country doctor. During his six decades of practice, he has delivered more than 5,000 babies. Then, too, there were many trips through the rough roads of the backwoods to heal the sick. Often he would travel 30 to 40 miles on a single call. Occasionally, he got there by horseback or sometimes on foot. When the shortest route to his patient was by water, he navigated the distance in a sailboat. In the winter he made the rounds on snowshoes or by dog team.

And the picture was made complete by the occasional kitchen-table operations on patients located in cabins of the rugged north country.

But there was a rub—a contradiction—in this idealistic picture of the country doctor. While the rose-colored concept remained the same, Dr. Willison and his confreres changed with time as scientific advances gave them new weapons to fight disease. Besides the new drugs and new medical knowledge, there was water purification, garbage collections and inside plumbing.

The people changed too, in a way, but they were caught in a dilemma. They still clung to the picture of the old country doctor, but they didn't want their kitchen turned into an operating room. They wanted the best hospital with the latest in operating tables and the most able surgical specialists. When they had pneumonia, they longed for the attention of the long-night vigil but expected penicillin. But the penicillin eliminated the night watch.

So the ideal picture of the country doctor didn't work out in practice in more recent years. And it was a lucky thing, too, because the medical advances adopted by these medical men meant a longer life for their patients.

Yet to learn of these advances, the doctors had to attend postgraduate courses and scientific meetings. Occasionally at these meetings they turned from the purely scientific to honor one of their own members with recognition of a Foremost Family Physician.

This year the honor went to Dr. Willison. The American Medical Association also recognized Dr. Willison's contributions to medical practice in December at the AMA Clinical Session at Los Angeles; the Sault Ste. Marie doctor of medicine was one of three finalists for the AMA General Practitioner Gold Medal Award.

In view of these honors accorded Dr. Willison, the Chippewa County Medical Society joined with a citizens' committee made up of Sault Ste. Marie business, professional, fraternal and service organizations and held a testimonial dinner, February 21, at the Sault. On this occasion Michigan's Foremost Family Physician was awarded a concurrent resolution passed by the Michigan Legislature which paid tribute to Dr. Willison as an outstanding medical doctor in Michigan.

But through all the honors and ceremonies, Dr. Willison has retained the flavor of the true country doctor. On the night of his initial triumph—the night he was named Michigan's Foremost Family Physician for 1951—when the news was flashed to Sault Ste. Marie, he was the last to know. Dr. Willison was busy making a house call.

CIVIL DEFENSE

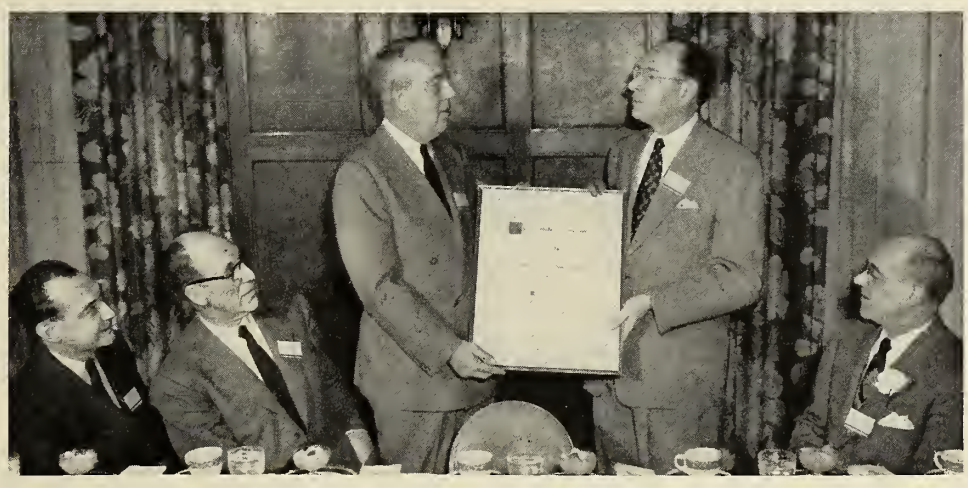
(Continued from Page 595)

might be disastrous to us, to our families, to our communities, to our country and to the world. And to repeat myself, it is up to each and every one to enlist in the particular civil defense activity in which he is best qualified to serve, in order to prevent the disaster from being a disaster.

In conclusion, life and the world continue day by day in the same manner as the waves wash the beaches and ocean shores. If there is anything we should do for tomorrow, we must do it today, as today will never come again and tomorrow will be too late.

Pictorial Highlights
Sixth Michigan Clinical Institute

Hillsdale County Medical Society Receives Recognition for Cancer Detection Pioneering



Every Doctor's Office a Detection Center

Arthur W. Strom, M.D., Hillsdale, official representative of the Hillsdale County Medical Society, accepts a scroll presented by Otto O. Beck, M.D., Birmingham, President of the Michigan State Medical Society, in recognition of the efforts of the Hillsdale County Medical Society members in developing an outstanding and successful cancer detection project. The award was presented March 13 during the Michigan Clinical Institute in Detroit. Present at the ceremony are, left to right, William Bromme, M.D., Chairman of The MSMS Council; R. J. Hubbell, M.D., Kalamazoo, MSMS President-Elect; President Beck; Dr. Strom; and E. F. Sladek, M.D., Traverse City, M.C.I. Chairman.

While three of the four scrolls presented by the Michigan State Medical Society at the 1952 Michigan Clinical Institute honored individuals, the fourth scroll honored a life-saving plan.

This plan—The Hillsdale Plan for Tumor Detection — was launched January 1, 1948, by members of the Hillsdale County Medical Society. It was a new development in the fight against cancer. The Hillsdale Plan makes every doctor's office a detection center for cancer.

According to a survey conducted by the MSMS Cancer Control Committee, more than two-thirds of cancer develops in areas of the skin, breast, uterus and rectum. These areas of the body could be examined in a doctor's office and cancer prevented.

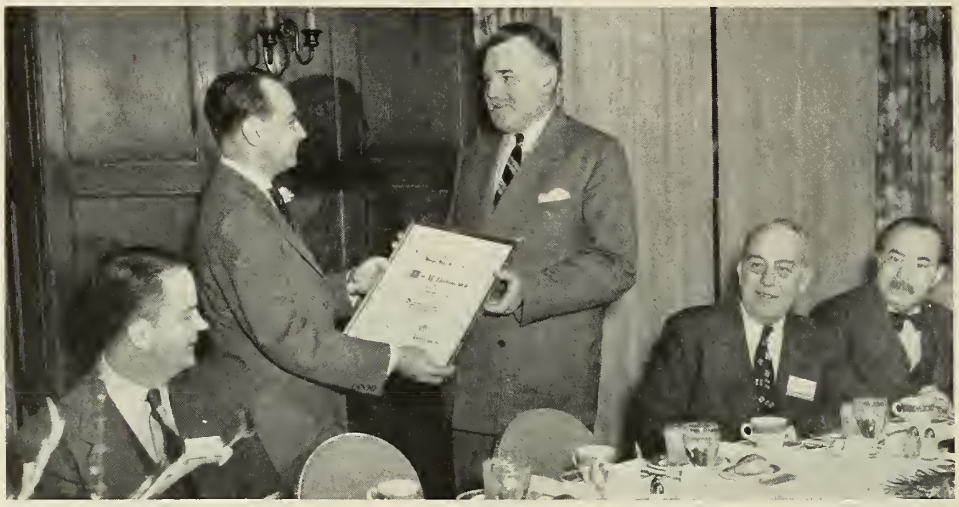
To the doctors of medicine in Hillsdale County, an examination of the patient for evidence of cancer of the skin, breast, uterus or rectum seemed a logical answer to finding cancer in early and curable stages.

From its inception in the rolling countryside of Hillsdale County, the Plan soon spread to other areas of Michigan and the United States. These communities and medical societies which have adopted a version of the original plan are also on the alert for early signs of the disease.

The pioneering efforts of the Hillsdale County Medical Society were recognized by the Michigan State Medical Society in its presentation of the scroll on March 13. The scroll is worded as shown in the insert.

This Certificate of Commendation
is presented by the
MICHIGAN STATE MEDICAL SOCIETY
to the
HILLSDALE COUNTY MEDICAL SOCIETY
for its pioneering effort in developing
THE HILLSDALE PLAN FOR TUMOR DETECTION
The most practical and effective plan yet devised for finding cancer in early and curable stages.

Two Michigan Doctors Lead National Medical Groups



Doctor Bartemeier's Work Recognized

Leo H. Bartemeier, M.D., Detroit, is honored by the Michigan State Medical Society with a scroll presented by William Bromme, M.D., Detroit, Chairman of The MSMS Council. Pictured *(left to right)* are: Howard A. Rusk, M.D., New York City, guest speaker; Dr. Bromme; Dr. Bartemeier; Otto O. Beck, M.D., MSMS President; and Gregory Zilboorg, M.D., New York, guest speaker at the Bartemeier Testimonial Dinner of March 12.

Two Detroit doctors of medicine, elevated to the presidency of their national specialty organizations, received recognition by the Michigan State Medical Society for distinguished service to medicine, medical education and research.

They are Leo H. Bartemeier, M.D., President of the American Psychiatric Association, and James Milton Robb, M.D., President of the American Academy of Ophthalmology and Otolaryngology.

Dr. Bartemeier received his scroll during the March 12 luncheon meeting at the Michigan Clinical Institute in Detroit. Dr. Robb was awarded his scroll the following day during the Institute luncheon.

Both physicians are on the faculty of Wayne University College of Medicine. Dr. Bartemeier is Associate Professor of Clinical Psychiatry while Dr. Robb is Professor of Otolaryngology.



Doctor Robb Honored

James Milton Robb, M.D., Detroit, receives his scroll from Otto O. Beck, M.D., Birmingham, MSMS President. Pictured left to right during the presentation are R. J. Hubbell, M.D., Kalamazoo, MSMS President-Elect; E. F. Sladek, M.D., Traverse City, M.C.I. Chairman; Dr. Robb; President Beck; and William Bromme, M.D., Detroit, Chairman of The MSMS Council.

1952 MCI Breaks Attendance Records

A total of 1,933—just sixty-six less than 2,000—registered at the 1952 Michigan Clinical Institute—this despite the blinding blizzard and snowstorm of Thursday and notwithstanding the railroad strike which delayed arrival in Detroit of the 2,000 printed programs!

This registration record included 1,395 Doctors of Medicine. It represented an increase of 354 over last year's Institute registration of 1,579.

Out-of-Michigan M.D.s who registered included physicans from California, Colorado, Illinois, Indiana, Massachusetts, Minnesota, Missouri, New York, Ohio, Pennsylvania, Texas, Virginia, Wisconsin, and from the Province of Ontario, Canada.

"Block System" Draws Big Registration

The new type of co-ordinated teaching pleased all who attended the 1952 MCI session. Wednesday, March 12, included six integrated *surgical* subjects in the morning and two *obstetrical* and four *pediatric* subjects in the afternoon; Thursday presented six integrated *medical* subjects in the morning and six co-ordinated teaching periods on *adult health* in the afternoon; Friday proved extremely interesting with six integrated heart subjects on the morning program and a similar number of integrated periods on metabolic diseases in the afternoon.

This organization permitted the presentation of an educational program for general practitioners and all other medical men that was without parallel among postgraduate clinical conferences and state medical conventions. It resulted in large audiences for the speakers, even to the last paper on Friday afternoon.

Three Luncheons Crowded

Extra tables were rolled in for a talk on Rehabilitation by Howard A. Rusk, M.D., Wednesday noon; the Sykes Lecture presented by Lauren V. Ackerman, M.D., on Thursday noon attracted a full house to hear "Differential Diagnosis of Cancer." An all-time attendance record was chalked up for the Annual Heart Luncheon of Friday, March 14, when Samuel A. Levine, M.D., spoke on "The Importance of the History and Physical Examination in the Diagnosis of Heart Disease."

Publicity

A total of 1,215 inches of publicity appeared in Detroit and Michigan newspapers in connection with the 1952 MCI. These stories consisted of advance releases announcing highlights of the three-day meeting and spot news articles during the session.

The top human interest story surrounded the honors accorded Clayton Willison, M.D., Sault Ste. Marie, Michigan's Foremost Family Physician for 1951. Great importance was also given by newsmen to the honors and celebrations concerning James Milton Robb, M.D., Detroit, President of the American Academy of Ophthalmology and Otolaryngology, and Leo H. Bartemeier, M.D., Detroit, President of the American Psychiatric Association.

The Wednesday evening talk on Civil Defense by Norvin C. Kiefer, M.D., Washington, D. C., also received good attention from the press. Dr. Kiefer is Director of Health and Special Weapons Defense Division of the Federal Civil Defense Administration.

The scientific speakers on the program all had noteworthy and newsworthy topics which created a wide interest. From the standpoint of columns of newsprint, the 1952 Michigan Clinical Institute proved once again that the individual is primarily interested in reading about his health.

Thanks to Convention Workers

The Executive Committee of The Council, Michigan State Medical Society, at its March 20, 1952, meeting in Detroit, placed on its minutes a vote of thanks to all who helped to make the Sixth Michigan Clinical Institute in Detroit such an unusual success. Deserving special commendation are: E. F. Sladek, M.D., Traverse City, Chairman of the Committee on Arrangements and Program with the following members: Wilfrid Haughey, M.D., Battle Creek; Otto O. Beck, M.D., Birmingham; C. E. Umphrey, M.D., Detroit; L. Fernald Foster, M.D., Bay City; B. R. Corbus, MD., Grand Rapids; G. C. Penberthy, M.D., Detroit; P. S. Barker, M.D., Ann Arbor; F. H. Bethell, M.D., Ann Arbor; F. A. Coller, M.D., Ann Arbor; H. H. Cummings, M.D., Ann Arbor; H. A. Towsley, M.D., Ann Arbor; Louis Jaffe, M.D., Detroit; L. R. Leader, M.D., Detroit; R.

C. Rueger, M.D., Detroit; D. I. Sugar, M.D., Detroit; B. T. Montgomery, M.D., Sault Ste. Marie; C. L. A. Oden, M.D., Muskegon; C. A. Payne, M.D., Grand Rapids; W. Z. Rundles, M.D., Flint; D. B. Wiley, M.D., Utica; A. E. Heustis, M.D., Lansing, and E. I. Carr, M.D., Lansing.

Ubiquitous Hosts.—W. D. Barrett, M.D., P. T. Chapman, M.D., W. B. Cooksey, M.D., J. W. Hawkins, M.D., all of Detroit; F. D. Johnston, M.D., Ann Arbor; D. H. Kaump, M.D., J. J. Lightbody, M.D., R. M. McKean, M.D., G. C. Penberthy, M.D., H. L. Smith, M.D., E. D. Spalding, M.D., and G. L. Waldbott, M.D., all of Detroit.

Chairmen of Assemblies.—B. T. Montgomery, M.D., Sault Ste. Marie; H. A. Towsley, M.D., Ann Arbor; Louis Jaffe, M.D., Detroit; W. Z. Rundles, M.D., Flint; P. S. Barker, M.D., Ann Arbor; F. J. Smith, M.D., Detroit, and D. B. Wiley, M.D., Utica.

Press Committee.—C. L. Weston, M.D., Owosso, Chairman; A. B. Gwinn, M.D., Hastings; H. F. Dibble, M.D., Detroit, and R. A. Johnson, M.D., Detroit.

F. Maxwell Shuster, Cleveland, and Richard A. Aubrey, Detroit, loaned by the E. I. du Pont de Nemours & Co., Inc., for the entire period of the Institute, rendered untiring service.

Eugene Wiard and Margalee Magoon, Lansing, of the Michigan Health Council staff; Jack Pickering, science writer, *Detroit Times;* James Trainor, city editor, *Detroit Times;* Allen Shoenfield, science writer, *Detroit News;* Merle Oliver, feature writer, *Detroit News;* Ralph Reed, state editor, *Detroit News;* Ed Winge, science writer, *Detroit Free Press;* Dale Nouse, feature writer, *Detroit Free Press;* and Bud Mitchell, Radio Station WJR, Detroit.

The Woman's Auxiliary to the MSMS, through the efforts of the President, Mrs. R. S. Breakey, Lansing, and of Mrs. A. H. Whittaker, Detroit, manned the Beaumont Memorial Restoration Booth during the Michigan Clinical Institute at the Sheraton-Cadillac Hotel, Detroit. The Woman's Auxiliary was assisted by officers of the Michigan State Medical Assistants Society as well as by the Woman's Auxiliary to the Wayne County and Oakland County Medical Societies.

Thanks for the "Doodle Diaries" which were distributed to all registrants go to Michigan Medical Service.

What They Thought of the 1952 Michigan Clinical Institute

Lauren V. Ackerman, M.D., St. Louis, Missouri (guest essayist): "I have never been to a meeting that was so well organized. The contrast to the many meetings that I have previously attended was prominent. Needless to say, I thoroughly enjoyed myself. The meeting gave me an opportunity to see old friends and make new ones. Please thank everyone for me."

Truman G. Blocker, Jr., M.D., Galveston, Texas (guest essayist): "I enjoyed the meeting immensely and my only regret was that I was unable to be with such a fine group for the entire length of the meeting."

Garfield G. Duncan, M.D., Philadelphia, Pa. (guest essayist): "The Michigan Clinical Institute was a most enjoyable experience for me."

Richard H. Freyberg, M.D., New York City (guest essayist): "I enjoyed participation in the recent Michigan Clinical Institute and the opportunity to see so many of my good old friends. I heard a great many compliments for the excellent program you and your committee arranged. I was surprised to see how many stayed to the end."

Franklin M. Hanger, M.D., New York City (guest essayist): "May I congratulate you on the very successful meeting. I found my trip to Detroit both pleasant and instructive, and I appreciate the honor of being one of your invited speakers."

Norvin C. Kiefer, M.D., Washington, D. C. (guest essayist): "It was a pleasure to be with you in Detroit and to address the Medical Civil Defense meeting. I thoroughly enjoyed your meeting and certainly profited by it."

Edward J. McCormick, M.D., Toledo, Ohio (guest essayist): "Thanks so much for the kind hospitality which you extended to me on the occasion of my recent visit to Detroit. I enjoyed my trip and I do hope that I may have added a little bit to the fine meeting which was held in Detroit. Mrs. McCormick summed it up on the way to Ann Arbor when she said: 'The Michigan doctors are an outstanding group.'"

Raymond O. Muether, M.D., St. Louis, Mo. (guest essayist): "It was a pleasure to meet your group during the Michigan Clinical Institute. I enjoyed the entire meeting and if I was, in

some small measure, a factor in its success, I am more than happy."

Jay A. Myers, M.D., Minneapolis, Minnesota (guest essayist): "There was a splendid attendance and the doctors seemed to be interested in refinements in the diagnosis of tuberculosis with considerable emphasis on the use of the tuberculin test. The officials were exceedingly kind to me. The audience was attentive and I thoroughly enjoyed the day."

Howard A. Rusk, M.D., New York, New York (guest essayist): "It was indeed a pleasure to attend and participate in the program of the Sixth Michigan Clinical Institute. I thought it was a fine meeting and I enjoyed so much being with you. Never have I met such a hospitable group; I do appreciate their kindness."

Oscar Swineford, Jr., M.D., Charlottesville, Virginia (guest essayist): "Ubiquitous host George Waldbott took me in tow immediately on my arrival and entertained me most pleasantly."

Charles F. Wilkinson, M.D., New York, New York (guest essayist): "I really enjoyed the opportunity of participating in the Michigan Clinical Institute and wish to thank you for inviting me."

E. F. Sladek, M.D., Traverse City (General Chairman of Arrangements): I am certainly proud of the Michigan Clinical Institute attendance, the whole program and the way it went over. The comments were enthusiastic. Please congratulate and extend my thanks to the entire Committee on Arrangements for a grand and well-done job. Also tell the office force they were even more efficient than usual—if that is possible."

John G. Bielawski, M.D., Detroit, Executive Secretary, Michigan Heart Association (sponsor of Heart Day on Friday, March 14): "The experiment of combining Michigan Heart Day into the program of the Michigan Clinical Institute this year was, I think, a resounding success. We had a greater attendance at our morning scientific sessions and at the luncheon than we have had heretofore. I feel that combining the two meetings was of benefit to both Heart Day and the Michigan Clinical Institute. Please accept my sincere thanks for your splendid help and guidance in planning and organizing our part of the meeting and for the co-operation of the State Society as a whole."

James C. McMeel, M.D., South Bend, Indiana (President, Northern Tri-State Post-Graduate Medical Association): "The Michigan Clinical Institute held in Detroit was the finest medical meeting I have ever attended, and with God's help I shall be present at the next meeting as I profited very much from the manner in which the meeting was conducted."

V. B. Halbert, M.D., Sylvania, Ohio: "It took forty years of medical meetings to reach the best one I ever attended, the Michigan Clinical Institute in Detroit last month. Who cares or remembers, for example, that in 1813 Pierre Bretonneau of Tours distinguished dothienenteritis as a separate disease? What we got at this meeting was condensed, concise, usable and if not exhaustive at least not exhausting. Certainly, I am planning right now to attend the next Michigan Clinical Institute."

Max L. Durfee, M.D., Director, College Health Service, Oberlin College, Oberlin, Ohio: "The Michigan State Medical Society is to be congratulated on its Michigan Clinical Institute of 1952. For years you have been at the forefront of medical progress. This was my reintroduction to the Michigan medical scene after a thirteen-year absence, and the Institute made me proud of my medical origin. Thank you again. I shall surely make every effort to be with you at next year's meeting."

K. B. Schlotzhauer, M.D., Stratford, Ontario: "I enjoyed the Michigan Clinical Institute very much."

Leonard A. Glenn, M.D., Chatham, Ontario: "It was extraordinary in scope, in the most timely subjects, in such a luxurious setting and presenting the most recent developments of present day medicine and surgery. A spirit of friendliness, characteristic of the middle West, was noticeable among the members and the distinguished guests, and this was also present among the exhibitors, most of whom had classy displays of the latest and finest in modern equipment."

W. L. Percival, M.D., Windsor, Ontario: "I enjoyed the recent meeting of the Michigan Clinical Institute. Certainly, the committee members are to be congratulated on the well-organized program which offered a wealth of information for both the specialist and the general practitioner."

G. C. Penberthy, M.D., Detroit: "It was a good meeting and I compliment you as chairman."

(Continued on Page 637)

Now Basic Sci

Legislature Adopts MSMS Recommendations

S.B. 251 — Basic Science Act

Significant changes with far reaching effects were made in the Basic Science and Medical Practice Acts by the 1952 Michigan Legislature. Companion bills SB 251 and SB 301, drafted by the Michigan State Medical Society, were introduced containing amendments to the Basic Science Act and to the Medical Practice Act as recommended by the MSMS House of Delegates at the September, 1951, Annual Session.

Both bills were passed by the Legislature and approved by Governor Williams. The Basic Science amendments will take effect in August, 1952; the changes in the Medical Practice Act were given immediate effect.

Briefly, the amendments to the Basic Science Act will permit the Basic Science Board to approve those applicants who have successfully passed the basic science examinations in practically any other "basic science" state; interns and residents will be exempt from taking Basic Science examinations; subjects, successfully passed, need not be taken again; the membership of the Basic Science Board will be subject to change; and the records of that Board with respect to the reason for approval of applicants will be open to public inspection.

Reciprocity

Prior to the passage of SB 251 the Michigan Basic Science law required that other states having basic science requirements grant exemption to those persons certified by the Michigan Basic Science Board: If such exemption was not granted by any state, then Michigan could not grant exemption to persons certified by that state. SB 251 deletes this qualification and the Basic Science Board is empowered to waive the Michigan examination for any applicant who has been certified in another state providing that the requirements of the other state "are not less than those required by this (the Michigan) Act."

In order that the requirements of the Michigan Act be not greater than those of other states, the number of examinations required was reduced from 6 to 5 by the deletion of "public health and hygiene"; and the passing grade required was reduced from 75 to 70%. This sufficiently lowers the Michigan requirements so that legally the Michigan Basic Science Board may approve nearly every other state having basic science examinations. Thus, the State of Michigan will no longer be deprived of doctors of medicine because of lack of reciprocity.

Re-examination

The Basic Science law has in the past required that if an applicant failed in his examination in two or more subjects, he must show proof of additional study in all the basic sciences and take *all* the examinations over again. SB 251 alters the law to permit re-examination in only the subjects failed. No longer will it be necessary, for example, for an applicant who has passed his examination in chemistry to repeat that examination simply because he failed in anatomy and physiology or any other two subjects.

Residents and Interns

It has been held that residents in hospitals are engaged in the practice of medicine. This made it necessary for them to have temporary permits from the Michigan State Board of Registration in Medicine to practice. But such temporary permits could not be issued unless the applicant had passed his Basic Science examination or was approved through reciprocity. As a result, Michigan hospitals were having difficulty obtaining residents from those states not requiring basic science examinations or not reciprocating in basic science

(Continued on Page 610)

Really Work

Improving Basic Science and Medical Practice Act

S. B. 301 — Medical Practice Act

A sweeping revision of the Medical Practice Act was made by the 1952 Legislature at the request of the Michigan State Medical Society. Only two minor amendments—neither objectionable to MSMS—were added to the bill as originally introduced.

No major change previously had been made in the Act since its original passage in 1899. Fifty-three static years demanded modernization.

Temporary Annual Licenses

One of the most important changes was the amendment permitting the Board to grant *temporary* annual licenses to practice to "doctors of medicine who are pursuing postgraduate study" in approved training hospitals. The net effect of this provision, combined with the exemption of interns and residents from Basic Science (see analysis of SB 251), will be to remove barriers to advanced training in Michigan and encourage more prospective residents and interns to seek opportunities in Michigan hospitals.

Most radical change was in the 800 words deleted which contained obsolete portions of the Act. Language pertaining to such archaic schools of medicine as eclectic and physio-medical was deleted. The Board of Registration in Medicine will now consist of ten doctors of medicine, nine of whom are to be from the "regular" school of medicine and one to be a graduate of a homeopathic school.

Small amendments were made with respect to details involved in the meetings and business transaction of the Board.

A series of amendments approximately doubled the examination fees. The purpose of this amendment was to provide additional monies to the Board of Registration in Medicine in order that it may better carry out its duties under the Act.

Several changes were made relating to the enforcement of the Act and the defining of "unprofessional and dishonest" conduct. The Board will now have power to suspend licenses of doctors who have been found by the courts to be mentally incompetent. It will also be cause for suspension as grossly unprofessional conduct if a doctor is found to be guilty of "making representations or claims of ability to cure or relieve human ailments by secret methods." Authority to restore licenses and to issue subpoenas to compel the attendance of witnesses and production of records also was given the Board.

Citizenship or Second Naturalization Papers Necessary

Attention was given to the problem of displaced persons by requiring that the doctor of medicine, to receive a licence to practice, must be a citizen of the United States or have taken out his second naturalization papers. The practical effect of this amendment is to require a doctor coming to Michigan from a foreign country to wait 2½ years before he can obtain a permanent license to practice. In the meantime, however, he may take additional training under the temporary annual license provision of the law.

Increased legal and financial power given to the Michigan State Board of Registration in Medicine now removes previously existing barriers to maximum effectiveness in (a) enforcement against offenders and (b) encouragement of more residents and interns to train in Michigan hospitals, with the inevitable result that many of these well-qualified M.D.s will remain to practice in this state. Michigan medical practice will benefit by a modern workable law.

S.B. 251—BASIC SCIENCE ACT

(Continued from Page 608)

with Michigan—a total of 44 states. This situation has been eliminated by specifically exempting from the provisions of the Basic Science Act those residents and interns training in Michigan hospitals. This exemption ties in with the permission given the State Board of Registration in Medicine to grant temporary annual licences (see accompanying article re Medical Practice Act changes). No longer will the Basic Science law serve as a barrier toward the obtaining of residents and interns for Michigan hospitals.

Records and Terms of Office

Objections to the *administration* of the Basic Science law have been heard repeatedly. Two steps, in addition to the liberalizations indicated above, were taken in SB 251 to assist in obtaining better administration. One of these was to require that the records of the Basic Science Board in respect to the certificates of eligibility issued, and *why* they were issued, be placed in the office of the Secretary of State where they will be open to public inspection. Should it be desirable to check on the reasons why a particular practitioner was approved by the Basic Science Board, it will be necessary only to check with a list filed with the Secretary of State.

In addition, the law will now provide that no member of the Basic Science Board who has served two consecutive terms (of six years each) "shall be eligible for reappointment until the expiration of a period of 10 years." It is of vital importance that devoted and hard working men continue to be members of this Board. The law as now amended permits an even wider latitude for good administration by encouraging periodic changes in the Board personnel resulting in new thinking and greater progress with the years.

Now the Basic Science law can work. The law has been improved. It now gives the Board both the legal opportunity and the social responsibility for effective administration.

DYNAMIC THERAPEUTICS IN CHRONIC DISEASE

(Continued from Page 559)

are frequently overlooked, but the personal, vocational, and social success of the handicapped person is dependent upon them.

The practice of rehabilitation begins with the belief in the basic philosophy that the doctor's responsibility does not end when the acute illness is ended or surgery is completed; it ends only when the patient is retrained to live and work with what he has left. This basic concept of the doctor's responsibility can be achieved only if rehabilitation is an integral part of medical care. Rehabilitation is only as sound as the basic medical service of which it is a part. The diagnosis and prognosis must be accurate, for it is upon them that the feasbility of retraining is determined.

Regardless of the type of disability, the responsibility of the physician to his patient cannot end when the acute injury has been cared for. It ends only when the physician has taken the responsibility for seeing that proper referral has been made to those agencies and institutions which are equipped to rehabilitate and retrain the patient with a residual physical disability. The physician who fails to see that those patients under his care receive the full benefits of modern methods of medical rehabilitation and retraining is in the same category as the physician who still persists in using dietary restriction alone in the management of diabetes when insulin is available, for medical care is not complete until the patient has been trained to live and work with what he has left.

GOVERNMENT GIVES NOTHING FREE

Oscar Ewing now wants the federal government to finance scholarships for 50,000 high school graduates every year, and the President is backing him by budgeting 30 million dollars to pay for the scheme.

Commenting on the proposal, the *Charlotte* (N. C.) *Observer* said, editorially: "It has long been an accepted principle that public education is the function of the state and not of the federal government. But not until Oscar Ewing came on the scene was it ever suspected that the United States government was obligated to provide a college education for anybody.

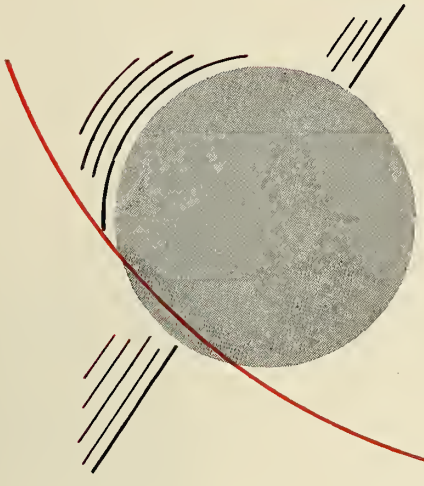
"Whenever Mr. Ewing comes forward with one of his devices to give Washington bureaucrats a stranglehold on another aspect of life in this so-called free America, we should remember that the Supreme Court has held that the Federal Government has a right to regulate whatever it subsidizes.—A.M.A. Secretary's Letter, May 16, 1952.

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1. Kissin, M., Stein, J. J., and Adelman, R. J.: Angiology 2:217 (June) 1951.
2. Rickles, J. A. J. Florida M.A. 38:263 (Oct.) 1951.

*Contains at least 80% of anhydrous theophylline.

ACCEPTED COUNCIL ON PHARMACY AND CHEMISTRY AMERICAN MEDICAL ASSOCIATION

SEARLE RESEARCH IN THE SERVICE OF MEDICINE

Michigan's Department of Health

Albert E. Heustis, M.D., Commissioner

A special detection project to determine the prevalence of venereal disease and tuberculosis in known high incidence areas was undertaken May 1 in Detroit under joint sponsorship of the Michigan Department of Health and the Detroit Department of Health. It will continue to July 15.

Areas to be surveyed will be selected on the basis of known high incidence of venereal disease as determined by records of the Detroit Department of Health. It is assumed, because of the socio-economic relationship, that these areas will also be high in tuberculosis.

Plans call for the establishment of thirty to sixty stations for taking blood samples of approximately 75,000 people. Two mobile x-ray units from the State Health Department and one from the Detroit Health Department will be placed in operation in conjunction with the blood sampling stations so that chest x-rays can be obtained of the same persons who volunteer for the blood tests.

Blood samples will be sent to the State Health Department Laboratories for analysis and the x-rays will be processed in the Department's Division of Tuberculosis and Venereal Disease Control.

Positive venereal disease findings will be reported to the Detroit Social Hygiene Clinic. Indigent persons found to have venereal disease will be treated in the clinic. Others will be referred to practicing physicians.

Chest x-ray films will be sent to the Detroit Health Department for interpretation and follow-up.

* * *

Anthrax, which has recently appeared among animals in Michigan, is primarily a disease of animals and is rarely transmitted to man. The animals most commonly involved are sheep, cattle, horses and swine. Many other species are infected but the ones mentioned are of chief importance. Dogs, rats, barnyard fowl and carrion birds are resistant to infection but are important due to the fact that if they are allowed to feed on animals who died from anthrax, they become a means of disseminating widely the spores of anthrax. Flies are another means of widespread dissemination.

Man may become infected by handling hair, wool and hides from infected animals or by coming in contact with the flesh, blood and feces of infected animals or products, such as bone meal, made from the bones of infected animals.

Man is generally infected by the inoculation of the anthrax spore into a wound or a scratch. Rarely, infection in man follows the inhalation of anthrax spores or the ingestion of insufficiently cooked meat from an animal who had anthrax. Man may also be infected mechanically by blood-sucking flies.

By far the commonest route of infection is the cutaneous route so the lesions will generally appear on the exposed parts of the skin. The cutaneous lesion (malignant pustle) has a characteristic evolution and appearance. It begins as a small red indurated area, in the center of which a vesicle develops. This vesicle is soon followed by satellite vesicles. The organism may be demonstrated easily in this early lesion. The surrounding tissues become edematous. Finally the center of the lesion softens and becomes necrotic, and a characteristic dark brown eschar is formed. The lesion itself is not painful but the regional lymph glands become swollen and tender. Malaise, fever and general prostration develop in keeping with severity of the disease. In from 10 to 20 per cent of untreated cases there develops a progressive cellulitis, overwhelming septicemia and death.

* * *

One of the less well-known services of the Department laboratories was given recently to a physician in a small northern Michigan town. He attended a family with several members suffering from what appeared to be severe poisoning. Investigation revealed that the mother had used what she thought was baking powder but proved to be louse powder on examination of the scratched-over label. The doctor suspected arsenic poisoning, so he sent the powder by State Police to the Department Laboratories for analysis. In telephoning the laboratory, he said that he had tried to get the antidote, BAL, but that none of the local drug stores had it.

The state trooper waited while the laboratories confirmed the presence of arsenic in the powder, and when he left he took with him a supply of BAL. No one died, but several people were very sick.

The laboratories carry stocks of both common and unusual antidotes and in an emergency when poisoning is suspected they are always willing not only to diagnose the poison but to make the antidote swiftly available to any physician anywhere in the state.

* * *

A section of Disaster Health Services has been set up temporarily in the State Health Department to spend full time on developing a comprehensive state civil defense plan for emergency health services and special weapons defense. Serving on the staff are a Department physician, public health nurse, veterinarian, public health dentist and a hospital administrator from a Detroit hospital.

* * *

Some 700 public health workers, allied professional workers and interested laymen from all over Michigan are expected to meet in Detroit May 14 to 16 for the 31st Annual Michigan Public Health Conference. The theme of the Conference will be "Working Together."

(Continued on Page 614)

protein?

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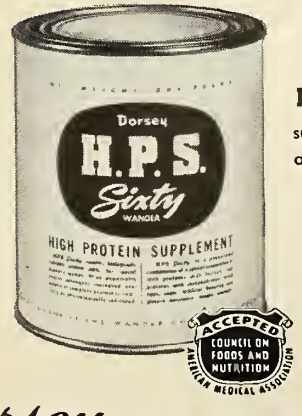
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(Continued from Page 612)

Two general sessions will feature speakers on topics of interest to all groups and a full day will be given over to discussion sessions for the specialties represented. Program committees have been at work for weeks on the group meetings for health officers, public health dentists, public health nurses, those interested in venereal disease control; sanitarians, nutritionists and health department clerks.

* * *

Flood relief measures figured prominently in Division of Engineering activities in early April. Engineers from the Department worked with local health departments in shoreline areas where people were forced from their homes, helping in surveying, rehabilitating homes and conducting demonstrations of chlorination of flooded wells. The Commissioner issued a statewide warning against possible outbreaks of dysentery, urging boiling of water, and advised vaccination against typhoid where indicated.

Since a rise of 18 inches is expected in lake levels through June and July, communities were urged to plan for necessary evacuation centers with provision for water, food, and safe waste disposal.

* * *

Detection of the organisms is best done by inoculation of white mice with material from the lesion, blood, tissues, or articles suspected of being contaminated; this technique screens out nonpathogenic organisms. Direct microscopic examinations of material from a cutaneous vesicle may reveal Gram-positive rods and permit a tentative diagnosis which should be confirmed by mouse inoculation.

At the present time the treatment of choice is the administration of penicillin in total doses as large as four or five million units if necessary. Ellingson (1946) treated twenty-five cases of proven cutaneous anthrax by giving thirty thousand units of penicillin every three hours around the clock until the anthrax bacillus had disappeared from the lesion and the patient appeared clinically well. The penicillin of choice now would be any one of the preparations which guarantee a therapeutic level for twenty-four hours or more per injection.

From the point of view of prevention of cutaneous anthrax those persons who come in close contact with animals or animal hair, wool, hides, should pay close attention to minor cuts, abrasions or scratches. These should be treated by the application of mild (2 per cent) tincture of iodine, since the anthrax bacillus is sensitive to the halogens.

* * *

The greater longevity of women is shown by figures of the Registrar-General of Britain. In the years 1946 and 1947, the number of deaths of persons aged a hundred years or over, was 232; of these 191 were women. Two of these reached 108. The highest male record was 106, two attaining that age.

* * *

A medical statistician imparts the following information about what the human body does every twenty-four hours: "Your heart beats 103,689 times; your blood travels 168,000,000 miles; you breathe 23,240 times; you turn in your sleep twenty-five to thirty-five times; you eat three and one-half pounds of food and you speak 4,800 words."

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In Memoriam

WILLIAM M. BELL, M.D., of Detroit, died March 18, 1952, at the age of fifty-nine.

Dr. Bell had practiced in Detroit since 1925. Previous to that, he had practiced in Jackson after his graduation from the University of Michigan Medical School in 1919.

At the time of his death, Dr. Bell was on the staff of Mt. Carmel Mercy Hospital, Detroit.

He is survived by his wife, Lora, and six children. They are Miss Jane Mary Bell, William B. Bell, W. Richard Bell, Mrs. Doris Peck, Mrs. Betty Kerr, and Alan Schroeder.

SAMUEL L. GREKIN, M.D., of Detroit, died March 1, 1952, at the age of fifty-six.

Dr. Grekin, a surgeon, had practiced in Detroit for the past quarter of a century following his graduation from the Wayne University College of Medicine in 1926.

He was a member of the Wayne County Medical Society and a veteran of World War I.

Dr. Grekin is survived by his wife, Hilda; a son, James; one brother, and three sisters.

JOHN J. MCCANN, M.D., of Ionia, died March 19, 1952, at Miami, Florida, where he was fatally injured in a traffic accident. Dr. McCann was seventy-four.

For the past forty-seven years he served the community of Ionia as a general practitioner. He was graduated from the University of Michigan Medical School in 1905.

He was a perennial secretary of the Ionia-Montcalm County Medical Society and a past president of the Ionia County Memorial Hospital. Besides being active in community affairs, Dr. McCann had been Ionia health officer for many years.

Organized Medicine lost a valued laborer with the passing of Dr. McCann.

MILTON M. ROZAN, M.D., of Lansing, died February 25, 1952, at the age of forty-nine.

For the past twenty-two years he served the community of Lansing as an obstetrician.

Dr. Rozan was graduated from the University of Michigan Medical School in 1929. He was a member of the Ingham County Medical Society, the American Board of Obstetricians and Gynecologists, the Detroit Gynecology Society and the Central Association of Obstetrics and Gynecology. He was also a Fellow in the American College of Surgeons as well as being secretary-treasurer of the Lansing Journal Club.

During World War II, he served for forty-two months in the U. S. Navy Medical Corps and rose to the rank of Commander before his separation from Service in 1945. In that period, he was stationed at the Portsmouth Naval Hospital in Virginia where he served as obstetrician and gynecologist. Later, he became senior medical officer at the naval base in Fort Lauderdale, Florida. In addition, he was stationed at the naval hospital at Norfolk, Virginia.

Dr. Rozan is survived by his wife, Ruth; a daughter, Kristine; his mother, Mrs. Lena Rozan, of Lansing; and two brothers, Josef S. Rozan, M.D., of Lansing, and William Z. Rozan of Houston, Texas.

WHY DEMORALIZING INACTIVITY?

(Continued from Page 600)

are utterly unable to see any justification for this provision and recommend that it be repealed.

The Social Security taxes which have been paid are described as truly a social security. The man who has paid has had no choice but has been compelled to pay.

There is a bill in Congress now to extend this work allowance to $100 per month, but there is still no justification for any penalty. This bill recognizes a real injustice. Why not correct the injustice completely? The amount of work possible by these older people who still have energy and ambition will not too greatly unbalance our economy. And if it did, what of it? Is not the older man a citizen with a right to earn his own living?

A CHALLENGE

WE HAVE outlined a few of the major problems which must be answered if we, as doctors, are to give our patients the security, the happiness, the confidence, the morale which must prevail in order to be successful doctors in our new field, Geriatrics. Many things go to make up the well-being of men. We cannot keep them physically healthy if we allow them to become psychiatric or sociologic problems. A healthy man must be a mentally alert and confident man.

Problems of living involve much more than food, shelter, clothing, and a few medicines to care for illness. The mind must be protected. A man must be allowed to keep some semblance of activity. He cannot just sit and rust. Do we have the answer? If not, we must put our minds to it and find an answer.

This is the great challenge of our times for the medical profession, which has the mentality to use. Will we use it?

Meat and its applicability in the Dietary Management of Atherosclerosis

Contrary to the former belief that serum cholesterol levels are primarily related to ingested animal fat and consequently to dietary cholesterol, it now appears that the total amount of fat in the diet, not its source or cholesterol content, is a more important factor in determining the blood cholesterol concentration.[1,2,3,4] Clinical observation has shown that ingestion of vegetable fat—which contains no cholesterol—will, like fats of animal origin, raise the serum cholesterol level.[3, 5]

Recent basic research on the influence of fats and cholesterol on human health has done much to further progress in the fight against atherosclerosis. It will serve well in dispelling the mistaken fear that reasonable amounts of foods of animal origin predispose the individual to this vascular disease.[6] As a matter of fact, a dietary inadequate in essential nutrients but providing too many calories and too much fat from *any* source may well be an important factor underlying the deposition of fat and cholesterol in the arteries and liver.

Cumulative evidence indicates that lowered blood levels of cholesterol may be effected by restricting the total fat intake.[1] Except in instances of refractory hypercholesteremia, in which a daily fat intake as low as 10 Gm. may not reduce cholesterol levels to normal, diets containing 20 to 30 Gm. of fat, or even more, often produce low cholesterol blood levels. In the clinical application of this principle, various palatable, low fat diets which supply three servings of meat daily (containing 18 Gm. of fat) have recently been suggested for the dietary management of arteriosclerosis and for enlisting the cooperation of patients.[1] The meat servings were chosen from a large variety of cuts and kinds of meat (fat trimmed off, as lean as possible). Meat adds to the eating appeal of the fat-restricted diet and contributes important amounts of biologically complete protein, the B group of vitamins including B_{12}, and food iron—all of which are important for a good state of nutrition in the atherosclerotic patient.

1. Hildreth, E.A.; Hildreth, D.M., and Mellinkoff, S.M.: Principles of a Low Fat Diet, Circulation *4*:899 (Dec.) 1951.
2. Bloch, K.: The Intermediary Metabolism of Cholesterol, Circulation *1*:214 (Feb.) 1950.
3. Keys, A.; Mickelson, O.; Miller, E.V.O., and Chapman, L.B.: The Relation in Man Between Cholesterol Levels in the Diet and in the Blood, Science *112*:79, 1950.
4. Gubner, R., and Ungerleider, H.E.: Arteriosclerosis, a Statement of the Problem, Am. J. Med. 6:60, 1949.
5. Hildreth, E.A.; Mellinkoff, S.M.; Blair, G.W., and Hildreth, D.M.: The Effect of Vegetable Fat Ingestion on Human Serum Cholesterol Concentration, Circulation *3*:641 (May) 1951.
6. King, C.G.: Trends in the Science of Food and Its Relation to Life and Health, Nutrition Rev. *10*:1 (Jan.) 1952.

The Seal of Acceptance denotes that the nutritional statements made in this advertisement are acceptable to the Council on Foods and Nutrition of the American Medical Association.

ACCEPTED COUNCIL ON FOODS AND NUTRITION AMERICAN MEDICAL ASSOCIATION

American Meat Institute

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Migraine In Children

"Migraine may appear during the first years of life. The presence of subjective signs, such as headache and flimmer scotoma, is often difficult to determine in young children. The true nature of the symptoms frequently remains obscure for years."

Vahlquist, B. and Hackzell, G.: Acta Paediatrica *38*: 622 (1949).

NO. OF CASES	SEX	AGE AT ONSET	CYCLIC VOMITING	DURATION OF ATTACK	INTENSITY
31	8 ♀ 23 ♂	3 yrs. (mean)	3 out of 31	2½ hrs.	severe in all cases

TABLE CONT'D

NO. OF CASES	UNILATERAL HEADACHE	NAUSEA	FLIMMER SCOTOMA	VERTIGO	HEREDITY
31	18 out of 31	31 out of 31	12 out of 31	6 out of 31	20 out of 31

(reference given above)

In a study of 400 adult migraine patients, it was revealed that 34% had suffered attacks before the age of 15.* These investigators concluded that childhood migraine was a much greater clinical problem than was previously believed and that psychodynamic mechanisms played an important part in the disease.

These criteria are useful in diagnosis:

Headache attacks with symptom-free intervals plus (at least two of the following) nausea, scintillating scotoma, hemicrania, and hereditary predisposition.

For symptomatic relief in these cases, Cafergot®, N.N.R. (ergotamine with caffeine) may be administered orally. For best results, give adequate dosage promptly.

For children within the age range 7 to 12 years—Cafergot® is administered, one tablet when the attack appears imminent followed by one additional tablet within 30 minutes. Not more than two Cafergot tablets should be administered to children within this age range.

In the adolescent age group, 12 to 18 years of age, the dosage may gradually be increased as necessary up to the usual adult dose, i.e., two tablets when the attack appears imminent followed by one tablet doses at half hour intervals until the attack is aborted. *(Total maximum dose for adults: six tablets for each attack.)*

*Katz, J., Friedman, A.P., and Gisolfi, A.: New York State J. Med. *50*: 2269 (Oct.) 1950.

Sandoz Pharmaceuticals
DIVISION OF SANDOZ CHEMICAL WORKS, INC.
68 CHARLTON STREET, NEW YORK 14, N. Y.

Correspondence

January 18, 1952

Dear Dr. Haughey:

Your letter of December 4, 1951, to Dr. Foster has been referred to me. The Bay-Arenac-Iosco County Medical Society has realized its responsibility in the Community Education Program and has selected as a field of special endeavor, the sponsorship of a series of the assumption of a place in the Community Co-Sponsored Series of Adult Education Courses at Central High School in Bay City Junior College.

Mr. Robert Stuart, Director for the Department of Continuing Education Program for Adults of Bay City has secured the co-operation of the majority of the community and professional groups in this series and the Bay County Medical Society will furnish eight speakers for a sixteen-hour course in "Medical Care Within the Home and Community."

It is perhaps of considerable interest that none of the prospective lecturers who were approached were unwilling to contribute their time and it is felt that it may be possible to work up some sort of a paper on the place of non-technical medical subject in a continuing education program for adults.

It was felt by this Society that this particular project was significant in fostering a better understanding between the profession and the public, at the same time providing material whereby those interested could improve the community in which they live.

Sincerely,

R. E. Fisher, M.D.

February 12, 1952

Dear Doctor Haughey:

In answer to your letter of December 5, 1951, requesting a report on our County Medical Society project, I am happy to report that we are at present engaged in doing the following physical examinations free of charge: (1) all girl scouts, boy scouts and cub scouts, prior to summer camp; (2) all high school athletic exams for track, football and basketball; (3) general physical fitness exams for all high school seniors; (4) any necessary athletic physicals required in connection with the city recreation department, which may include boxing or other sports.

Sincerely,

Samuel Osborn, M.D.,
Secretary, Manistee County Medical Society

March 4, 1952

Dear Dr. Haughey:

In response to your letter of December 5, 1951, let me say that this small Medical Society has several very ambitious projects of which we are very proud.

First, free immunization of school children has been carried on in this county for at least twenty years through the personal efforts of local private physicians.

(Continued on Page 620)

Say you saw it in the Journal of the Michigan State Medical Society

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Each teaspoonful (5cc.) contains:

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Homatropine Methylbromide	2.5 mg.	(1/25gr.)
Alcohol	25%	

Elixir Almesed is specially indicated in such spastic disorders as spastic colitis, peptic ulcer, biliary colic, pseudo-ulcer syndrome, dysmenorrhea, nervous tension and emotional disturbances.

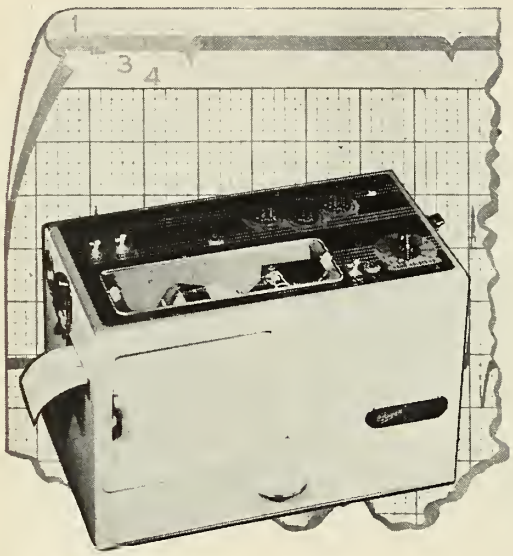
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ACCEPTED

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(Continued from Page 618)

This was organized by Harry B. Zemmer, M.D., of Lapeer, who began immunizing all Lapeer City school children whose parents were desirous of having their children protected against contagious disease. This project has been promoted until this service has been made available, free of charge, to all town and rural schools in the county. The motherhood clubs organize immunization clinics with the assistance of the teacher in any school where the service is requested and some local doctor with his nurse gives D-P-T and smallpox vaccine. This is done annually, in most schools, at the beginning of the school year.

Our newest project is the Lapeer County Medical Foundation, organized this year by the Lapeer County Medical Society with lay assistance. Its purpose is to improve medical service to the people of Lapeer County. Its scope will depend on the amount of money which is available from time to time. At present, we have established two annual scholarships for the four years of medical school of $500.00 each per year. These scholarships are in honor of the memory of two fine Lapeer County physicians, Herbert M. Best, M.D., and William J. Kay, M.D. In the first year of existence of the scholarships, one has been awarded to a senior at Tufts Medical School and one to a freshman at the University of Michigan Medical School. It is the purpose of these scholarships to encourage young men to go into rural practice and assist them financially. We feel that we are thus helping the cause of better medicine in two ways. We hope that the Foundation will extend its activities into other fields as funds become available.

Very sincerely,

James R. Doty, M.D.,

President, Lapeer County Medical Society

GOVERNOR WARREN AND SOCIALIZED MEDICINE

(Continued from Page 546)

the duty of our country and the duty of everyone in government to try to find a way to make that good medical care that we have in this country available to those who need it without any socialization of medicine whatsoever.

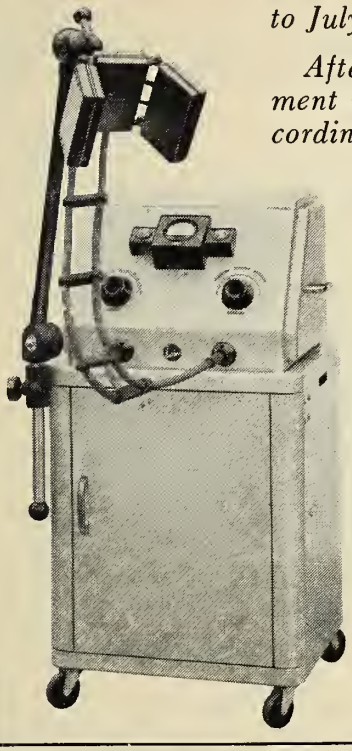
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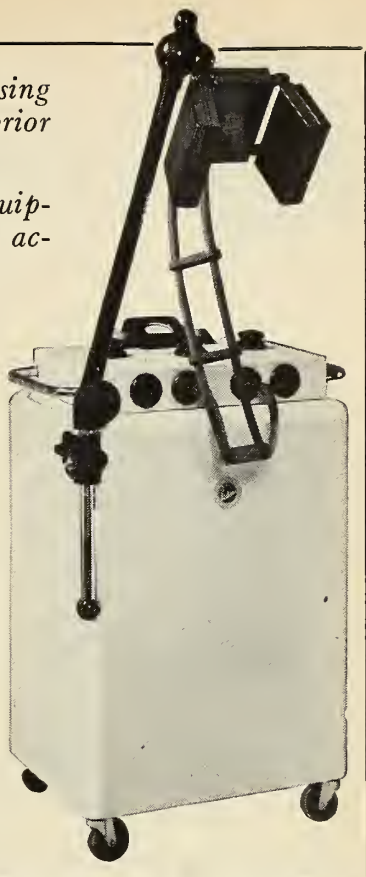
Huie: So as a Republican President, your business would not be to repeal anything that's been done but simply to tidy it up and be a better housekeeper. Is that, in effect, what you stand for?

Warren: Yes, yes. I don't know of any social program that has been initiated by the Federal Government in recent years that I would repeal, and I might say to you also at the same time, that I don't know of any such social welfare program that wasn't adopted by a bi-partisan vote in the Congress.

An important day for doctors' still using Diathermy equipment manufactured prior to July 1, 1947.

After July 1, 1952 all users of such equipment must obtain approved apparatus according to law.

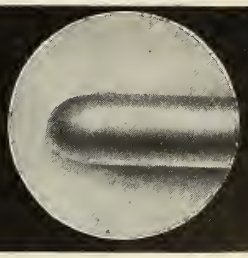




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NEWS MEDICAL

MICHIGAN AUTHORS

Otto Tod Mallery, Jr., M.D., of Ann Arbor, is the author of an article, "Graduate Education for Physicians in Industrial Health and Occupational Medicine," published in *Industrial Medicine and Surgery,* March, 1952.

F. X. Krynicki, M.D., of Detroit, is the author of an article, "The Chronic Low Backache," published in *Industrial Medicine and Surgery,* March, 1952.

Henry Reinfert, Jr., M.D., of Ann Arbor, is the author of an article, "Post-Graduate Course of the American College of Chest Physicians," published in *Industrial Medicine and Surgery,* March, 1952.

A. D. Ruedemann, M.D., of Detroit, is one of the authors of an article, "Symposium: Orbital Implants After Enucleation," published in the Transactions of the American Academy of Ophthalmology and Otolaryngology, January-February, 1952.

Harris B. Schumacker, Jr., M.D., of Indianapolis, Indiana, is the author of an article, "Aneurysms and Arteriovenous Fistulas," in the *General Practitioner of Australia and New Zealand,* January 15, 1952, which was reprinted from THE JOURNAL of the Michigan State Medical Society, February, 1951.

The General Practitioner of Australia and New Zealand for February, 1952, republished an article by **Raymond W. McNealy, M.D.**, and **John W. McCallister, M.D.**, "Parotid Gland Tumours and Their Surgical Management" originally published in THE JOURNAL of the Michigan State Medical Society in April, 1951.

Samuel J. Nichamin, M.D., of Detroit, is the author of an article, "Pleurodynia in Children," published in *The Jourrnal of the American Medical Association,* March 22, 1952.

H. L. Stewart, Jr., M.D., of Detroit, is the author of an article, "Duration of Pregnancy and Postmaturity," published in *The Journal of the American Medical Association,* March 22, 1952.

Lida Mattman, Ph.D., of Detroit, is one of the authors of an article, "Geotrichum in Blood Stream of an Infant," published in *The Journal of the American Medical Association,* April 5, 1952.

Dan P. **Boyette, M.D.**, Ahoskie, N. C., and **Fred L. Rights, Ph.D.**, of Detroit, are the authors of an article, "Heretofore Undescribed Aërobic Spore Forming Bacillus in Child with Meningitis," published in *The Journal of the American Medical Association,* April 5, 1952.

E. Dwight Barnett, M.D., formerly Director of Harper Hospital Detroit, is the author of an article, "Comparing Patient Costs in Wards and Private Rooms, published in *The Journal of the American Hospital Association,* April, 1952.

Postgraduate Training.—The following members of the Michigan State Medical Society attended postgraduate courses at the Cook County Graduate School of Medicine in March: Gordon T. Brown, M.D., Detroit; Edward P. Gunderson, M.D., Frankfort; Hugh M. Jardine, M.D., West Branch; Burke W. Arehart, M.D., Detroit; Russel C. Rowan, M.D., Albion.

* * *

Mental Health Group.—The first meeting of the new AMA Committee on Mental Health was held at Chicago headquarters, March 27. Dr. Leo Bartemeier, Detroit, was elected chairman and Dr. Lauren H. Smith, Philadelphia, vice chairman. The chairman, vice chairman, and Dr. Walter H. Baer, Peoria, were chosen to serve as the executive committee of the group. Many problems in the fields of psychiatry and neurology were discussed and plans were formulated for other meetings of the committee in the near future.

* * *

AMA and Hoover Report.—The AMA has explained its opposition to the present attempt by medical groups to enact the provisions of the Hoover Report as provided in S. 1140.

While certain minor suggested changes have been made, the revised bill (S. 1140) still includes the transfer of the major military and all Veterans Administration hospitals —a transfer opposed by the A.M.A. Also, no provisions were incorporated which would clearly define the extent of the government's responsibility for furnishing medical care, particularly to veterans with nonservice-connected disabilities and the dependents of service personnel. Neither did it provide for the establishment of a federal board to control the distribution of beds among the several federal hospital services to insure joint planning in the field of hospital construction and to determine the need and location of proposed new hospitals in the United States."

* * *

The Berrien County Rheumatic Fever Diagnostic and Consultation Center, organized under the auspices of the Berrien County Medical Society was officially opened on May 2. 1952, at St. Joseph-Benton Harbor Memorial Hospital, St. Joseph, Michigan. The Center offers diagnostic and consultation service with regard to Rheumatic Fever and Rheumatic Heart Disease on referral by physicians and will serve Berrien County and parts of Van Buren and Cass Counties. The Center is operated by a committee of the Berrien County Medical Society appointed by **R.** C. Conybeare, M.D., President, consisting of M. J. Feeley, M.D., chairman; F. H. Lindenfeld, M.D., and John Manning, M.D.

(Continued on Page 624)

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of St. Vincent de Paul

Newly reorganized and modernized for individualized care and treatment of the nervous and mentally ill and alcoholics.

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Refresh...add zest to the hour



(Continued from Page 622)

Marriage Licenses Decrease Sharply.—The marriage license boom that began at the start of the Korean war has come to an end, according to U. S. Public Health Service statistics. For all of 1951, a total of 1,621,159 licenses were issued, compared with 1,691,673 for 1950. However, in the first six months of 1951 licenses were 6 per cent ahead of the same period in 1950, but in the last half of 1951 they had declined to 12 per cent below the total for the second half of 1950.

* * *

UMW Picks Sites for Most Hospitals.—United Mine Workers Welfare and Retirement Fund's three Memorial Hospital Associations have engaged architects and selected locations for most of the 10 hospitals they will build in Kentucky, Virginia and West Virginia. Largest single hospital in the program will be at Beckley, W. Va., with a capacity of not less than 200 beds.

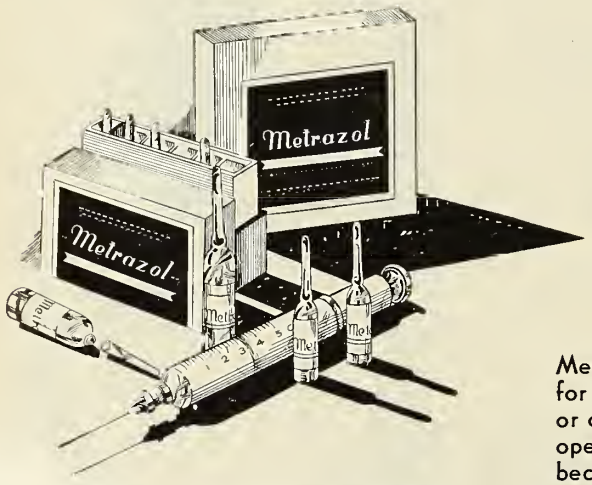
* * *

Wage Stabilization Board has established a separate policy on health and welfare plans for the *construction industry.* It uses contributions rather than benefits as the criteria and in several other respects varies from the policy governing most other industries. Under the construction industry policy, recommended by the Construction Industry Stabilization Commission, the following will prevail: (a) new plans and liberalizations must receive Commission approval, (b) negotiations will determine kind of benefits, but these must comply with established WSB criteria, (c) employer contributions generally will be limited to 7½ cents per hour, although benefits, not contributions, are the criteria in other industries, (d) contributions may start before all details have been approved, and (e) once a plan is approved as an "area practice," any contractor may conform without getting separate WSB approval.

* * *

Defense Production Act Should Expire.—"Even when prices are below ceiling, which many are, the OPS compliance problem remains. The grind of administrative machinery is still there; the interpretative work of legal counsel is still there; the labors of great corps of accountants and clerks are still there; the time consuming job of analyzing regulations and making reports is still there; the particular situation of customers and suppliers is still there; prospects of new regulations with another new wave of interpretations, analyses, conputations, surveys, studies, investigations, determinations, reports, protests and appeals are still there.

"These are the difficulties that are tangible, physical and measurable. As they boil and flame in the mind of management, their fusion creates a new substance which is psychological. Its effect is poisonous. It may be described as American psychology thrown into reverse. Confidence is turned into doubt; courage becomes fear, resourcefulness is replaced by caution; planning is turned into waiting; the taking of normal business risks gives way to a drawing-in of all commitments; the sense of freedom is thwarted by a feeling of imprisonment. The dynamic motivation which is the very essence of business progress is stifled."—WILLIAM J. GREDE, president of the National Association of Manufacturers, before the Senate Banking and Currency Committee relative to the proposed extension of the Defense Production Act.



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Inject 3 cc. Metrazol intravenously, repeat if necessary, and continue with 1 or 2 cc. intramuscularly as required.

Bilhuber-Knoll Corp. Orange, N. J.

Thousands Waiting for Operations.—The *Chicago Daily News* reports that in Britain, where medicine has been socialized for nearly four years, there are 124,587 persons waiting to be admitted to hospitals for operations. "There's a scarcity of both beds and nurses plus a bigger demand for operations which now are 'free'," the story said.

* * *

A new effort is being made to induce about 1,000 physicians rated in Priority I of the doctor-draft to sign up for service in the military reserves. Men involved were educated at government expense during World War II or deferred from service to continue their medical educations, but so far have not applied for reserve commissions.

National Advisory Committee to Selective Service (Dr. Howard A. Rusk, Chairman) declares: "Various state committees, as well as the National Committee, have been deeply concerned over these individuals who did not at the time of special registration apply for a commission and have not subsequently done so *while other more willing individuals have accepted commissions and many of them are now serving in the armed forces.*"

Selective Service Director Louis B. Hershey says these "inequities" can only be prevented by calling up physicians through Selective Service (not the reserves).

* * *

H.R. 7426 Deductions from Income for Retirement.—By Mr. Coudert, of New York, April 7. *To provide that certain amounts expended by individuals for the purchase of non-interest-bearing United States bonds may be deducted in computing net incomes.* Referred to the Committee on Ways and Means.

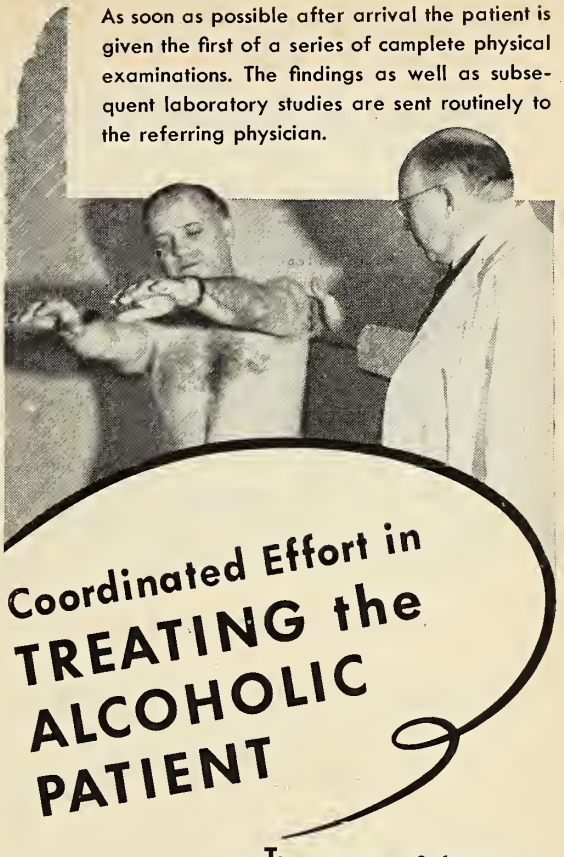
Comment: Would enable taxpayers to lay aside savings during more productive years for disability and retirement eventualities. Taxpayers would be permitted to purchase United States bonds up to 10% of their adjusted gross income. Bonds would be non-interest bearing, have no fixed maturity, be payable in full on demand, and would be issued only to individuals. The proceeds received by the U. S. from the sale of these special bonds would be used to retire outstanding, high interest-bearing bonds.

A deduction from income would be permitted during the years in which bonds were purchased but the proceeds would be taxable when sold by the individual on the same basis as any other income. If the individual dies, proceeds would be included in his gross estate.

Representative Coudert, previously in this Congress, introduced two other bills to accomplish the same purposes, H.R.3456 and H.R.5847. The first bill provided for postponement of federal income taxes for a limited portion of income which could be contributed to a restricted retirement fund. The second bill would allow income tax deduction for premiums paid on life insurance and annuity contracts.

* * *

The Dickinson-Iron County Medical Society will be hosts to the Upper Peninsula Medical Society meeting in Iron Mountain, Michigan, June 27 and 28, 1952. Scientific papers will be presented by outstanding physi-



The system of therapy at The Keeley Institute is aimed (1) at overcoming the *acute attack* of alcoholism; restoring the patient's well-being, and (2) through group and individual re-education attaining a condition of *permanent sobriety*.

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cians formerly of the Upper Peninsula. A program for the ladies is being planned by the Woman's Auxiliary. The public meeting will be held Friday evening, June 27, with Rear Admiral C. A. Swanson, former Surgeon General of the Navy, as the speaker. The annual banquet will be held Saturday evening, June 28. Technical exhibits will be shown.

* * *

Federal Government and Blue Cross-Blue Shield.—It is a fundamental fact that the Government does not insure; cannot buy insurance from private firms.

In the course of its survey of federal medical services, the AMA special committee, headed by Dr. Elmer L. Henderson, inquired into the feasibility of the Federal Government's being insured by private companies. Frank G. Dickinson, Ph.D., head of the Bureau of Medical Economic Research, who later prepared a detailed memo that to the best of his knowledge the Government has never purchased insurance from a private company or firm. There may be a few isolated and unimportant instances, he said, but the concensus is that "the government has probably never been an insured of a private insurer."

Dr. Dickinson's memo, in the April 12, *Journal AMA,* said in part:

"The federal government from the standpoint of insurance is 155 million people, the broadest possible base for the distribution of risk. . . . It is larger than all insurance companies combined because it is the sovereign power. . . . The federal government should not buy accident and health insurance from Blue Cross or Blue Shield plans or insurance underwriters. The very notion of the federal government as the sovereign power eliminates it from any rational consideration of being made an insured of an insurance company.

"There is nothing in the history, theory and principles of insurance to warrant the federal government becoming an insured of a private insurance company. It would make the sovereign power of government subservient to a private business institution. It would be contrary to public policy."

* * *

Penicillin Prices Reduced.—Upjohn, Eli Lilly, and other companies have announced a reduction in the price of penicillin for the second time in three months. Improvements in production methods are chiefly responsible for the continuing downward trend of prices. Little more than ten years ago, penicillin cost about eighty times the price today. In addition, improved forms of the drug are ten times as potent and last six times as long as the old product.

* * *

The inauguration of Dr. Louis H. Bauer, Hempstead, N. Y., as president of the American Medical Association, will be heard on nationwide radio broadcasts at 7:30 p.m. (CDST) Tuesday, June 10.

* * *

Specific Substance Found for Use Against Radiation.—Dr. Shields Warren, Director of Atomic Energy Commission's Division of Biology and Medicine, reports that a specific substance has been found to work against radiation poisoning and that the discovery is of "very real significance." In testimony before the House Appro-

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priations Committee, Dr. Warren said it has been determined that an emulsion of bone marrow will protect experimental animals against radiation, and added:

"The material in itself is not so important as the fact that one gets protection. That is, the bone marrow itself is not so important as the fact that you can get protection by the substance that is formed there. This is an injection from which we ought to be able to get a specific chemical substance that can be used here. This is the same sort of scientific lead as was the failure of bacteria to grow on mold-contaminated plates, when the initial discovery of penicillin was being foreshadowed. It is very early in the process, but this is the first time a specific substance has been found which will work against radiation."

* * *

Meyer O. Cantor, M.D., and Leonard Haking, M.D., of Detroit, are authors of an article entitled "Carcinoma of the Pancreas with Roentgen Pattern of Nontropical Sprue," published in *The Journal of the International College of Surgeons,* November, 1951.

* * *

Michigan speakers on the program of the American Goiter Association at its annual meeting in St. Louis, Missouri, May 1, 2 and 3, included Brock E. Brush, M.D., Detroit, William S. Reveno, M.D., Detroit, and Herbert Rosenbaum, M.D., Detroit.

* * *

The position of Director of Public Health, Kalamazoo City-County Health Department, is now open. Applications should be submitted to the Board of Health, City of Kalamazoo, City Hall, Kalamazoo, Michigan, in care of the Office of the City Manager.

* * *

Civil Defense Administration desires full time medical directors to handle medical civil defense problems arising within its regional geographical areas.

Region 4 includes Michigan, Ohio, and Kentucky; headquarters are located at 33467 West Lake Road, Avon Lake, Ohio (near Cleveland). A salary of $10,800 per year is paid the civil defense medical directors. For information, write Reed M. Winegardner at Avon Lake, Ohio.

* * *

The Michigan Society Executive Secretaries Conference, sponsored by the Michigan State Medical Society on April 16 in Lansing, was attended by Mrs. Lucy Bartlett, Muskegon, Executive Secretary of the Muskegon County Medical Society; Miss Else Kolhede, Detroit, Executive Secretary of the Wayne County Medical Society; Mrs. Flora Mayer, Ann Arbor, Executive Secretary of the Washtenaw County Medical Society; Mrs. Sara Burgess Warren, Executive Secretary of the Genesee County Medical Society; and Carl G. King, Business Manager of the Saginaw County Medical Society.

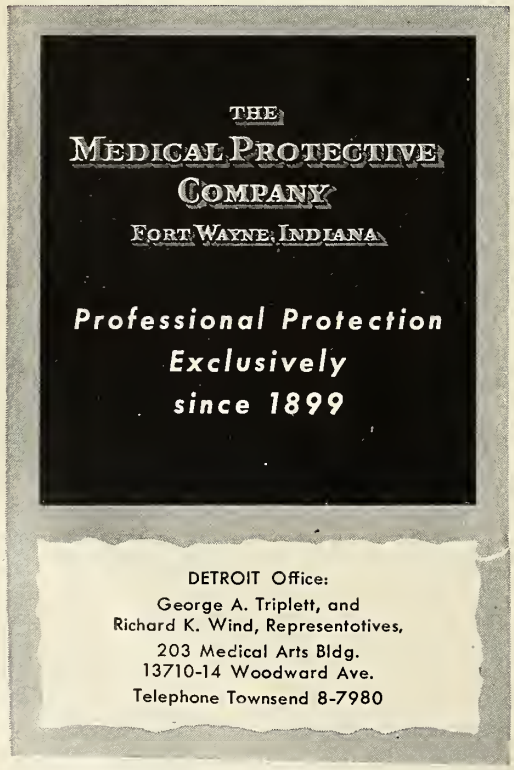
After a tour of the new home of the Michigan State Medical Society, at 606 Townsend, the County Executive Secretaries surveyed the activities of the State Medical Society and its various departments. The services available to county societies and to the individual doc-

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SURGERY—Intensive Course in Surgical Technic, two weeks, starting May 12, June 2, June 16.
Surgical Technic, Surgical Anatomy and Clinical Surgery, four weeks, starting June 2, September 8.
Surgical Anatomy and Clinical Surgery, two weeks, starting June 16, September 22.
Surgery of Colon and Rectum, one week, starting May 12, June 2.
Gallbladder Surgery, ten hours, starting June 16.
Basic Principles in General Surgery, two weeks, starting September 8.
General Surgery, one week, starting May 12, October 6.
Breast and Thyroid Surgery, one week, starting June 23.
Esophageal Surgery, one week, starting June 23.
Thoracic Surgery, one week, starting June 2.
Fractures and Traumatic Surgery, two weeks, starting June 16.
GYNECOLOGY—Intensive Course, two weeks, starting June 16.
Vaginal Approach to Pelvic Surgery, one week, starting June 9, September 22.
OBSTETRICS—Intensive Course, two weeks, starting June 2, September 29.
PEDIATRICS—Informal Clinical Course every two weeks.
Cerebral Palsy, two weeks, starting July 7.
MEDICINE—Electrocardiography and Heart Disease, two weeks, starting July 14.
Gastroenterology, two weeks, starting May 19.
Hematology, one week, starting June 16.
Gastroscopy and Gastroenterology, One Week Advanced Course, June 23.
CYSTOSCOPY—Ten Day Practical Course starting May 26, June 9, July 7.
DERMATOLOGY—Intensive Course, two weeks, starting October 13.

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tor of medicine were outlined by Secretary L. Fernald Foster, M.D., Bay City, Executive Director Wm. J. Burns, Lansing; Public Relations Counsel Hugh W. Brenneman, Lansing; Field Secretaries Daniel E. Ford, Detroit, and Stuart A. Campbell, Grand Rapids; Assistant Executive Director R. J. Roney, Secretaries Helen Schulte and Geraldine Chapman; and by E. H. Wiard, Lansing, Executive Secretary of the Michigan Health Council.

* * *

The General Practice Group of the University of Tennessee has established a postgraduate clinical training program for general practitioners, approved by the American Academy of General Practice for its members. One week to one month of training is offered in a program designed for the general practitioner, on an individual basis according to his needs. No fee is charged for this training. For information write General Practice Office, University of Tennessee, Memphis, Tennessee.

* * *

LeRoy A. (Cap) Potter, long-time inspector for the Michigan Department of Health-Michigan State Board of Registration in Medicine, was elected honorary member of the Ingham County Medical Society on March 18, in recognition of his work in enforcement of the Medical Practice Act.

Congratulations, "Cap" Potter!

* * *

The Michigan Medical Assistants Society was featured in the February Number of *Medical Economics*. The story included part of a letter written by Helen M. Huskens, R.N., of Bay City, a member of the M.M.A.S.

* * *

Canon Robert Bohaker, Detroit, presented a talk on "The Healing Mission" before the Wayne County Academy of General Practice on March 12. Canon Bohaker outlined the work in the psychosomatic field as conducted at St. Paul's Episcopal Cathedral.

* * *

The Genesee County Medical Society announces that its eighth Annual Cancer Day is scheduled for Wednesday, April 9, 1953. The meeting will be held at Hurley Hospital and the dinner will be at the Durant Hotel, Flint.

* * *

Hack Shoe Company announces a new store building being erected on East Warren at Yorkshire. The store will be a children's branch duplicating the three-year-old branch on Livernois in the Williamsburg Row. The Hack Company will continue its main store in the Mutual Building, Detroit, where it has been located for twenty-seven years.

* * *

The American Congress of Physical Medicine will hold its thirtieth annual scientific and clinical session August 25-29, Roosevelt Hotel, New York. For information and program, write the Congress at 30 North Michigan Avenue, Chicago 2, Illinois.

* * *

"Serpent-Wreathed Staff" is the title of a 402-page novel by Alice Tisdale Hobart which, in its last forty



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or fifty pages, turns into an amazing propaganda piece for national compulsory health insurance. AMA Secretary George F. Lull, M.D., states: "This sounds as if Mrs. Hobart knocked out the last fifty pages at a desk piled high with pamphlets, speeches, and news releases handed out by Federal Security Administrator Ewing and the Committee for the Nation's Health."

* * *

University of Pittsburgh School of Medicine announces a postgraduate symposium on the basic sciences related to Anesthesiology, June 2-6, 1952. Registration fee is $25, with the course limited to fifty participants. For full information, write Chairman of Committee on Graduate Medical Education, University of Pittsburgh School of Medicine, 3941 O'Hara Street, Pittsburgh 13, Pennsylvania.

* * *

Remus G. Robinson, M.D., Detroit, has been appointed vice chairman of the 1952 United Negro College Fund Campaign of Michigan. Dr. Robinson will head the campaign to obtain Michigan's $80,000 quota of the $1,500,000 national goal.

* * *

The General Electric Company (X-ray Department) is sponsoring a series of full-page advertisements designed to provide a better understanding and appreciation of the role the medical profession plays in maintaining the nation's health. These advertisements are being placed in most of the leading magazines, and have such noteworthy captions as: "There *is* a doctor in the house!"; "He brings hope to the battlefields . . ."; "Here's a man looking for trouble!"; and "Now atomic energy works to save lives!"

Keep up the good work, G. E. X-Ray!

* * *

The Calhoun County Medical Society and the Calhoun County Unit of the American Cancer Society presented its ninth Cancer Education Day on April 1 in Battle Creek. Speakers included M. T. Macklin, M.D., Columbus, Ohio, and Danely P. Slaughter, M.D., Chicago. James W. Hubly, M.D., Battle Creek, was chairman of the Calhoun CMS Cancer Commitee aided by Robert K. Curry, M.D., A. R. Dickson, M.D., A. A. Humphrey, M.D., and Gilbert T. Patrick, M.D.

* * *

The Genesee County Medical Society's Seventh Annual Cancer Day was held in Flint on April 9 and introduced the following scientific speakers: Charles A. Doan, M.D., Cornelius P. Rhoads, M.D., New York City; Paul A. O'Leary, M.D., Rochester, Minnesota; William J. Boyd, M.D., Vancouver, B. C.; R. Arnold Griswold, M.D., Louisville, Kentucky. The meeting was held at the Hurley Hospital followed by dinner at the Durant Hotel. Grover C. Penberthy, M.D., was toastmaster.

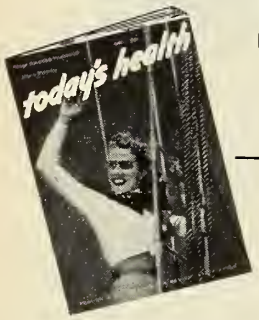
Traian Leucutia, M.D., Detroit, was one of the members of a panel with Drs. Doan, Rhoads, O'Leary, and Boyd.

* * *

The Berrien County Medical Society printed in its March, 1952, *Bulletin* a "Membership Record" in order

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to keep information on its members up to date. For copies of this complete membership record, write H. J. Klos, M.D., 2121 Niles, St. Joseph, Michigan.

* * *

"Who planned the nationalization of medicine?" is the title of a very searching article which appeared in the *Bulletin* of the Genesee County Medical Society (March 11, 1952, number). A thought-provoking sentence states: "Every citizen should realize that government-controlled medicine is at the heart of every scheme of state socialism and communism." The article is signed with the initials "G. V. C."

* * *

The Muskegon County Medical Society Bulletin includes a page each month dedicated to "Auxiliary News." Another is engagingly titled "Pursuits of the Practitioners" and gives the vital statistics on the medical families of Muskegon. Then there's always an amusing cartoon by Muskegon's medical cartoonist C. L. A. Oden, M.D.

The March number featured a page showing a hand with not one but two strings attached to the fingers and the caption, "Don't Forget to Register and to Vote!"

* * *

The Wayne County Medical Society Council on March 7 approved a tuberculosis and venereal disease survey by the United States Public Health Service. This project will call for combined x-ray and blood tests taken in certain high incident areas in Detroit from approximately March 15 to July 1. The purpose of the survey is twofold: (1) it is a case-finding program; (2) it will provide valuable and informative statistics. Any positive cases will be screened according to the economic status of the patient, and all patients except those unable to pay will be referred for treatment to their family physician.

* * *

Status of Hill-Burton hospital construction in Michigan is as follows:

Completed and in Operation.—Eighteen projects at a total cost of $14,383,781, including federal contribution of $5,176,257 and supplying 943 additional beds.

Under Construction.—Fifteen projects at a total cost of $17,426,530, including federal contribution of $6,683,768 and designed to supply 1,024 additional beds.

Approved, But Not Yet Under Construction.—Five projects at a total cost of $2,083,155, including $995,683 federal contribution and designed to supply 153 additional beds.

* * *

Leo H. Bartemeier, M.D., Detroit, was chosen chairman of the new AMA Committee on Mental Health (a Committee of the AMA Board of Trustees) at its initial meeting of March 27 in Chicago.

Congratulations, Doctor Bartemeier!

* * *

The Joint Commission on the Accreditation of Hospitals, recently organized by the AMA, the American Hospital Association, the American College of Surgeons, the American College of Physicians, and the Canadian Medical Association, has selected Edwin L. Crosby, M.D., as director of the Commission. Doctor Crosby,

who has been serving as director of the Johns Hopkins Hospital in Baltimore, will assume his new post September 1. He is also president-elect of the American Hospital Association.

* * *



F. L. Rector, M.D., Secretary, Cancer Control Committee, MSMS, has been awarded the first of the Public Health Cancer Association's awards for "meritorious services in the field of cancer control." The award will be presented at the next annual meeting of the Association in Cleveland, Ohio, next October.

* * *

Wilfrid Haughey, M.D., Battle Creek, JMSMS Editor, addressed the Battle Creek Kiwanis Club on March 20. His subject was "Problems Facing Medicine."

* * *

Four Fellowships for the Postgraduate Study of Rheumatic Fever and Rheumatic Heart Disease have been awarded by the Rheumatic Fever Control Committee of the Michigan State Medical Society for 1952 to the following recipients: John D. Littig, M.D., of Kalamazoo; Anthony Cefai, M.D., of Pontiac; David P. Gage, M.D., of Saginaw, and Scott T. Harris, M.D., of Ypsilanti. The fellowships carry a stipend of $500.00 for registration and expenses while attending the two-week comprehensive course to be given at St. Francis Sanatorium for Cardiac Children, Roslyn, Long Island, New York, beginning May 19, 1952.

* * *

"Doctors Lead an Old-Fashioned Crusade" is the title of a feature article in the March number of *Medical Economics* about the MSMS "Formula For Freedom—Know Yourself—Know How to Live—Know Your Government." This article, written by Roger Menges, who made a special trip to Michigan to learn about the "Formula For Freedom" points out: "Every step that will emphasize the individual's responsibility for himself will be one step away from socialism. This is what Medicine has needed—a dynamic, positive long-term program."

Medical Economics, in its March number, also features a story on Michigan's most recent Rural Health Conference with a news item on "mock trial proves worth of health program."

* * *

J. M. Robb, M.D., Detroit, has accepted appointment as General Chairman of Arrangements for the Michigan Clinical Institute of March 11-12-13, 1953.

* * *

The Genesee County Medical Society presented a "Formula For Freedom" Night on April 15 and invited key representatives of business and industry to its monthly meeting.

The session, held at Hotel Durant in Flint, attracted approximately 300 persons, including members of the

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Woman's Auxiliary who aided the Committee on Arrangements with the details of the meeting.

$1,864.00 Presented to President Beck

Genesee County Medical Society President W. W. Stevenson, M.D., presented to MSMS President Otto O. Beck, M.D., Birmingham, a check for $1,864.00 as its contribution to the Beaumont Memorial Restoration. In presenting the check, Dr. Stevenson gave a brief historical sketch of the pioneering work of Dr. William Beaumont at Mackinac Island 130 years ago.

Three "FFF" Talks

J. E. Livesay, M.D., Vice Speaker of the MSMS House of Delegates, moderated the Formula For Freedom program and introduced Joseph R. Hainline of Detroit, WJR news commentator, who gave a fifteen-minute delineation of "Know Yourself."

John B. Martin, Jr., Grand Rapids, Auditor General of the State of Michigan, urged the audience to "Know Your Government" and outlined the means of doing so.

L. Fernald Foster, M.D., Bay City, Secretary of the Michigan State Medical Society, spoke on "Know How To Live."

The civic meeting was arranged under the joint sponsorship of the GCMS Program Committee and Public Relations Committee of which C. K. Stroup, M.D., and J. E. Livesay, M.D., are chairmen, respectively. Fleming A. Barbour, M.D., was chairman of arrangements for the dinner.

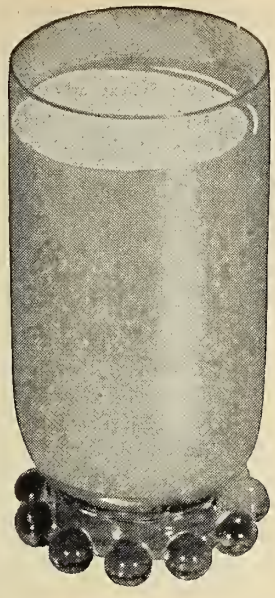
* * *

"Housing the Aging" is the topic for the University of Michigan Fifth Annual Conference on Aging to be held in Ann Arbor, Michigan, July 24-26, 1952. The three-day conference will consider the housing needs of healthy, chronically ill, confused, and disabled older people living in urban and rural areas. Among the topics to be discussed are types of housing and living arrangements; architectural designs and costs; hygiene and safety standards; health, social and economic aspects of housing; and auxiliary services. The conference is designed to serve as a forum for interchanging information and for getting action on the difficult problem of financing housing for the aging.

The conference is directed to national, state, and local planners; doctors of medicine, nurses, and public health workers; industrial retirement counselors; welfare and social work personnel; architects, builders, realtors; safety and sanitary engineers; public and private investment and financing agencies; directors of old age homes, nursing homes, hospitals, and housing projects; and to older people themselves who are interested in contributing to the solution of the housing problem of the aging.

The conference is under the co-sponsorship of the Institute for Human Adjustment, Schools of Architecture, Business Administration, Social Work, Public Health, and the Medical School, Extension Service and Summer Session of the University of Michigan; the Michigan State Medical Society; the Committee on Aging and Geriatrics of the Federal Security Agency, Washington, D. C., and the Housing and Home Finance Agency, Washington, D. C.

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* * *

Medical Care Featured in Eleven Adult Education Courses.—Adult Education courses, "Medical Care Within the Family and Community," taught in cooperation with local adult education programs and County Medical Societies, have enjoyed wide popularity.

The Adult Education program is part of the element, "Know How to Live," of the Michigan State Medical Society's Formula For Freedom program.

Typical of the programs is that of the St. Clair County Medical Society, the most recent medical group to introduce the project. Under the direction of Frederick E. Ludwig, M.D., Port Huron, President of the St. Clair County Medical Society, an eight-week course has been inaugurated at Port Huron. The course, "Home Medicine Within the Family," began on April 7.

The topics for instruction include: The Importance of the Family Doctor, The Cardiac Housewife and Rheumatic Fever, Prenatal and Postnatal Care, Immunization and Allergies, How to Teach Sex to Your Children, High Blood Pressure and Living Tension plus Problems of the Aged, Cancer, and Atomic Medical Care.

Participating doctors of medicine from Port Huron are Claude Ludwig, M.D.; E. W. Meredith, M.D.; Walter Novak, M.D.; James Tisdale, M.D.; William Clelland, M.D.; Arthur Gholz, M.D.; Frederick Ludwig, M.D.; Leslie McCoy, M.D.; and Arthur Ulmer, M.D.

Earlier this year similar courses were instituted at Lansing, Bay City, Marquette, Ishpeming, Negaunee, Millington, Lake Fenton, Royal Oak, Flint, and Jackson.

In each instance, wide publicity has been given the introduction of this new program into the adult education courses. Plans are currently being made for continuation of the program in the Fall with additional communities indicating strong interest.



Provisional figures from the Michigan Department of Health show 1,164 tuberculosis deaths in Michigan during 1951 and 6,144 new cases reported.

These figures represent a 10 per cent increase over 1950 in new cases reported, following the pattern of recent years—a pattern of fluctuation with slightly upward trend. They represent a 9 per cent decline in tuberculosis deaths—a continuation of a downward trend which has cut tuberculosis deaths by more than half in the past five years.

Both the increase in cases reported and the decrease in deaths are evidences of effective effort toward tuberculosis control. They also testify to a problem not yet solved and the need for unrelaxed vigilance.

MICHIGAN TUBERCULOSIS ASSOCIATION

THE DOCTOR'S LIBRARY

Acknowledgment of all books received will be made in this column, and this will be deemed by us as full compensation to those sending them. A selection will be made for review, as expedient.

THE PRACTICE OF ENDOCRINOLOGY. Edited by Raymond Greene, M.A., D.M., M.R.C.P. Philadelphia: J. B. Lippincott Co. Price: $12.50.

This book summarizes for the busy general practitioner, the facts necessary for the diagnosis and treatment of diseases of the endocrine system without unnecessary theory, and gives only enough anatomy and physiology to serve as an adequate background. It is not intended to be a technical manual on Endocrinology. The subject matter is well presented, emphasizing the problems facing the physician and in a practical way offering suggestions for their treatment. The more important advances in the field of Endocrinology are adequately covered. In the chapter on diabetes, while insulin mixtures are thoroughly discussed, no mention is made of NPH Insulin which is used so largely in this country. The use of potassium in the treatment of severe diabetic coma is only briefly mentioned.

In the treatment of thyrotoxicosis, the English have used largely methyl thiouracil and state that their experiences with prophyl thiouracil have not been sufficient to report their results in a larger series of cases. The author does state, however, the derivatives have entirely supplanted thiouracil itself.

These criticisms are minor. The book is an excellent one, adequately covering the important advances in the field of Endocrinology, and is particularly recommended for the general practitioner as an authoritative guide to the diagnosis and treatment of endocrine diseases.

L.E.V.

LIVING IN BALANCE. By Frank S. Caprio, M.D. Washington, D. C.: The Arundel Press, Inc. Price $3.75.

Dr. Caprio presents an interesting, informative treatise written in non-technical language explaining the causes of emotional conflicts. The first four chapters orient the reader and give him a basis for understanding the remainder of the book. The concluding chapters offer a plan for not only understanding oneself and the people about, but suggests a definite plan for living in this hectic world. This reader was pleased to note that, while the author recognizes the Freudian concept as to etiology in certain conditions, this part is not emphasized.

The book is written for the laity but is well worth the time of the physician. Regardless of the type of medicine we practice, we all need a sane approach to our patients' problems. Dr. Caprio gives us this in an easily understandable form.

STANDARD NOMENCLATURE OF DISEASES AND OPERATIONS. Fourth Edition. Richard J. Plunkett, M.D., Editor, and Adaline C. Hayden, R.R.L., Associate Editor. Published for The American Medical Association. Philadelphia: The Blakiston Co., 1952. Price $8.00.

For twenty years, more and more librarians, record departments of hospitals and, in general, all those having to do with study and classification of disease and operations have been developing standard methods. The first edition of this volume was published in 1932. This is the fourth edition, and the volume has been enlarged to meet advances. The book is invaluable to medical librarians, to teaching staffs, and for reference generally. The names of conditions and diagnoses are given in reg-

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ular order according to a prearranged classification, giving values to groups, etiology, area involved, et cetera. The index number is given at the left of the column, and the international listing given in italics and parantheses at the right. Every figure and digit has a meaning, making the diagnosis clear. For instance *(left)* 871-776 and *(right)* (260) (272) *Diabetes Mellitis with hyperpituitarism.*

This book is published for the American Medical Association, and is worth while for any doctor of medicine who is really interested in the finer aspects of medical diagnosis and records.

A TEXTBOOK OF ORTHOPEDICS. With a Section on Neurology in Orthopedics. By M. Beckett Howorth, M.D., Clinical Professor of Orthopedic Surgery, New York University Post-Graduate Medical School; formerly Assistant Clinical Professor of Orthopedic Surgery, College of Physicians and Surgeons, Columbia University; Associate Attending Surgeon, New York Orthopedic Hospital. In association with: Fritz J. Cramer, M.D., A. Wilbur Duryee, M.D., Donovan J. McCune, M.D., J. Wm. Littler, M.D., and Walter A. Thompson, M.D., Illustrated. Philadelphia: W. B. Saunders Co., 1952. Price $16.00.

Dr. Howorth's new text on Orthopedics is a product of a rich experience in both the practice and teaching of Orthopedic Surgery in the large New York centers. Abnormalities and diseases of the musculoskeletal system from the rarest to the more common ones are all discussed, not in minute detail, but very adequately. Etiology, pathology, and diagnosis of these conditions are given, and although detailed techniques and treatment are not stressed, there is an excellent discussion of the general principles of treatment.

The chapter on History of Orthopedics is always an interesting one, and it is well to look back and note the hardships and difficulties that have been overcome by the pioneers in this field.

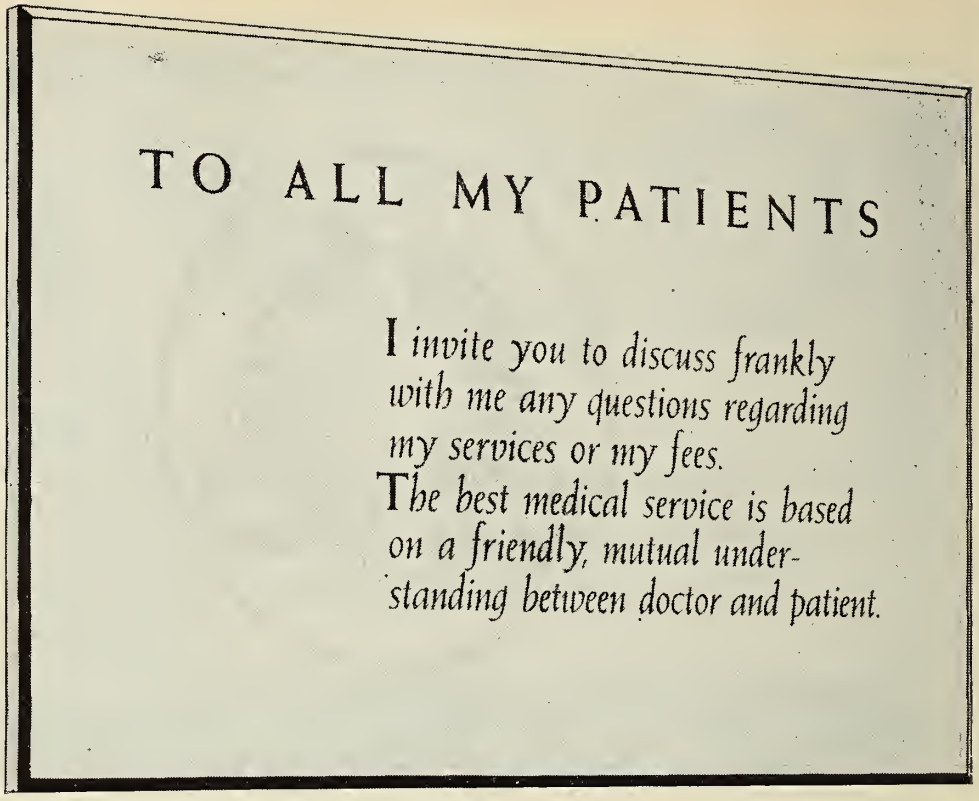
Following the section on The Basic Principles of Orthopedic Practice comes Regional Orthopedics, which deals rather briefly with conditions affecting each individual region of the body. The main portion of the book is taken up with the Orthopedic Disorders, and it is to Dr. Howorth's credit that here he has included even the most unusual and least understood abnormalities.

The last 200 pages are given over to the very important relationship between Neurology and Orthopedics which is seldom discussed in a text such as this. For this reason, this last section is most important and is extremely valuable to the Orthopedic Surgeon.

Dr. Howorth has given us a magnificent text on Orthopedics. P.C.K.

HOW TO IMPROVE YOUR SEXUAL RELATIONS. By Edwin W. Hirsch, M.D., Member of the American Urological Association; formerly Associate in Urology, College of Medicine, University of Chicago. Chicago: Zeno Publishing Company, 1951. Price, two for $1.00.

This little book is well written, intended for the doctor to give to his patient or get by prescription. It gives clear descriptions of the male and female parts, the meaning and method of the sexual act, and attempts



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CALLANDER'S SURGICAL ANATOMY. By Barry J. Anson, M.A., Ph.D. (Med. Sc.), Professor of Anatomy, Northwestern University Medical School, and Walter G. Maddock, M.S., M.D., F.A.C.S., Elcock Professor of Surgery, Northwestern University Medical School. Third Edition, 929 Illustrations. Philadelphia: W. B. Saunders Co., 1952. Price $14.00.

This book, a revision of the original text is well done. Doctors Anson and Maddock have retained the original pattern of presentation chosen by Doctor Callander, but have felt quite free to draw from the literature, to quote passages, to use or substitute engravings or original drawings when they felt such changes would clarify the text. This has, in part, affected the uniformity of the book. For example, Figure 818 suffers by comparison with Figure 819. In general, this is a minor defect and does not detract from the overall excellence of the text.

Without question the student, the intern and the surgeon will do well to add this volume to his library.

J.W.H.

BACKACHE, BIRTH AND FIGURE RELIEF BY SELF-REVOLVING HIPBONES. By Wm. Schoenau. The words herein are all defined in Webster's Dictionary. Published by Wm. Schoenau, Los Angeles, California. Price $2.00.

Our reviewer, an orthopedic surgeon, was unimpressed by this book, could find nothing to tie to, and declined to write about it. He asks, "What are self-revolving hips?" We have read the paragraph "How to Self Revolve the Hip Joint Forward by Pulling With the Legs," and admit we cannot understand what is being described.

FROM THE HOOVER REPORT

Today, four great agencies and thirty smaller ones independently obtain funds annually, erect their own hospitals to care for their own clientele, and compete with each other for scarce medical personnel. The various agencies operate with no regard for the facilities available or the needs of the other agencies. So don't fret about Government's coming into the medical field—it's here!

1952 MCI BREAKS ATTENDANCE RECORDS

(Continued from Page 607)

J. Milton Robb, M.D., Detroit: "The Institute was most successful. My Congratulations!"

Florence Ames, M.D., Monroe: "Let me say that the Michigan Clinical Institute in Detroit was a splendid meeting. I liked the grouping of related subjects into the same session."

Mrs. Robert S. Breakey, Lansing, President, Woman's Auxiliary to the Michigan State Medical Society: "Thanks for all the countless things you and all the others constantly do for us, especially at our recent meeting during the Michigan Clinical Institute in Detroit."

Ethel Balko, Director, Film Distribution, Davis & Geck Surgical Film Library, Brooklyn, N. Y. (exhibitor): "I was very happy to be able to take part in the recent Michigan Clinical Institute and much of that pleasure I must admit was due to the many courtesies extended to me by you and the members of your staff. I shall certainly look forward to attending future meetings of the Institute. Best personal regards."

Max M. Schuster, Cleveland, District Manager, E. I. du Pont de Nemours & Co., Inc. Photo Products Dept.: "I wish to thank you for the opportunity you gave to me to enjoy the contacts and comradeships with the members (both medical and technical exhibitors) of the 1952 Michigan Clinical Institute in Detroit. The privilege of attending and being with the group was the tonic the doctor ordered. It is always a pleasure to be able to say 'Hello' to old friends."

Morton Hack, Hack's Shoe Company, Detroit (exhibitor): "Good contacts, as always, were enjoyed by us last week at the 1952 Michigan Clinical Institute."

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LOCUM TENENS: for month of July and until August 20. General practice, Grosse Pointe, Michigan. Guarantee of $1,000 per month and bonus after certain amount. Address Box 9, 606 Townsend Street, Lansing 15, Michigan.

WANTED: Physician to take over active medical and obstetrical practice in rural west Michigan community for a ten-month period beginning August 1, 1952. Excellent facilities. Remuneration and living quarters adequate and desirable. Possibility of later partnership, if mutually desirable. In reply supply full biographical information and photo. Address Box 10, 606 Townsend Street, Lansing 15, Michigan.

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BRITISH MEDICAL PLAN SLIDING DOWNHILL

The once-famous and highly tooted British health plan is running into more trouble.

Newspapers reported recently that Churchill's government has introduced legislation to cut the cost of Britain's socialized medicine scheme by 21 million pounds or $58,800,000 a year.

The cut is being accomplished by sharply modifying the "free" provisions of the service. Under new provisions patients will have to pay.

The bill seeks to impose a charge of one pound ($2.80) for a course of dental treatment. A shilling (14 cents) charge will be imposed for drugs supplied through hospital outpatient departments.

Before going out of office last fall, the Labor party, which gave birth to the socialized medicine scheme, made the first big modification in the plan. The Laborites required patients to assume half of the cost of false teeth and spectacles. Now patients also will have to pay half the cost of such items as wigs, hearing aids, surgical boots and elastic stockings if the bill goes through. And the Conservatives, with a majority of fourteen, are expected to push it through.

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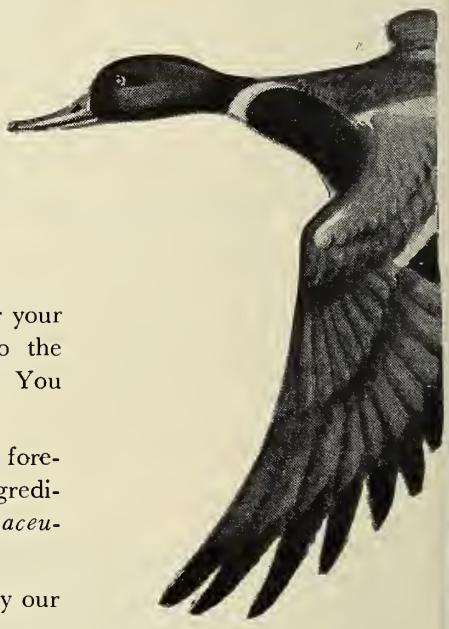
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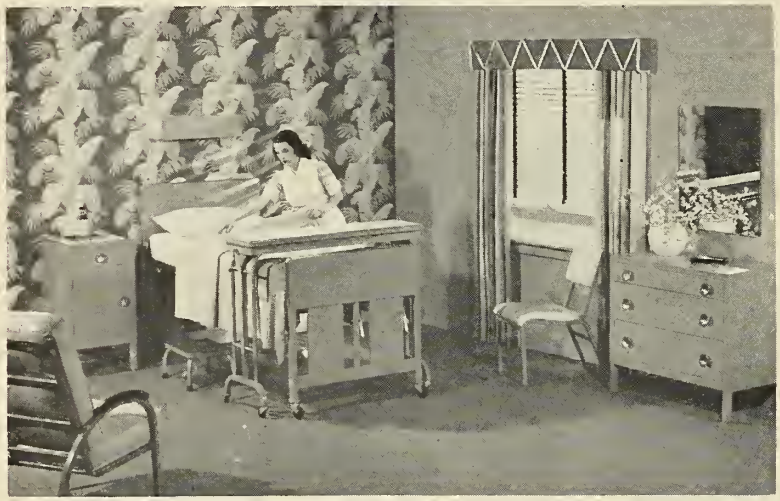
1. Greene, G. G.: Kentucky M. J. *50*:8, 1952.
2. Stevenson, C. S., et al.: Am. J. Obst. & Gynec. *61*:498, 1951.

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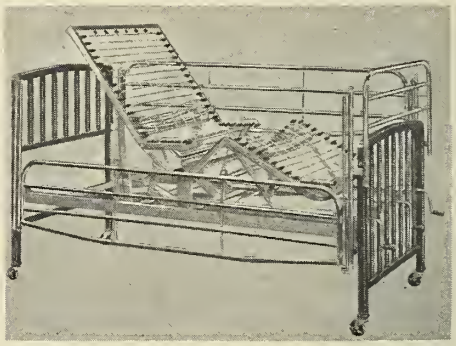




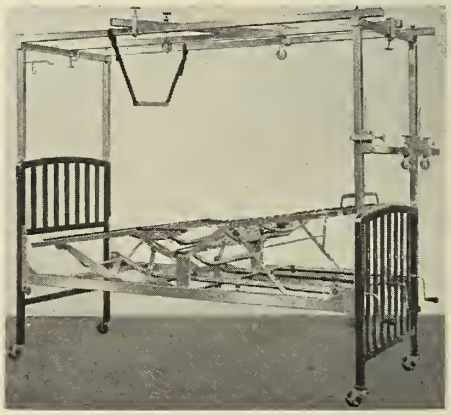
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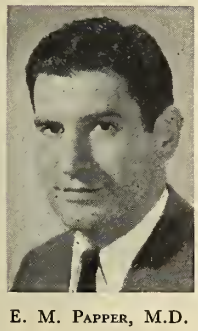
C. R. Doyle, M.D.



T. T. Mackie, M.D.



A. Marble, M.D.



E. M. Papper, M.D.

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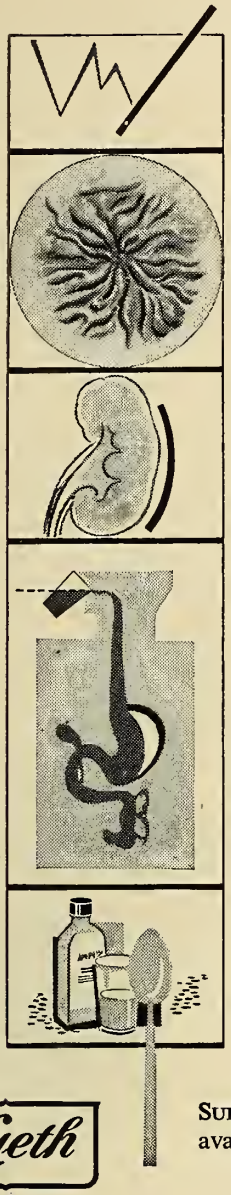
W. D. Barrett, M.D., Detroit.....1952
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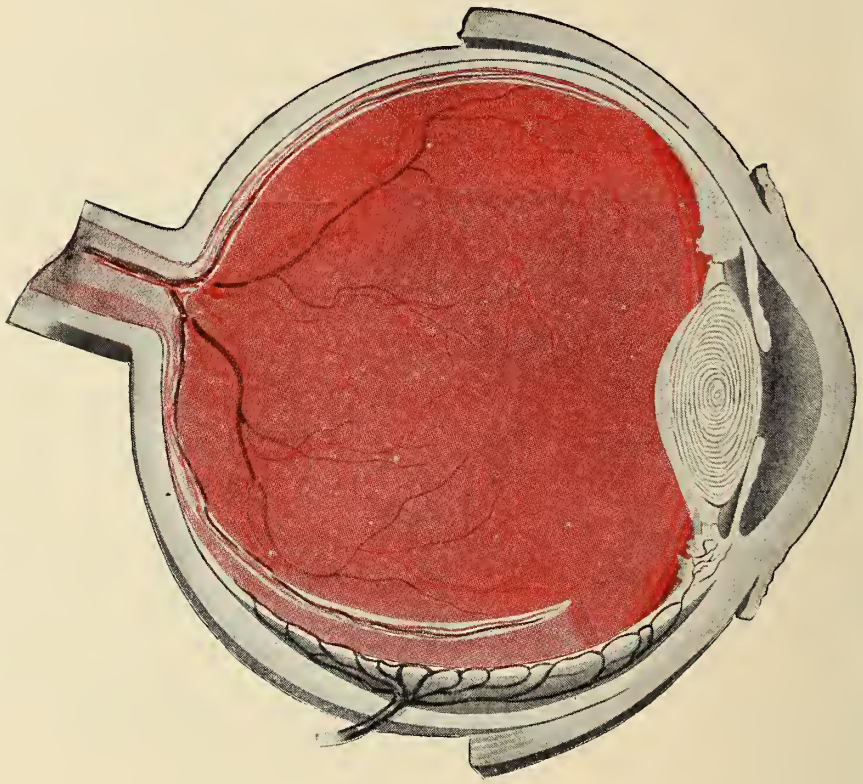
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1. Mitsui, Y., et al.: Antibiotics & Chemotherapy 1:253 (July) 1951.
2. Mitsui, Y., and Tanaka, C.: Antibiotics & Chemotherapy 1:146 (May) 1951

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MICHIGAN STATE MEDICAL SOCIETY ANNUAL SESSION
DETROIT—September 24-25-26, 1952

SUPPORT AMERICAN MEDICAL EDUCATION FOUNDATION

The support of every Doctor of Medicine is needed to insure the success of the American Medical Education Foundation. This noteworthy project is of the utmost importance to the medical profession. The Council of the Michigan State Medical Society has urged that all county medical societies and individual doctors not only maintain an active interest in the American Medical Education Foundation but contribute generously to its support.

Doctor, the Foundation is proof that the voluntary way is the only way for Medicine in the United States.

HIGHLIGHTS OF EXECUTIVE COMMITTEE OF THE COUNCIL

Meeting of April 23, 1952

Seventy-three items were presented to the Executive Committee of The Council on April 23 in Detroit. Chief in importance were:

- Financial reports were presented, studied, and approved.
 Purchase of short term U. S. Treasury Certificates of Indebtedness, out of temporary surplus from 1952 dues, was authorized.
 Bills payable were presented and approved for payment.
 The Cancer Control Committee's financial report for the first quarter of 1952 was presented and approved.
- Group health and accident insurance for MSMS members. Finance Chairman W. S. Jones, M.D., reported on his April 8 Chicago conference with a firm of insurance brokers who will present a plan to the Executive Committee of The Council on May 24.
- Purchase of property in Lansing next to 606 Townsend Street. Completion of this transaction, previously authorized, will be made in a week to ten days; thus the MSMS property will be rectangularized with 126 feet on Townsend Street and 100 feet on Hillsdale Street.
- The purchase of swing wing panels for photographs of past presidents, to hang in the Past Presidents Room in the MSMS "home" in Lansing, was authorized. All but four photographs of MSMS past presidents have been secured.
- A joint meeting with Michigan's delegates to the American Medical Association resulted in discussion of: (a) Oregon State Medical Society letter re military service call-ups; (b) role of the hospitals and their financial plight; and (c) study of proposed reorganization of the American Medical Association, with the following committee appointed to make this study: R. A. Johnson, M.D., Detroit, Chairman, W. D. Barrett, M.D., Detroit, J. S. DeTar, M.D., Milan, R. L. Novy, M.D., Detroit, G. C. Penberthy, M.D., Detroit, and C. E. Umphrey M.D., Detroit.
- Committee reports were given consideration as follows: (a) Permanent Conference Committee, meeting of March 19; (b) Rheumatic Fever Control Committee, meeting of March 26; (c) Geriatrics Committee, meeting of April 2; (d) Emergency Medical Service Committee, meeting of April 2; (e) Liaison Committee with Michigan Medical Service, meeting of April 16; (f) Special Committee to meet with Basic Science Board, meeting of April 23. In addition, Secretary L. Fernald Foster, M.D., reported on the successful county society executive secretaries' conference held at the Lansing MSMS headquarters, April 16, with the executive secretaries of Genesee, Muskegon, Saginaw, Washtenaw and Wayne County Medical Societies present.
- President Otto O. Beck, M.D., Birmingham, reported that contributions to the Beaumont Fund to April 23, 1952, totaled $12,710.50. Dr. Beck stated that a total of $40,000 from the profession is necessary to build the Beaumont Memorial on Mackinac Island. The President recommended that the names of all contributors to the Beau-

(Continued on Page 652)



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HIGHLIGHTS OF THE COUNCIL

(Continued from Page 650)

mont Fund be published in THE JOURNAL MSMS, which suggestion was approved by the Executive Committee of The Council.

- Committee appointments: Sibley W. Hoobler, M.D., Ann Arbor, to the Beaumont Memorial Resoration Committee; Perry C. Gittens, M.D., Detroit, to the Geriatrics Committee; Goldie P. Corneliuson, M.D., Lansing, to the Maternal Health Committee.
- The Public Relations Counsel's report included progress in MSMS television, radio and cinema activity; the active Formula For Freedom Night schedule; meeting of the Public Relations Advisory Committee to the AMA held in Chicago, April 14 and 15; and the final report of the MSMS Legislative Committee.
- The Executive Committee of The Council placed on its minutes a vote of approval and thanks to Public Relations Counsel H. W. Brenneman and to Field Secretaries Daniel E. Ford, Stuart A. Campbell and John B. Kantner for their excellent work in interpreting the requirements of the 1951 MSMS House of Delegates re amendments to the Michigan Medical Practice Act and to the Basic Science Act.
- Request of the Michigan State Medical Assistants Society for listing of their membership in the JMSMS Roster Number and also for the printing of their convention program in the official MSMS Annual Session Program, was approved.
- The personnel of the 1953 Michigan Clinical Institute Committee on Arrangements and Program was appointed by the Executive Committee of The Council: J. M. Robb, M.D., Detroit, Chairman; W. D. Barrett, M.D., Detroit; R. J. Hubbell, M.D., Kalamazoo; Otto O. Beck, M.D., Birmingham; L. Fernald Foster, M.D., Bay City; E. F. Sladek, M.D., Traverse City; G. C. Penberthy, M.D., Detroit; A. C. Furstenberg, M.D., W. O. Badgley, M.D., O. T. Mallery, M.D., H. H. Cummings, M.D., and J. M Sheldon, MD., all of Ann Arbor; W. H. Huron, M.D., Iron Mountain; F. E. Luger, M.D., Saginaw; R. A. Frary, M.D., Monroe; A. B. Gwinn, M.D., Hastings; M. G. Becker, M.D., Edmore; A. E. Heustis, M.D., Lansing, E. I. Carr, M.D., Lansing.

MSMS PAST PRESIDENTS' PHOTOGRAPHS

The Council has taken action to place photographs of all MSMS Past Presidents (covering the years from 1866 on) in the Past Presidents' Room of the new MSMS "home" at 606 Townsend Street, Lansing.

Photographs of the following have not as yet been located:

1875—Wm. Brodie, M.D., Detroit
1880—J. R. Thomas, M.D., Bay City
1885—E. P. Christian, M.D., Wyandotte
1922—W. T. Dodge, M.D., Big Rapids

If you have a photograph of any of the above-listed Past Executives of the Michigan State Medical Society, The Council would appreciate your contributing a print for the Past Presidents' Room; or if you know of some person who might be contacted, please inform the MSMS Executive Office, 606 Townsend Street, Lansing.

Thank you,
THE COUNCIL,
Michigan State Medical Society

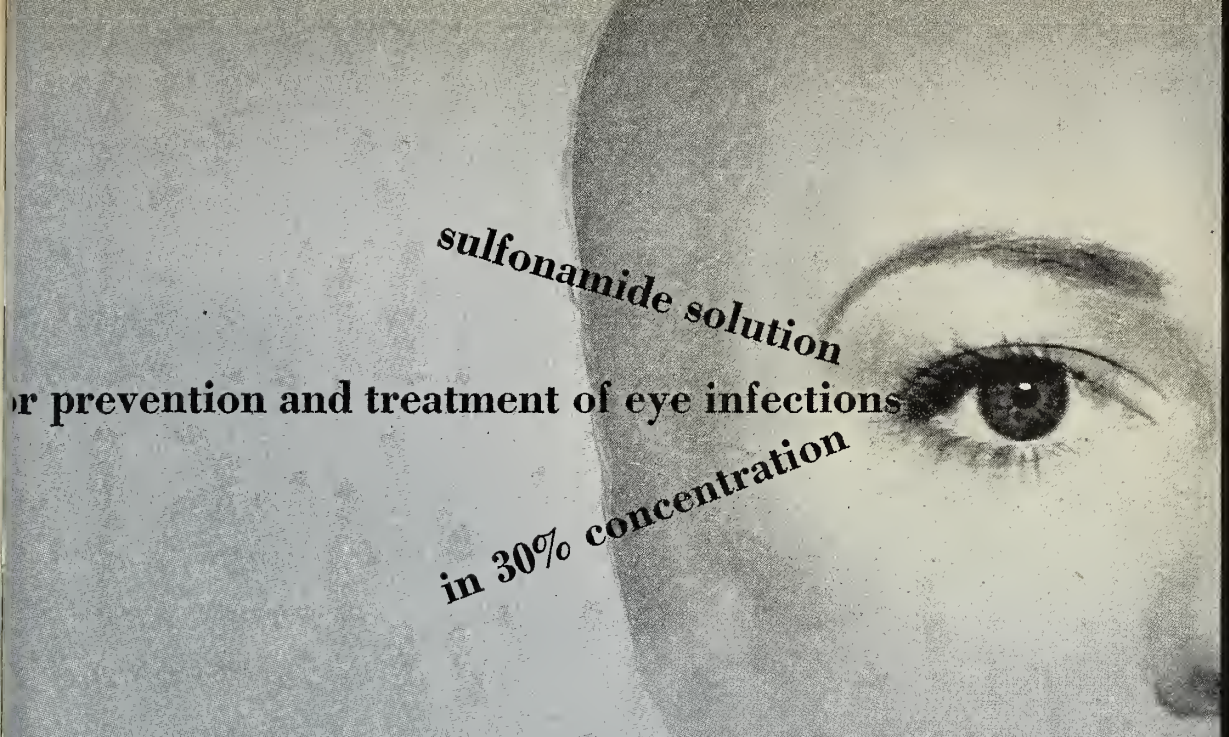
Four more, representing Wayne University College of Medicine and the Wayne County Medical Society, were to be nominated by WCMS on May 5.

- William Henry Gordon, M.D., Detroit, was authorized to accept appointment as a member of the American Medical Association's voluntary medical advisory committee (in civil defense matters).
- Monthly reports of Editor Wilfrid Haughey, M.D., Battle Creek; Rheumatic Fever Co-ordinator Leon DeVel, M.D., Grand Rapids, and Legal Counsel J. Joseph Herbert, Manistique, were presented and approved.
- Frank A. Weiser, M.D., W. B. Harm, M.D., and E. G. Merritt, M.D., all of Detroit, were appointed MSMS representatives to the Planning Committee of The Nurses Regional Conference to be held in Detroit on May 23.
- Resolution re S.1140, now in the Federal Congress, was approved and transmitted to the American Medical Association with a copy to be forwarded to the National Doctors' Committee for Improved Federal Medical Services.

GROUP ENROLLMENT CAMPAIGN LAUNCHED

Blue Cross-Blue Shield will hold a statewide group enrollment campaign in Michigan this summer. Through this plan, Michigan Hospital Service-Michigan Medical Service coverage is made

(Continued on Page 654)



sulfonamide solution

›r prevention and treatment of eye infections

in 30% concentration

Higher concentration—Sodium SULAMYD® Ophthalmic Solution provides sulfacetamide, a sulfonamide soluble to a concentration of 30% *at physiologic pH.*

Wide therapeutic range—Effective against all common eye pathogens, both gram-positive and gram-negative.

Rapid, deep penetration—Higher solubility and concentration produce local therapeutic levels within 15 minutes.

Excellent results—In eye injury—no loss of working time in 98.87 per cent of one series of 11,953 cases; in eye infections—rapid healing.

Well tolerated—Outstanding freedom from irritation and sensitization.

ACCEPTED COUNCIL ON PHARMACY AND CHEMISTRY OF THE AMERICAN MEDICAL ASSOCIATION

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Sodium SULAMYD Ophthalmic Solution 30%

SCHERING

GROUP ENROLLMENT CAMPAIGN LAUNCHED

(Continued from Page 652)

available to families who do not qualify through a group plan.

From experience gained in the campaign held last summer, Blue Cross-Blue Shield have worked out additional details which will make it easier for families to enroll right in their own community or by mail.

For further information, write to Blue Cross-Blue Shield, Washington Boulevard Building, Detroit, Michigan, attention of J. C. Ketchum.

FULL-TIME FIELD SECRETARY FOR HEALTH COUNCIL

The Michigan Health Council Board of Directors has taken action to create the position of full-time Field Secretary. The Board felt that such a person is necessary to serve better the communities throughout the state having local health councils and to expand further the MHC and Community Health Council activities.

STATISM DOOMS SIXTY-FIVE-YEAR-OLDS, DOCTORS TOLD

Persons over sixty-five should be free from geriatric (old age) slavery imposed on them by retirement regulations of statism. Dr. C. Paul White of Kewanee, outgoing president of the Illinois State Medical Society, said yesterday.

Speaking in the Sherman hotel at the society's 112th annual meeting, Dr. White assailed Oscar F. Ewing, federal security administrator. He accused Ewing of planning to socialize medicine through compulsory sickness insurance.

If that law ever becomes effective, he said, it would tend to make 12,000,000 Americans now over sixty-five the objects of involuntary charity because they would be excluded from provisions of the bill.

"Society and the business world, as determined by the federal security agency and public aid commission rulings, have retired folks at sixty-five as worn out machines," Dr. White declared.

"You and I know that a large percentage of them have many years of mental and physical stability left in which to complete a productive career.

"If the politicians must do something, let them release these people of sixty-five, condemned by law, from their geriatric slavery, by creating new and realistic standards by which one can measure their efficiency and thus restore their self-respect and remove a very heavy burden from our tax-weary citizens."

Dr. White said many physicians contend there is a wide range—from 50 to 80—of individual variation in the age at which human beings become aged.

He also noted that in opposing the establishment of 65 years as the arbitrary age supposed to mean the end of all productive activity, medical authorities have observed that premature retirement frequently hastens ultimate collapse into senility and death.

"Very definitely," said Dr. White, "sixty-five years is not the ultimate goal." In his talk on "American Medicine on the March," he reviewed health achievements made during the last 50 years and said these accomplishments prove the effectiveness of the free profession, which is learning to make people ever healthier and happier.—*Chicago Daily Tribune,* Thursday, May 15, 1952.

HOSPITAL COMMISSION OUTLINES COURSE OF TWO-YEAR INVESTIGATION

The Commission on Financing of Hospital Care, a non-government group financed by private subscription, has decided on a pattern to be followed in its two-year study of hospital costs. Although the survey was conceived by American Hospital Association, it is now being handled entirely by the Commission.

Commission Chairman Gordon Gray said a large part of the organization's budget and staff resources will be devoted to finding answers to the following:

1. What are the factors making for rising costs of hospitalization . . . and how can physicians and hospitals help to keep costs down?

2. How can hospital care be more satisfactorily financed for moderate income families and individuals?

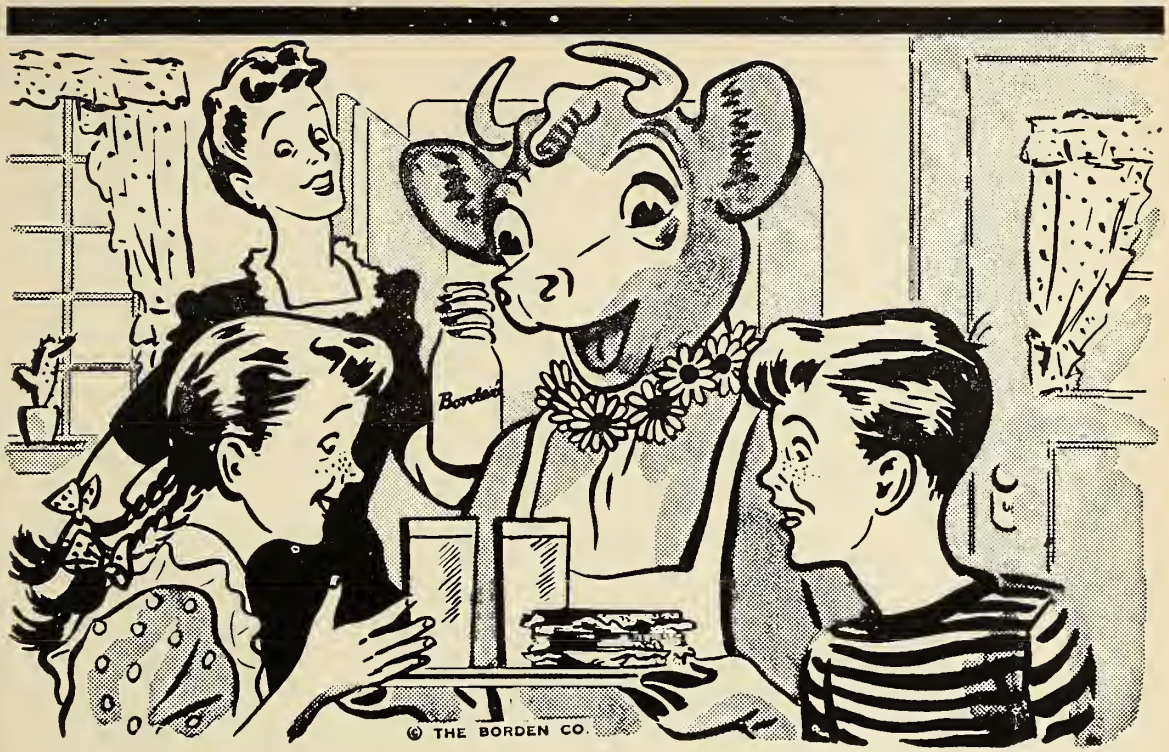
3. How can prepayment plans further serve the interests of the public and hospitals?

The Commission also will investigate length of stay, utilization of X-ray and laboratory services, rehabilitation, the chronically ill, and financial and other problems involved in the use of expensive drugs and antibiotics.

DOCTOR, YOUR STATISTICS ARE SHOWING

The AMA's Membership Department has gone mechanical. To facilitate the processing of membership records, more than 350,000 IBM cards—approximately two and one-third cards per AMA member—have been added to the Department's files. These cards contain statistics such as the physician's dues payment, specialty, medical school, date of graduation, address and birth date. This new system will make possible a record of membership which can be readily tabulated and processed.

(Continued on Page 656)



Borden's

"Homogenized Vitamin D Milk is a Wonderful Addition to any Diet!"

Has 400 U.S.P. units of Vitamin D added to EACH QUART.

Homogenization insures equal caloric value with each serving . . . plus a more uniform and better tasting product. Many persons who "don't like" ordinary milk, enjoy Homogenized Vitamin D.

FOR THESE REASONS, MAY WE SUGGEST CONSIDERATION OF THIS IMPROVED MILK FOR THE DIETS OF GROWING CHILDREN . . . FOR INVALIDS AND UNDERNOURISHED PERSONS . . . FOR ANYONE WHOSE DIETARY NEEDS INDICATE THE INGESTION OF MORE MILK NUTRIENTS.

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Michigan Milk Division

Detroit, Michigan

Say you saw it in the Journal of the Michigan State Medical Society

CHANGES IN THE MEMBERSHIP AND FELLOWSHIP STRUCTURE OF THE AMERICAN MEDICAL ASSOCIATION 1949-1952

1918 to 1949 Prior to 1950, and since the year 1918, all physicians who were active members of their State Society were non-dues paying members of the American Medical Association. Of the 144,211 members of the A.M.A. in June, 1949, 77,723 were listed as fellows. Fellows paid dues to the A.M.A. and received THE JOURNAL A.M.A.

1949 The House of Delegates of the A.M.A. assessed all members of the A.M.A. $25.00, but this assessment was voluntary and not compulsory. This was the only *assessment* made.

1950 There was no assessment in 1950. The A.M.A., for the first time, set the dues for membership in the A.M.A. at $25.00 a year. If these dues were not paid by the end of the year the member was dropped for nonpayment; before he could be reinstated, it was necessary for him to pay the delinquent year's dues.
The 1950 dues did not include a subscription to THE JOURNAL A.M.A.
A member in 1950 again had to pay fellowship dues to receive THE JOURNAL A.M.A., or could subscribe to it separately.

1951 The membership dues in the A.M.A. in 1951 were $25.00 and included a subscription to THE JOURNAL A.M.A. Fellowship dues were reduced but no longer included a subscription to THE JOURNAL A.M.A.

1952 The same as 1951, except that there are no fellowship dues and fellowship cards are not being issued. Fellowship will probably be abolished after the Annual Meeting of the A.M.A. in June, 1952.
The following summary will further clarify the changes from 1949 to 1952:

YEAR	MEMBERSHIP IN THE AMERICAN MEDICAL ASSN.	FELLOWSHIP IN THE AMERICAN MEDICAL ASSN.	SUBSCRIPTION PRICE OF THE JOURNAL A.M.A.
	Membership dues in the A.M.A. never included Fellowship dues. Membership dues have been payable only through the County and State Societies.	Fellowship in the A.M.A. was dependent upon membership in the State and County Societies and the A.M.A. Fellowship dues were payable to the A.M.A. and were in addition to the membership dues.	Since January 1, 1951, the price of THE JOURNAL has been included in membership dues; rates below for 1951 and 1952 are for non-members, and laymen. Anyone may subscribe to THE JOURNAL.
1949	Assessed $25.00 but payment *not compulsory.*	Dues of $12.00 *included* THE JOURNAL A.M.A.	$12.00
1950	Dues of $25.00 *did not* include THE JOURNAL.	Dues of $12.00 *included* THE JOURNAL.	12.00
1951	Dues of $25.00 *included* THE JOURNAL.	Dues of $5.00 *did not* include THE JOURNAL.	15.00
1952	Dues of $25.00 *include* THE JOURNAL.	No fellowship dues for 1952	15.00

MILLIONS PLEDGED BY U. S. TO HOSPITALS

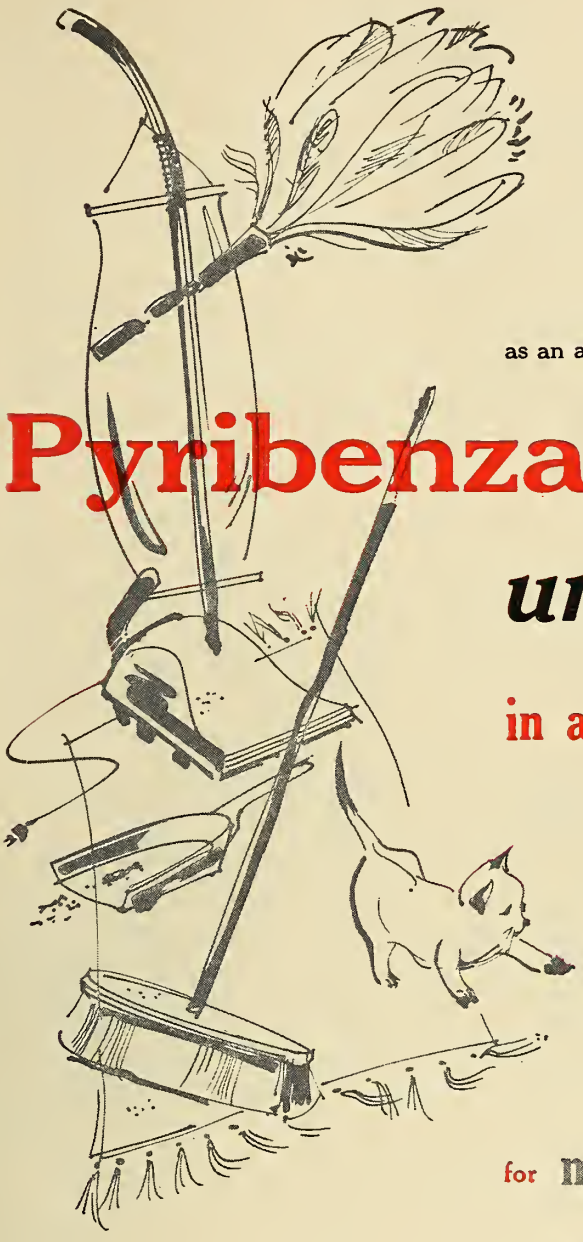
Hill-Burton hospital construction summary for the end of March gives the total federal contribution to all projects (completed, in operation, under construction or only initially approved) at $483 million, with the final cost—federal and local—set at $1,353 million. In all, 1,773 projects (85,012 beds) have been processed since start of the H. B. program. Below is a summary of the status of all construction:

	Total Projects	Total Cost	Federal Cost	Beds Added
Completed	850	$440,643,376	$141,390,874	29,969
Under construction	762	762,544,996	286,654,490	46,573
Initially approved	161	149,559,082	55,028,800	8,470

ATOMIC ENERGY COMMISSION RELEASES FIVE-YEAR SUMMARY OF U. S. ISOTOPE DISTRIBUTION

More than 600 universities, hospitals and research laboratories in forty-six states are using isotopes produced by the U. S. Atomic Energy Commission for medical, biological, industrial, agricultural and scientific research and medical diagnosis and treatment, states the Commission-issued report, "Isotopes—A Five Year Summary of U. S. Distribution," which is available to the public from the Superintendent of Documents, U. S. Government Printing Office, Washington 25, D. C., for $1.00 per copy. A summary of isotope applications considered to be of significance to industry has been compiled from the Five Year Summary and

(Continued on Page 658)



as an antihistaminic agent

Pyribenzamine® *is unsurpassed*

in allergic rhinitis . . .

in urticaria

in serum sickness

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for **maximal relief**

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ATOMIC ENERGY COMMISSION RELEASES FIVE-YEAR SUMMARY OF .U. S. ISOTOPE DISTRIBUTION

(Continued from Page 656)

printed separately as document TID-5078 available at the Office of Technical Services, Department of Commerce, Washington 25, D. C., for 30 cents per copy.

The full report on isotope distribution for five years shows more than 18,900 shipments of radioactive isotopes and 1,500 stable isotopes have been made to users in the United States and 1,100 radioactive isotope shipments to users outside the United States.

A brief summary of the growth of the isotopes program and descriptions of their uses are included in the report with a list of the users and the titles of 1,400 technical reports and papers published on isotope work in the past two years.

The vice of capitalism is that it represents the unequal sharing of blessings; whereas the virtue of socialism is that it stands for the equal distribution of misery.—WINSTON CHURCHILL.

All important laboratory examinations; including—

Tissue Diagnosis
The Wassermann and Kahn Tests
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The pathologist in direction is recognized by the Council on Medical Education and Hospitals of the A. M. A.

MEDICAL MEETINGS AND CLINIC DAYS

A list of known medical meetings and clinic days, sponsored by county medical societies and other physicians' groups in Michigan, follows:

1952

Spring	MSMS Postgraduate Extramural Courses State-wide
June 9-13	AMA Annual Session.....Chicago
June 27-28	Upper Peninsula Medical Society Annual Meeting.....Iron Mountain
June	St. Clair County Medical Society Clinic Day.....St. Clair
July 24-25	Annual Coller-Penberthy Medical Surgical Conference.....Traverse City
July 24-26	Conference on Housing of the Aging Ann Arbor
August 21	Third Annual Clinic, Central Michigan Committee, ACS Michigan Committee on Trauma, plus Michigan National Guard Medical Personnel, and Medical Society of North Central Counties Grayling
Sept. 24-26	MICHIGAN STATE MEDICAL SOCIETY ANNUAL SESSION.....Detroit
Oct. 8	Clara Elizabeth Fund—Genesee County Medical Society—Lectures of 1952...Flint
Oct. 9	Fourth Michigan Cancer Conference Kellogg Center, East Lansing
November	American Academy of General Practice of Wayne County.....Detroit
Autumn	MSMS Postgraduate Extramural Courses State-wide

1953

April 8	Genesee County Medical Society Eighth Cancer Day.....Flint
May 13	Annual Clinic Day and Reunion of Wayne University College of Medicine Hotel Fort Shelby, Detroit

Additions to this list of meetings are invited by the Editor of JMSMS, in order to make this monthly announcement complete and accurate.

Oscar C. Pogge, director of Bureau of Old Age and Survivors Insurance, reports that 4,600,000 persons now are on OASI rolls; the total will be 7,195,000 by 1960 and by the year 2000 it will be 19,872,000.

How to Get

COMPLETE STERILIZATION

in LESS TIME *than Simple Boiling*

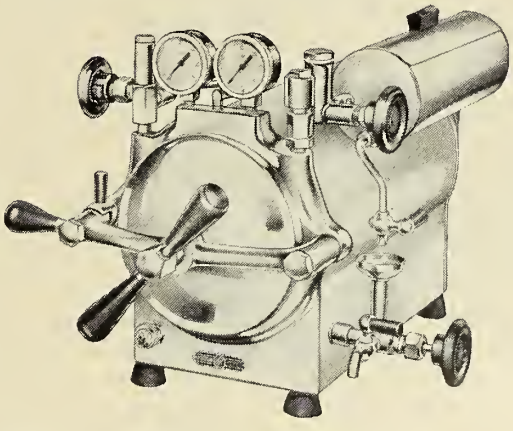
Bacteriologists and other authorities agree
1) That boiling merely sanitizes, or makes objects sanitary.
2) That only autoclaving, by utilizing steam under pressure, actually sterilizes, or completely destroys every form of life, harmful or innocuous.

And *now* that safe autoclaving, by means of the Pelton FL-2, can be accomplished in less time than simple sanitization by boiling water, why should any private office risk the danger of serious cross-infection from spore-bearing bacteria?

In addition, FL-2 autoclaving assures safe sterilization of absorbent materials, dressings and solutions. Needles, too, can be removed from the autoclave completely sterilized and perfectly dry, inside and out. Delicate instruments stay sharper, last longer, when autoclaved.

SEE the
PELTON FL-2

The FL-2 generates and then stores steam under pressure in its outer chamber ready for instant use. That means fast sterilizing. In all-day operation, current is off two-thirds of time. That means economy. One quart of water lasts one to several days without replenishing. Inner chamber is 6″ x 12″. Automatic controls, sturdy construction, lustrous chrome finish.



Ask your dealer about the FL-2, or write for literature

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Heart Beats

THE CARDIAC HOUSEWIFE LEARNS HOW TO LIVE

During the past two years the Michigan Heart Association has developed a very comprehensive program designed to be of aid to the Doctor of Medicine in the management of his women cardiac patients. It is called the Cardiac Housewife Program and has received the endorsement of the Michigan State Medical Society.

The initial study on the program was conducted by the Michigan Heart Association in co-operation with the Wayne University Home Economics Department in Detroit where it proved to be a very successful undertaking. From these studies, which were carried out under medical guidance, a complete course of instruction was developed which fills the medical doctor's prescription of "take it easy" by showing the homemaker with a cardiac disorder how to save as much as 75 per cent of her walking, 75 per cent of her movements and 60 per cent of her reaching while performing her daily household tasks.

This tremendous savings of time and energy, which is so vital to the cardiac patient, was accomplished by analyzing the daily work habits of women cardiac patients and recording each detail performed. Wasted motions and useless trips were pointed out; rearrangement of dishes and utensils was made; a cart to transport dishes and utensils was suggested. In the preparation of one meal alone, these simple changes resulted in cutting steps walked from 672 to 266, stooping from twenty to eight times, standing on tip-toe from forty-four to twenty-nine times. The total number of steps saved at preparing one meal alone were calculated to represent a savings of more than 62 miles of walking in a year. The patient became very motion conscious and was soon finding new short cuts by herself. She found that not only was her actual work-load decreased, but that she had more time in which to rest, for the more efficient method was also the shorter. The patient informed us that she was now able to plan her rest periods rather than interrupt a job because dyspnea made her rest. She also was very happy because she said that she was now able to do more for herself, yet feel no fatigue at the end of the day. It was felt that this was proof that work-simplification was of value to a cardiac homemaker.

Accordingly, other cases were studied and the same interest generated in the patient. Our home economist consultant, meanwhile, was learning of the restrictions important to the cardiac. Pictures were taken, charts and graphs drawn of the changes in arrangement. Thus, visual teaching aids were obtained during the study of actual cardiac patients. It is these data which are now being offered in the Michigan Heart Association's course for cardiac homemakers. The changes suggested are inexpensive and the techniques taught can and do benefit any economic level.

Following the initial pilot study at Wayne University, formal classes were started and women cardiac patients were admitted to the free course of instruction upon recommendation of their family Doctor of Medicine. The free work-simplification classes being held at Wayne University under the auspices of the Michigan Heart Association, have been in operation for more than a year. During that time nearly 200 Detroit and Wayne County women cardiac patients have attended the demonstration-lectures.

Because of the success of the program in the Detroit area a grant of funds was made by the Michigan Heart Association to the School of Home Economics at Michigan State College in East Lansing to conduct a similar program for use throughout Michigan.

Accordingly, the classes were developed at Michigan State and offered to Lansing and Ingham County cardiac homemakers. After very favorable and highly successful results in the Ingham County area, the classes were extended last fall by the Michigan Heart Association, through the Extension Service of Michigan State College, to

(Continued on Page 662)

EDITOR'S NOTE: The Cardiac Housewife Program is an example of the splendid cooperation of an organization under the Know How To Live element of the Formula for Freedom. This action program has educational benefits that go far beyond the advice given to cardiac housewives.

Reasons for effectiveness of Furacin

A wide antibacterial spectrum, including many gram-negative and gram-positive organisms • Effectiveness in the presence of wound exudates • Lack of cytotoxicity: no interference with healing or phagocytosis • Low incidence of sensitization: less than 5% • Ability to minimize malodor of infected lesions • Stability.

Furacin® preparations contain Furacin 0.2% brand of nitrofurazone N.N.R. in water-miscible vehicles which dissolve in exudates.


(1)


(2)

IN CHRONIC VARICOSE ULCERS...

In a female aged 47 years, varicose ulcers had proven refractory to rest, elevation of the leg, compresses and diverse topical applications. There was profuse discharge with Micrococcus pyogenes aureus, Streptococcus pyogenes, P. aeruginosa (pyocyaneus) *(Fig. 1).*

October 15. Furacin Soluble Dressing applied. There was rapid diminution in drainage. The ulcers soon showed a clean, granulating surface.

December 10. Linton skin flap operation performed. Furacin Soluble Dressing used postoperatively.

February 26. Patient discharged *(Fig. 2);* complete healing two weeks later.

Literature on request

ACCEPTED COUNCIL ON PHARMACY AND CHEMISTRY AMERICAN MEDICAL ASSOCIATION



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LABORATORIES, INC.
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THE CARDIAC HOUSEWIFE LEARNS HOW TO LIVE

(Continued from Page 660)

Berrien, Kent, Genesee, Isabella, Grand Traverse, Benzie, and Leelanau Counties where they were attended by 196 women cardiac patients. The program is being expanded as rapidly as possible and eventually will be available in every county of the state.

Plans have already been formulated to offer the work-simplification classes in the above counties again this spring. In addition, cardiac patients in Bay, Emmet, Charlevoix and Cheboygan Counties will also be served by the Cardiac Housewife Program. You and your local County Medical Society will be informed of the exact dates for the classes to be offered in your area. You may then refer your cardiac patients to the free classes.

No medical advice, treatment, diagnosis or examination is given to anyone in the classes. The course consists only of the adaptation of work-simplification techniques to the various household tasks performed by the housewife. The instruction offered will be of valuable assistance to you in prescribing relaxing work habits for cardiac patients.

In working with cardiac patients in the classrooms, two important factors have been realized from the instruction offered: (1) a new attitude of hopefulness on the part of the patient, resulting from the constructive attitude of emphasizing what can be done rather than what cannot be done, and (2) a reawakening of interest and spirit of helpfulness on the part of the husband and children in helping the disabled mother.

For further information and details regarding the classes held in the counties listed above, contact the following persons:

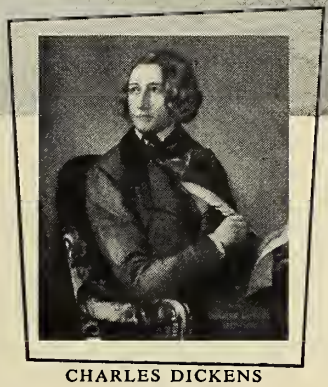
Bay County—Mr. Robert Stuart, Director Adult Education, Board of Education, Bay City.
Berrien County—Miss Ina Redman, 150 Water Street, Benton Harbor.
Emmet-Charlevoix-Cheboygan County—Mrs. Sidney Reinbold, Court House, Petoskey.
Genesee County—Mrs. Clara P. Hay, Court House, Flint 3.
Grand Traverse-Leelanau-Benzie County—Mrs. Edna Deo, Federal Building, Traverse City, or Leland.
Ingham County—Mrs. Ruth C. Kettunen, Home Management Department, Michigan State College, East Lansing.
Isabella County—Miss Josephine Brighenti, Federal Building, Mt. Pleasant.
Kent County—Mrs. Ruth E. Mawby, Court House, Grand Rapids.
Wayne County—Michigan Heart Association, 4421 Woodward Avenue, Detroit 1.



The Wayne University College of Medicine Senior Class visited Eli Lilly & Company on May 11, 12 and 13, 1952, at the Laboratory of Indianapolis and Greenfield.
There was an interesting program including dinner Sunday evening followed by entertainment. A full Monday and Tuesday program was enjoyed with breakfast, luncheon and dinner as guests of the Company.



Scene from "Oliver Twist"



CHARLES DICKENS
1812-1870

Psychoneurotic Men of Genius

Charles Dickens, the renowned British novelist, was subject to cyclic moods of pronounced depression characterized by intense nervous irritability and by the shedding of tears all day long. He was exceedingly sensitive to his own experiences as well as to the suffering of others.

In the great majority of psychoneurotics, there is no serious mental illness, but merely an emotional imbalance which often can be greatly improved by proper psychotherapeutic and sedative management. In the treatment of psychoneurosis, particularly agitated, depressed and anxiety states, Mebaral is preferred by many because it combines a high degree of sedative effectiveness — producing emotional stability — with a relative freedom from side effects such as languor and drowsiness. Patients usually become calmer, more cheerful and better adjusted to their surroundings without clouding of mental faculties.

ACCEPTED COUNCIL ON PHARMACY AND CHEMISTRY AMERICAN MEDICAL ASSOCIATION

Average sedative dose:
Adults, 32 mg. to 0.1 Gm. (½ to 1½ grains) three or four times daily;
children, 16 to 32 mg. (¼ to ½ grain) three or four times daily.

Supplied in tablets of 32 mg., 0.1 Gm. and 0.2 Gm.

Mebaral®

tasteless daytime sedative

EFFECTIVE ANTIEPILEPTIC

Winthrop-Stearns INC. New York 18, N. Y. • Windsor, Ont.

Mebaral, trademark reg. U. S. & Canada, brand of mephobarbital

Beaumont Memorial Contributors

Michigan's doctors of medicine, through their generous contributions, are bringing closer to realization the plans of the Beaumont Memorial Restoration Committee to erect a symbol of wood and stone marking the location of a renowned advance in medical science.

This symbol—restoration of the American Fur Company store on Mackinac Island—will serve as a constant reminder to the public of the pioneering experiments of Dr. William Beaumont and of other medical men through the centuries.

The Michigan State Medical Society needs $40,000 to rebuild the historic fur store where Alexis St. Martin was felled by the blast of a musket but who providentially lived with a natural window in his stomach. Through this fistula, Dr. Beaumont made his famous observations on the French-Canadian voyageur.

While individual doctors of medicine are responding to the request for funds, organizations within MSMS are contributing sizeable lump sums secured from their membership.

Besides the original contribution by Parke, Davis and Company of Detroit to purchase the Mackinac Island property, the largest single contributor to date has been the Genesee County Medical Society. The members raised a total of $1,864 for the Beaumont Restoration project.

The generous contribution of $500 by the Woman's Auxiliary to the Wayne County Medical Society also helped swell the total received up to May 31 to $13,701.25.

The 795 individual doctors of medicine who have helped build the fund on towards the goal of $40,000 have made average contributions of $11.50.

The list of contributors follows:

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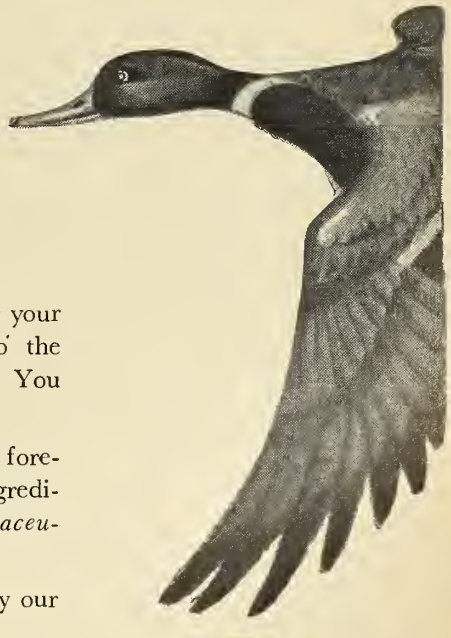
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WHEN FOOD INTAKE *is inadequate*

When the patient's food intake is inadequate to supply essential nutrients in proper amounts, clinical experience has demonstrated the supportive value of a dietary supplement providing substantial quantities of virtually all needed nutrients—protein, vitamins, minerals, carbohydrate, and fat. The choice of the supplement prescribed, to a large extent, can determine the efficacy of the supplemented diet since over-all nutrient adequacy is the primary aim.

It is apparent from the data shown below that Ovaltine in milk can serve well in markedly increasing the intake of virtually all known nutrients. Taken daily during periods of inadequate consumption of other foods, it offers an excellent means for preventing subclinical nutritional deficiencies which can undermine general health or retard recovery from illness.

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Ovaltine

Three Servings of Ovaltine in Milk Recommended for Daily Use Provide the Following Amounts of Nutrients

(Each serving made of ½ oz. of Ovaltine and 8 fl. oz. of whole milk)

MINERALS		VITAMINS	
*CALCIUM	1.12 Gm.	*ASCORBIC ACID	37 mg.
CHLORINE	900 mg.	BIOTIN	0.03 mg.
COBALT	0.006 mg.	CHOLINE	200 mg.
*COPPER	0.7 mg.	FOLIC ACID	0.05 mg.
FLUORINE	3.0 mg.	*NIACIN	6.7 mg.
*IODINE	0.7 mg.	PANTOTHENIC ACID	3.0 mg.
*IRON	12 mg.	PYRIDOXINE	0.6 mg.
MAGNESIUM	120 mg.	*RIBOFLAVIN	2.0 mg.
MANGANESE	0.4 mg.	*THIAMINE	1.2 mg.
*PHOSPHORUS	940 mg.	*VITAMIN A	3200 I.U.
POTASSIUM	1300 mg.	VITAMIN B_{12}	0.005 mg.
SODIUM	560 mg.	*VITAMIN D	420 I.U.
ZINC	2.6 mg.		

*PROTEIN (biologically complete)	32 Gm.
*CARBOHYDRATE	65 Gm.
*FAT	30 Gm.

*Nutrients for which daily dietary allowances are recommended by the National Research Council.

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(Continued on Page 670)



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RECORD NUMBER OF LIVE BIRTHS

Live births for 1951 may have topped the all-time high set in 1947, but U. S. Public Health Service is waiting for final returns before making formal announcement. The 1947 figure for live births was 3,818,000 and the 1951 unofficial total is 3,833,000 but PHS points out this is just an estimate and the totals are too close together to make any claims for 1951's birth rate without final figures. One of the factors contributing to the rise was the continuing decline in infant mortality. For the fifteenth straight year the infant death rate declined, reaching 28.8 per thousand live births last year.

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Cancer Comment

BREAST CANCER STUDIES

In unpublished data, Paul R. Gerhardt, M.D., and Irving D. Goldberg, B.S., Bureau of Cancer Control, New York State Department of Health, Albany, present some interesting information regarding incidence and control of breast cancer in that state.

In New York, exclusive of New York City, cancer has been reportable by legislative enactment since January 1, 1940. Reporting received the approval of the state medical society at its inception and has been supported actively since that time. Cancer reporting has proven useful in epidemiologic investigations; for evaluation of progress in cancer control; in public and professional education; in aiding tumor clinics in follow-up of patients; and in providing public health nursing service to cancer patients.

In New York, exclusive of New York City, breast cancer is the most frequently reported human malignant tumor, nearly 2,200 cases of breast cancer being reported yearly out of a total of almost 19,000 cases of all types. In the female population of that state, sixty cases of breast cancer per 100,000 population develop annually. This study showed that with increasing age both morbidity and mortality rates of female breast cancer increased. Some five per cent of the state's female population are expected to develop breast cancer after their 45th birthday. Breast cancer incidence is continuously rising and may be due, in part, to better reporting and other artificial factors. Mortality from this form of the disease apparently is lessening in recent years. This situation indicates that treatment is more effective and also may be due in part to such patients seeking diagnosis and treatment in earlier stages of development.

During the period under study, 1943-1949, radical mastectomy as the treatment of choice increased four per cent. Preoperative biopsies were reported for less than one-third of the cases in either year but most likely many table biopsies were done at the time of surgery that were never reported. The needle punch biopsy, quite popular in 1943, had been almost abandoned in 1949. Radical mastectomies increased markedly over simple mastectomies during this same period even though in many cases, metastases to adjacent lymph nodes could not be demonstrated at time of operation.

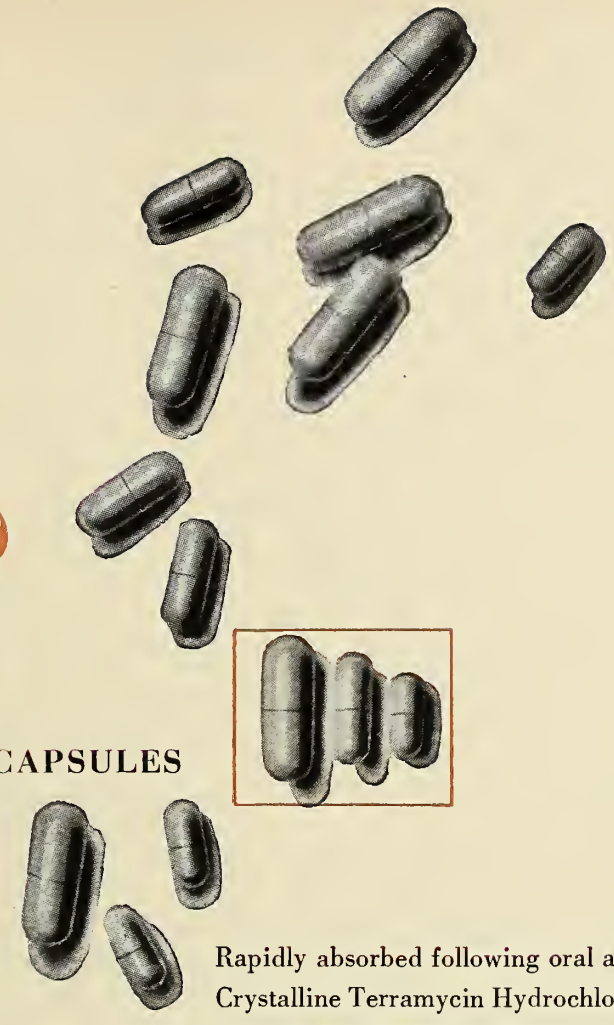
In both 1943 and 1949 studies, the stage of the disease at time of diagnosis was the same. In 46 per cent of cases there were metastases to or beyond regional lymph areas. Only 30 per cent were classified as in early stages with no metastases. The authors emphasize that the most significant index of control in breast carcinoma is that which indicates the proportion of all breast cancers undergoing radical mastectomies before axillary node metastasis. Among their 1943 breast cases, 26 per cent had radical mastectomies without axillary metastases, while in 1949 this percentage had increased to 35, a 35 per cent increase in this important control index. This experience is borne out in other studies of a similar nature, indicating that the long continued and intensive lay education program, especially among women, may be showing favorable results.

An important factor to be considered in this study is the availability of a large number of accurate and comparable cancer morbidity reports. Cancer reporting is approximately 80 per cent complete in New York and is due in large measure to the active co-operation of the medical profession. Professional interest in cancer control is further stimulated by fifty-three tumor clinics organized under the minimum standard requirements of the American College of Surgeons and operating in various cities outside New York City. These tumor clinics are organized into a state group which meets regularly for scientific discussion of cancer problems as well as holding professional education meetings in their own organization. These clinics are fully approved and supported by the Medical Society of the State of New York.

Further, the Roswell Park Memorial Institute, Buffalo, currently undergoing a building program to increase the bed capacity from 110 beds to 516 beds, is devoted to cancer research as well as clinical care of patients admitted by referral from their own physicians. The Institute is administered by the State Department of Health. It is adequately staffed for both clinical and research

(Continued on Page 674)

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Workers' Medical Problems Reviewed on Michigan Industrial Health Day

The health of Michigan's industrial workers was scrutinized by industrial physicians and surgeons on the Third Annual Industrial Health Day. Topics ranged from the workers' psychiatric conflicts to the types of shoes they should wear.

More than 200 doctors of medicine attended the one-day conference, May 7, which was conducted at Hurley Hospital and the Durant Hotel in Flint. Otto J. Preston, M.D., President of the Michigan Association of Industrial Physicians and Surgeons, presided at the sessions.

The program was climaxed in the evening at a banquet, sponsored by General Motors Corporation, in the Durant Hotel. The featured speaker at the annual banquet was Andrew C. Ivy, M.D., Professor of Physiology, University of Illinois. Dr. Ivy covered the topic of "The Physiological Background to the New Concepts of Artificial Respiration." Toastmaster at the banquet was Max R. Burnell, M.D., Medical Director of General Motors Corporation, Detroit.

T. I. Boileau, M.D., Detroit, assumed the presidency of the Michigan Association of Industrial Physicians and Surgeons for 1952-1953. Sherman Andrews, M.D., of Kalamazoo, was named President-Elect of the organization. The other officers elected at the annual business meeting were Paul J. Ochsner, M.D., Lansing, Vice President, and Edwin DeJongh, M.D., Lansing, Secretary-Treasurer.

During the day, nine Michigan leaders in industrial health presented scientific papers in the clinical section of the meeting. Joseph Shapiro, M.D., Flint psychiatrist, spoke on "Psychiatric Problems Observed in Industry." Paul C. Kingsley, M.D., Battle Creek orthopedic surgeon, discussed "Office Treatment of Common Foot Disorders as seen in Industry." Harold W. Woughter, M.D., Flint, Chief, Section of Surgery of Trauma, McLaren General Hospital, presented a paper on "Skin Coverage of the Hand." Walter Z. Rundles, M.D., Chief of Otolaryngology, Department of Surgery, Hurley Hospital, Flint, discussed "Clinical Use of the Audiometer in Industry."

E. A. Osius, M.D., Assistant Professor, Clinical Surgery, Wayne University College of Medicine, Detroit, led off the afternoon session with a paper on "Venous Status of the Lower Extremities." Raymond M. Engleman, M.D., Chief, Division of Thoracic Surgery, McLaren General Hospital, Flint, discussed "Abnormal Chest Films Which Do Not Preclude Employment." George J. Curry, M.D., Chief, Section of Surgery of Trauma, Hurley Hospital, Flint, considered "Romance of Trauma." Otto T. Mallery, M.D., Associate Professor of Internal Medicine, University of Michigan Medical School, concluded the clinical program with a paper on "Recent Advances in Medical Education."

Those attending the conference from outside Michigan were Carl M. Peterson, M.D., Secretary, Council on Industrial Health, American Medical Association, Chicago; Edward C. Holmblad, M.D., Managing Director, Industrial Medical Association, Chicago; Maurice G. Woolff, M.D., General Motors, Port Elizabeth, South Africa; and Gerd Carow, M.D., of Germany.

The meeting was sponsored by the Michigan Association of Industrial Physicians and Surgeons, Michigan State Medical Society Committee of Industrial Health, American College of Surgeons, University of Michigan, Wayne University, and Michigan State Department of Health.

CANCER COMMENT

(Continued from Page 672)

studies, and as part of the equipment has approximately eight grams of radium.

To improve further the professional treatment and care of cancer patients in this state, Michigan physicians might well study in more detail the New York State Program of Cancer Control, especially their program of cancer reporting which enables emphasis to be placed on some of the weak spots in any cancer control program.

Patient history-taking is a difficult task but one which is highly remunerative in end results.

* * *

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Date	Place	Speakers
Dec. 18, 1951	Kalamazoo Kalamazoo Academy of Medicine	R. J. Hubbell, M.D., Kalamazoo Otto O. Beck, M.D., Birmingham L. Fernald Foster, M.D., Bay City D. Hale Brake, Lansing State Treasurer Hugh W. Brenneman, Lansing
Jan. 15, 1952	Grand Rapids Kent County Medical Society	L. Fernald Foster, M.D., Bay City Senator Carlton H. Morris, Kalamazoo Hugh W. Brenneman, Lansing
Jan. 22, 1952	Saginaw Saginaw County Medical Society	L. Fernald Foster, M.D., Bay City J. E. Livesay, M.D., Flint H. B. Zemmer, M.D., Lapeer L. C. Harvie, M.D., Saginaw Hugh W. Brenneman, Lansing
Feb. 5, 1952	Big Rapids Mecosta-Osceola-Lake County Medical Society	L. Fernald Foster, M.D., Bay City Senator Milo A. Johnson, Greenville Hugh W. Brenneman, Lansing
Feb. 12, 1952	Owosso Shiawassee & Clinton County Medical Societies	L. Fernald Foster, M.D., Bay City Senator James M. Teahen, Jr., Owosso Hugh W. Brenneman, Lansing
Feb. 14, 1952	Ann Arbor Washtenaw County Medical Society	L. Fernald Foster, M.D., Bay City Bradley M. Harris, M.D., Ypsilanti D. Hale Brake, Lansing State Treasurer Hugh W. Brenneman, Lansing
Feb. 15, 1952	Muskegon Muskegon County Medical Society	L. Fernald Foster, M.D., Bay City William C. Vandenberg, Lansing Lt. Gov., State of Michigan Hugh W. Brenneman, Lansing
Feb. 19, 1952	Mt. Pleasant Gratiot-Isabella-Clare County Medical Society	L. Fernald Foster, M.D., Bay City Hugh W. Brenneman, Lansing
March 4, 1952	Battle Creek Calhoun County Medical Society	L. Fernald Foster, M.D., Bay City Senator Creighton R. Coleman, Marshall Hugh W. Brenneman, Lansing
March 7, 1952	Holland Ottawa County Medical Society	L. Fernald Foster, M.D., Bay City Senator C. H. Geerlings, Holland Hugh W. Brenneman, Lansing
March 18, 1952	Port Huron St. Clair and Sanilac County Medical Society	L. Fernald Foster, M.D., Bay City John B. Martin, Jr., Lansing Auditor-General, State of Michigan Hugh W. Brenneman, Lansing
March 19, 1952	Bay City Bay-Arenac-Iosco County Medical Society	D. Hale Brake, Lansing State Treasurer J. E. Livesay, M.D., Flint Hugh W. Brenneman, Lansing
April 1, 1952	Monroe Monroe County Medical Society	Bradley M. Harris, M.D., Ypsilanti D. Hale Brake, Lansing, State Treasurer Hugh W. Brenneman, Lansing
April 15, 1952	Flint Genesee County Medical Society	L. Fernald Foster, M.D., Bay City John B. Martin, Jr., Lansing Auditor-General, State of Michigan Joseph R. Hainline, Detroit
April 24, 1952	Hastings Barry County Medical Society	L. Fernald Foster, M.D., Bay City
April 24, 1952	South Haven Van Buren County Medical Society	L. Fernald Foster, M.D., Bay City Senator G. Elwood Bonine, Vandalia

Formula For Freedom Nights

At County Medical Societies

Continued

Date	Place	Speakers
May 6, 1952	Traverse City Grand Traverse-Leelanau-Benzie County Medical Societies	D. B. Wiley, M.D., Utica D. Hale Brake, Lansing, State Treasurer Hugh W. Brenneman, Lansing
May 27, 1952	Genesee County Medical Society Woman's Auxiliary	L. Fernald Foster, M.D., Bay City
May 29, 1952	Dowagiac Cass County Medical Society	L. Fernald Foster, M.D., Bay City Senator G. Elwood Bonine, Vandalia Hugh W. Brenneman, Lansing
June 5, 1952	Ann Arbor Michigan Tuberculosis Association Annual Meeting	L. Fernald Foster, M.D., Bay City D. Hale Brake, Lansing, State Treasurer Hugh W. Brenneman, Lansing
June 17, 1952	Lansing Ingham County Medical Society	D. Bruce Wiley, M.D., Utica Rep. Lawrence B. Lindemer, Stockbridge Hugh W. Brenneman, Lansing
June 27, 1952	Iron Mountain Annual Meeting, Upper Peninsula Medical Society	To be announced



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Editorial Comment

MICHIGAN STATE MEDICAL SOCIETY ANNUAL SESSION
SHERATON-CADILLAC HOTEL—DETROIT
September 24-25-26, 1952

64 YEARS AND 364 DAYS

Talking with one of our doctors at lunch at the recent Michigan Clinical Institute the talk casually turned to medical student days and classmates and the doctor, one of our honored and distinguished, remarked the year of his graduation—he didn't seem that old—and surprise and implied doubt were mentioned. To emphasize the year of his graduation he said that he had reached 65 the previous year at which time retirement was compulsory from the active staff of his hospital. He belies his years in appearance, activity, and more importantly in the retention of his mental faculties.

Biological age and retention of mental vigor do not parallel the years ticked off on the calendar. Some people have psychological true old age with fixed accompanying patterns of senescence before pubescent tempers have cooled. By what rule of reason and common sense is a man able to be head of a medical or surgical service at 64 years and 364 days, and the next day he considered as inadequate, a has been?

Medicine instead of taking directives from business and industry should set the pattern for industry in this increasing problem of compulsory rule of retirement at a fixed age. Stereotypy is recognized as a symptom, regardless of whence it comes.

Everyone can name some of the great in the golden book of achievement in science, and art, and literature who continued or made their greatest contributions in the 6th, and 7th, and 8th decades.

The big accelerating waste of our mechanical age is the loss of the wisdom and creative and productive output of those who have only by the decree of the passage of time been relegated to the junk heap, so to speak, with the stamp of finality—pensioned, retired, emeritus! By what mis-rule of reason and common sense is a doctor able to be a senior medical or surgical staff-man at 64 years and 364 days and by administrative fiat the next day be considered inadequate, a has been, incapable. Who's telling who?

Look around. Some of the older doctors with the wisdom and ability acquired through a lifetime possess an entirely modern and up to the minute grasp of medicine. And they shine with the joie de vivre.

This tragic loss that industry indulges should not be transposed to and fatalistically and objectively, and silently accepted by medical men. No group is better fitted to mold and direct its own destiny.

Sixty-four years and 364 days is a variable and shifting milestone. While in some it post dates an era, in many it is but another day in a busy useful life.—Dave Sugar in *Detroit Medical News,* April 21, 1952.

TRAINING OR EDUCATION?

Recently, the mental institutions of the State of Michigan announced salaries of $5,808.00 for the first year psychiatric resident. Salaries for interns in accredited hospitals also are increasing, with $3,600.00 a year and full maintenance no longer a rarity.

The primary purpose of intern-resident training is to prepare young doctors to render better service to the public, as practicing physicians. It must be basically an educational experience. Therefore, proper training programs combine the vocational part of patient care with adequate supervision and instruction by staff men selected for soundness of medical knowledge and willingness and ability to teach. It does not consist of just letting the intern or resident tag along with the staff men. Neither does it mean that a series of textbook-rehash lectures organized for the edification of the young doctors will convert a vocational program into an educational experience. Interns and residents are more familiar with the context of such lectures than we are. The very best of teaching is done at the bedside by the qualified clinician. This is always a time-consuming and laborious project when done right, and when so done, superior care is the result.

In contrast, some hospital staffs still believe the primary responsibility of the intern and resident is the care of the patient. The duties outlined are to keep up the records required by accrediting agencies and to function generally as a medical houseboy. This school of thought fights off any attempt to balance the vocational with educational opportunities, by labeling anything beyond manual training as "spoon feeding." Whatever education takes place under such a philosophy is minimal, incidental and accidental.

We have no objection to the purely apprenticeship concept, if so advertised. In fact, we admire

(Continued on Page 680)



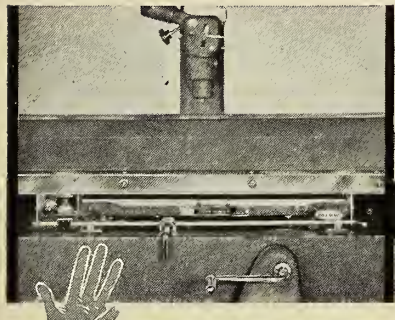
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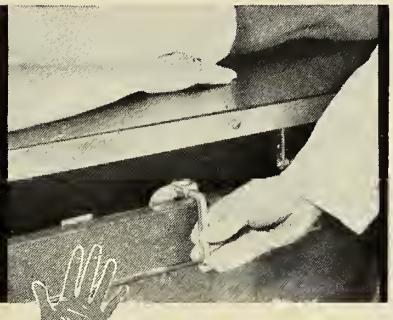
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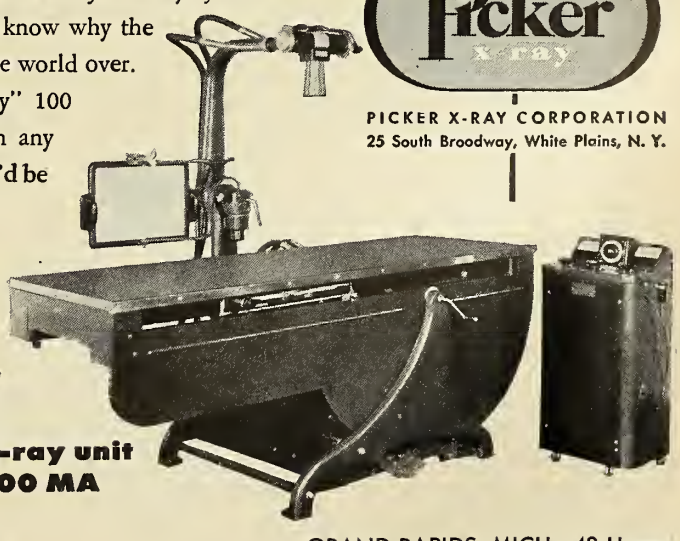
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TRAINING OR EDUCATION?

(Continued from Page 678)

a staff that recognizes its lack of competent teachers, makes no pretense of carrying out an educational program, and hires interns and residents for the specific purpose of supplying technical help to provide good care for patients. What we object to is the misrepresentation and the low wages paid for such highly technical and important services by hospitals that palm off a vocational program under the guise of an educational program.

Usually the stipend is in direct proportion to the vocational demands of the staff, so the higher the pay the lower the educational opportunities. So, we are justified in assuming that high salaries are a tacit admission of a manual training program—or the hiring of interns to take care of patients without adequate teaching supervision.

And, isn't it too bad that the Council on Education and Hospitals of the A.M.A. hasn't the courage to differentiate the two types of hospitals—the vocational and the educational—so students may know!—Frank A. Weiser, in *Detroit Medical News,* April 28, 1952.

FORMULA FOR FREEDOM

Perhaps one of the most significant projects to be undertaken by a medical organization has been launched by the Michigan State Medical Society in its "Formula For Freedom." A specific, well-thought-out activity around which a complete public relations program can be built, "Formula For Freedom" is based on the hypothesis that no force or subterfuge can take freedom away if Americans understand and appreciate it and prepare themselves to exercise properly their powers and privileges. Emphasizing three elements, "know yourself," "know how to live," and "know your government," the Michigan plan places responsibility on the shoulders of the individual. By helping people to become self-reliant, the program will fight the increasing dependence of the individual on his government which underlies any trend toward socialism.

Although envisioning the co-operation of other professions and businesses, each group translating the formula into its own terms, the Michigan doctors are setting out to apply the "Formula for Freedom" particularly in the area of health. They expect first to distribute a personal appraisal form which will help the person filling it out to know himself better. Space will be allowed for health, social-religious, economic, and legal appraisals, and the forms will be distributed through doctors, lawyers, bankers, churches, insurance agents, service clubs, schools, and unions to an estimated 2,000,000 people. The health appraisal will recommend a comprehensive physical examination which the doctors plan to place within the financial reach of everyone. After taking an inventory, the doctors hope, a person will know better how to improve himself and should feel that he has a greater control over his own destiny.

The second step is to get across some of the basic socio-economic facts with the assumption that the more a person knows about such things the more competent he will be in coping with them. Newspaper stories, radio and television shows, motion pictures, and health education classes in Michigan already make available information about medicine and health with doses of socio-economic material interspersed.

Finally, the Michigan medical profession seeks to interest citizens in good government, pointing out that citizens should learn what candidates for public office stand for and should vote their convictions in every election.

True enough, the idea behind "Formula For Freedom" is not new. The medical profession has stood for free enterprise, individual effort, and self-reliance and has urged a program to "inform the public" for a long time. Nevertheless, the Michigan formula has a new twist that makes it basic and apparently workable. It will be worth watching and perhaps worth adopting in Texas.—Editorial, *The Texas State Journal of Medicine,* April, 1952.

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X-ray sickness
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Pylorospasm
Spasm of biliary tract
Spasm of colon
Peptic ulcer
Colitis
Biliary dyskinesia

Allergic Disorders
Irritability
To combat stimulation of ephedrine alone, etc.

Irritability Associated With Infections

Restlessness and Irritability With Pain

Central Nervous System
Paralysis agitans
Chorea
Hysteria
Delirium tremens
Mania

Anticonvulsant
Traumatic
Tetanus
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Federal Medicine

THE SHERMAN ANTITRUST LAW

On October 18, 1948, the Federal Government filed suit in the District Court in Oregon against the Oregon State Medical Society, the Oregon Physicians Service, eight County Medical Societies, and eight physicians in Oregon, alleging that they are in restraint of the development of prepayment medical care service in Oregon and surrounding states.

The District Judge after hearing the Government's case ordered a verdict of not proven, without hearing the defense. The Government appealed. The case has been proceeding.

On April 28, 1952, the Supreme Court rendered a final decision. It decided, 7 to 1, that the Federal Government had failed to prove its charges of antitrust law violation by a nonprofit medical and hospital insurance program sponsored by the Oregon Medical Society.

The ruling was a blow to the Justice Department, which has been investigating similar plans operated by doctors' groups in nearly a dozen other states.

The American Medical Association had assailed the Government's moves as an attempt to "terrorize" the medical profession and impose the Truman Administration's plan for compulsory Government health insurance.

We published a complete transcript of the case as first presented in the District Court, because we believed then, and now, that every attempt will be made to discourage the doctors and hospitals in their effort to maintain a free and independent practice of medicine. The Government has been stymied in its attempt through the courts to discredit medicine, but is constantly nibbling off a small item here and there, and someday we may find the core only remaining, and that poor picking. Mr. Ewing's latest bid for the hospitalization of persons over sixty-five is a part of the planned economy.

OSCAR EWING'S LOGIC AGAIN

In a press release covering the annual report of the U. S. Public Health Service for 1951, Federal Security Administrator Ewing preached the same old gospel: "the year's end found 40,000,000 Americans still without the protection of full-time local health services."

"Only half of the 3,070 counties of the United States are served by public health departments," the news release said.

For propaganda purposes, Oscar has a habit of tossing figures around with complete abandon. Sometimes, however, he confuses an issue by contradicting his own figures. He has used the 40,000,000 figure time after time. Yet he had this to say when he testified on local public health units at hearings before the House Committee on Interstate and Foreign Commerce on May 8, 1951:

". . . the 40,000,000 figure was geared to the fiscal year 1949, and was based on 1940 population figures adjusted to 1949 by the Census Bureau on an estimate basis. Since then, new and accurate population figures have become available as a result of the 1950 decennial census, and we have just completed—within the last two or three weeks—a recomputation of these figures. The recomputation shows that the population served by the 1,301 full-time health units—serving 1,734 counties and 268 cities—is approximately 119,000,000, leaving about 31,000,000—instead of 40,000,000—not served by full-time units."

This was his testimony May 8, 1951. But in April, 1952, he was still using the 40,000,000 figure!

Another interesting fact is that while the press release mentioned 40,000,000, no reference was made to this figure in the annual report itself.—AMA Secretary's Letter, April 14, 1952.

PHYSICIANS IN SERVICE

Army is calling up 232 physicians from its reserves for duty beginning in July. Dentists, called at the same time, will come from Priority II for the first time because all Priority I dentists available have been called. . . . One hundred and forty-six senior medical students have been chosen for the Army internship program beginning this July 1.

Selective Service will begin re-examining the status of some 230,000 draft-eligible students this spring as colleges finish out the academic year.

DICKINSON TESTIFIES BEFORE HEALTH COMMISSION

Testifying before the President's Commission on the Health Needs of the Nation in Washington, Frank G. Dickinson, Ph.D., director of the Bureau of Medical Economic Research of the AMA, said that "there has not been to date a realistic study which supports any valid claim that a national doctor shortage is pending."

Dr. Dickinson brought out some good points. He said that "since people need everything, it can be safely assumed that there are unmet needs for medical services, legal services, dental services, Grade A milk, shoes, and any other goods or services which sell for a price. Since all needs are relative, it follows that all unmet needs are relative. Any approach to the study of regionalization will fail at the start if it is based upon the notion that unmet needs are absolute."

Dr. Dickinson pointed out that in recent years two estimates of the doctor shortage for 1960 have been made by the federal government.

"Both of these attempts," he said, "assumed a national shortage rather than bothering to prove a national shortage."

He said further that many factors have been ignored in the two studies for making a reasonable estimate of the surplus or deficit in the 1960 supply of physicians.

"What do physicians do for people? What would more physicians do for people?

(Continued on Page 684)


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21A52

DICKINSON TESTIFIES BEFORE HEALTH COMMISSION

(Continued from Page 682)

"The median age of the dying has jumped from age 30 in 1900 to age 67. Volumes are being turned out currently on the social and medical care of the aged. Although a physician must always try as hard to prolong the life of an 80-year-old man as he would to prolong the life of a 10-year-old boy, the formulation of national policy on the need for physicians must seriously and sympathetically consider the increasing number and percentage of older people—products of medical progress."

FEDERAL LEGISLATION

Bills for Hospitalization-at-Age-65.—S-3001 and H.R.-7484, identical bills introduced by Senator Murray and Representative Dingell to authorize establishment of a system of government-paid hospitalization for everyone eligible for social security benefits. Eligibles would include persons sixty-five and over who are covered by social security and their dependents as well as the survivors of deceased persons so insured. Hospital benefits would be limited to sixty days in any one calendar year.

Some of the provisions: 1. Beneficiaries would be eligible for drugs, services and appliances "customarily furnished by such hospital to its bed patients," but tuberculosis or mental hospitals "or any hospital or institution which furnished primarily domiciliary or nursing care" could not participate in the program. 2. A physician would have to determine that hospitalization was required. 3. Although costs would be paid out of the Social Security Trust Fund, state departments of health would handle details. The states could, if they so decided, turn administration over to Blue Cross or other non-profit insurance organizations.

In a statement, Senator Murray and Rep. Dingell said about seven million persons would be eligible. They estimated the cost at $200 million annually.

Extent of benefits—Bed, board, nursing, laboratory, ambulance, operating room, and usual drugs and appliances when hospitalized.

Exclusions—Surgery, domiciliary care, hospitalization for tuberculosis and mental conditions.

Maximum hospitalization annually—Sixty days.

Number of persons eligible—7,100,000 (FSA estimate).

Certification for benefits—By individual's attending physician.

Control of program—The Administrator of the Federal Security Agency would prescribe and promulgate rules and regulations for the conduct of the program. A state would merely act as the agent of the Administrator in carrying out details, functioning through its designated health agency. In the event a state refuses to accept the agency agreement the FSA Administrator would operate the program within such state.

Advisory Committee—Federal Hospital Council, presently functioning under Hill-Burton Act.

Role of private insurance plans—States or the Federal Security Administrator *may* utilize "the services of private nonprofit organizations" in dealing with hospitals.

Cost of program—Between $191 and $235 million annually at the outset, according to FSA estimates. Basis is $15 per day hospital cost multiplied by approximately two days hospitalization annually per person, multiplied by 7.1 million eligibles.

Financing—Financed entirely by the federal government from the Social Security Trust Fund. No financial contribution would be required from states.

Social Security Amendments—H.R. 7549 by Mr. Kean, of New Jersey, April 23, proposes *to extend and improve the Old-Age and Survivors Insurance System, to prevent loss of benefit rights in the event of disability, to provide for rehabilitation,* and for other purposes. Referred to the Committee on Ways and Means.

Comment.—Bill seeks to: (1) increase monthly benefits approximately 10 per cent; (2) extend coverage to approximately 5 million additional persons, including 3.5 million agricultural operators, 450 thousand agricultural workers, 500 thousand professional persons (including physicians), 115 thousand domestics, and several hundred thousand casual workers; and (3) provide rehabilitation services and insurance preservation rights for disabled persons.

The bill would remove the exclusion from coverage in the present law of physicians, lawyers, dentists, accountants, architects, engineers, funeral directors, etc.

Rehabilitation services presently available under the federal Vocational Rehabilitation Act, including medical care, hospitalization, appliances, etc., would be rendered through state agencies to disabled persons who are expected to be disabled throughout a six-month waiting period or longer and to totally and permanently disabled persons so that workers might be returned to gainful employment. The entire cost of such rehabilitation services would be borne by the Social Security Trust Fund. Presently federal funds are being expended under the Vocational Rehabilitation Act at the rate of 21½ million dollars annually. During the period of disability, insurance rights for workers would be preserved so that in computing old age benefits later, the period of disability would not be included in determining an average monthly wage.

The Administrator of the Federal Security Agency would determine whether a claimant is permanently and totally disabled, *or is likely to be,* unless rehabilitated. The Administrator would arrange for medical examinations and re-examinations of disability claimants. Examinations would be performed in existing facilities of the federal government, if available, and by impartial private physicians, clinics, hospitals or other medical facilities designated by the Administrator. The Administrator would be authorized to secure the co-operation of public agencies and private medical, dental, hospital, nursing, health, educational, social, and welfare groups for advice and service in carrying out the vocational rehabilitation and examination sections of the bill.

No increase in payroll deduction for social security insurance is provided in the bill.

House Passes Bill Favoring Physicians and Other Skilled Immigrant Applicants.—The House, on April 25, passed a bill drastically revising the Nation's immigra-

(Continued on Page 714)

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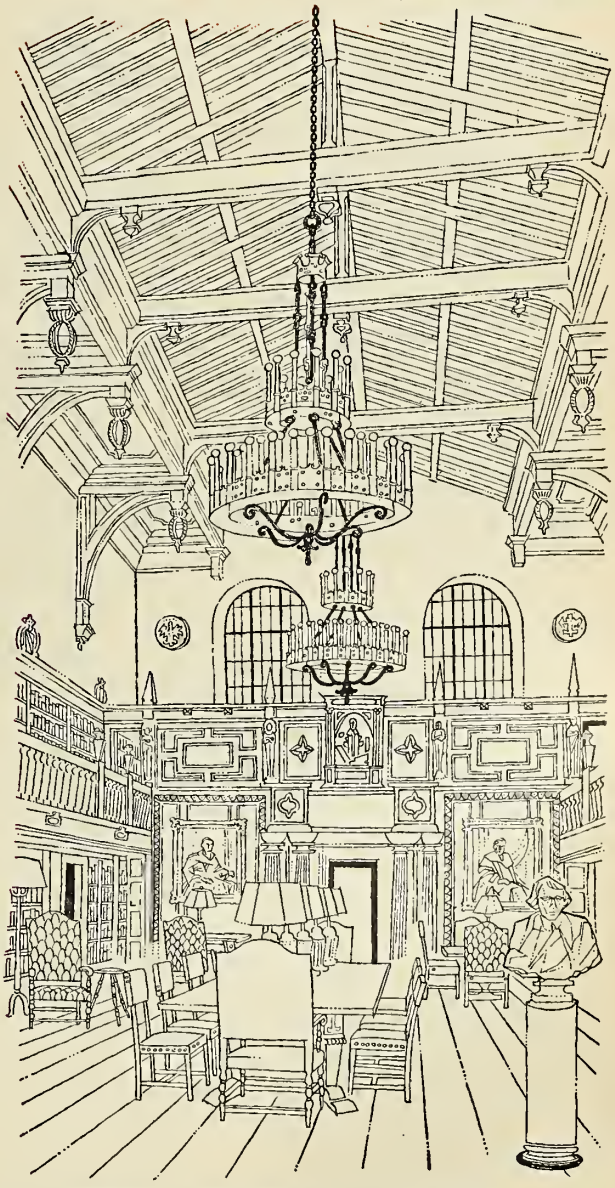
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In the home, sufficient powder for each feeding may be measured into capped, clean, dry, sterile nursing bottles and warm, boiled water added at feeding time. When traveling, the bottles may be prepared at home, and the boiled water carried in a thermos bottle.

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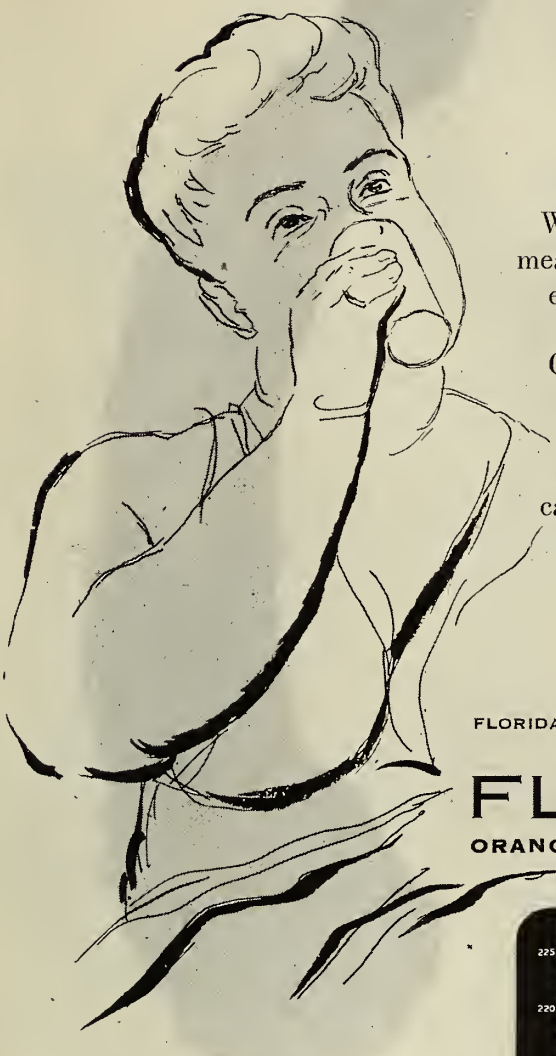
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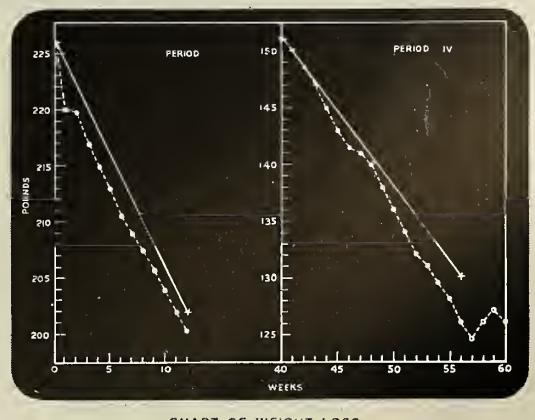


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Principles of Good Clinical Anesthesia

By E. M. Papper, M.D.
New York, New York

THERE IS NO physician who favors "bad" clinical anesthesia. Almost all of us, in keeping with our human heritage, prefer to be aligned on the side of the righteous and the "good." It could be pleasant, therefore, to describe the elements of good clinical anesthesia as facts and know that we would nod our collective heads in agreement or boredom and feel that an unimportant problem has been settled. To do so would be smug and dishonest.

It appears more useful and valuable to develop a point of view about thinking and practice in anesthesiology than it would to confine this discussion to current methods alone. The tacit and sometimes open implication that there are "ideal" ways to anesthetize patients for surgical operations is misleading. One cannot quarrel with the desire to establish secure and finite goals directed toward the safe management of anesthetized patients. But much issue can be taken with the reluctance to accept the fact that the production of surgical anesthesia bears a physiological price tag in exchange for the benefits of pain relief and adequate operating conditions for the surgeon. We will be concerned with some of the factors which minimize that price tag. They consist in general of the technical skill of the administration of potent anesthetic drugs and the intellectual aspects of clinical judgment and scientific knowledge which are essential guides to the practicing hand.

The technical aspects of anesthesiology have occupied a rather curious position in the thinking of specialists in this field, as well as in the minds of physicians whose interests are in other branches of medicine and surgery. On the one hand, there are those who cherish the performance of a given anesthetic maneuver with technical finesse as the sole criterion of good clinical anesthesia. There are others who have looked upon the technical nature of anesthesia very much like the citizens of classical Greece and Rome looked upon the artisan and craftsman. This feeling is one of contempt for manual labor and for the exercise of purely technical skill. The apparently simple maneuvers in the administration of many surgical anesthesias have not always been appreciated as exercises worthy of the dignity of the thinking physician. A second aspect of good clinical anesthesiology is concerned with judgment and scientific knowledge. It involves, among other things, the necessity of understanding the impact of anesthetic agents and methods upon physiological activity. It appears sensible to believe that the fruitful application of anesthesiology to the care of the surgical sick is the development of both the technical and the intellectual aspects of the specialty. It is not enough to apply a technical maneuver without mature judgment and understanding of what is implied and what the result of that technical maneuver may be. It is also not sufficient to understand the effects of anesthetic agents and drugs without competent skill in using them for the surgical patient.

It will serve our purpose to consider some of the aspects of clinical anesthesia in terms of the specific problems that arise from the effects of

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anesthetic agents and methods upon surgical patients.

It is certainly not a new thought to suggest that the beginnings of good clinical anesthesia are concerned with the skills of the anesthesiologist. It is also not new to point out that the best anesthesiologist is first a good physician before he is a competent specialist. Since the planning of anesthesia starts with the understanding of the nature of the surgical operation, the anesthesiologist must have a clear picture of the plan of attack of the surgical team in the specific problem at hand.

Secondly, consideration is given to the deviations from normal physiological activity of the patient who is to be subjected to an operation. The anesthesiologist must know as much as can be known about the health and organ function of the patient. He is also responsible for a thorough knowledge of the effects of anesthetic drugs which will be administered.

Before selecting the anesthetic agent or method, much must be learned about the patient himself as a person. This type of information can be gathered, not only from the history acquired by the patient's physician or surgeon, but by a sensible and searching interview prior to the administration of anesthesia. Frequently a surgical patient is more fearful and more concerned about his anesthetic experience than he is about the operation itself. By the time he is admitted to the hospital, the patient usually accepts the need for the removal of a pathological organ or for the alterations of physiological activity by surgical attack. It is usually within the hospital that he begins to consider seriously what will happen to him in the process of securing pain relief, loss of consciousness or other forms of anesthesia. It has become evident that such disturbing thoughts occur to surgical patients and that a good answer for these anxieties is the provision of information with sympathetic understanding about the anesthetic experience immediately ahead.

It has been poor practice, in our experience, to attempt to deceive the patient with the simple statement that all will be well. Such flamboyant optimism may be satisfactory for some patients, but by and large, most expect and deserve a more effective and a closer relationship with the anesthesiologist. On the basis, then, of the evaluation of the surgical requirements, the medical situation, and the personality of the patient, it is possible to select a method of anesthesia in most instances that will provide good working conditions for the surgeon, a minimum of harm to the patient, and on the whole a not unpleasant experience for the most important member of the operating team, the patient.

Although it is manifestly impossible to blueprint a good method of clinical anesthesia for all circumstances, it is feasible to consider in the actual administration of anesthesia the twin aspects of technical proficiency and clinical and scientific judgment in terms of a few of the common problems encountered in the operating room.

The intact function of respiration is a basic axiom in the performance of all good clinical anesthesia. The maintenance of normal respiration in the surgical patient is a primary goal. The reasons must be obvious. This is the only method available for the oxygenation of the tissues of the body and for the elimination of carbon dioxide. With inhalation anesthesia, it is the portal of entry for the agent which is to provide comfort for the patient and a satisfactory working arrangement for the surgeon. Unfortunately, almost all anesthetic agents produce changes in respiration. Many are central depressants, which can, if manipulated either improperly or in a circumstance not ideally suited to their use, produce harmful changes associated with either deficient oxygenation, carbon dioxide accumulation or both. These effects are observed not only with inhalation anesthesia, but also with intravenous anesthesia, with the use of premedicant drugs, with spinal anesthesia and, in certain circumstances, with other forms of regional or local anesthesia. The anesthesiologist is concerned with maintaining adequate oxygenation and eliminating carbon dioxide. The first of these requirements is apparent and needs no further elaboration. The role of carbon dioxide accumulation bears further comment. It has been well known that retention of carbon dioxide is a possible cause of convulsions, hypertension and tachycardia.[5] In recent studies the role of carbon dioxide has been appreciated further. In an incredibly short few minutes the deficient elimination of carbon dioxide can produce an acidosis of great enough magnitude to overcome the buffering effects of the blood and plasma to the point of producing significant reduction in arterial blood pH.[2] The full implications of such an acidosis are not known at the present time, but there is evidence to suggest that this is a possible underlying basis for the pro-

duction of circulatory catastrophe, renal damage and even cessation of the heart beat. It might appear that the problem is relatively easy to solve, but such is not the case. With the aid of assisted breathing techniques, the achievement of adequate oxygenation is not so difficult as the efficient elimination of carbon dioxide. Assisted or controlled breathing techniques may also precipitate undesirable circulatory effects in the form of reduction of cardiac output.[3] The competent anesthesiologist who is skillful technically and proficient in judgment and knowledge may avoid a good many of the situations which lead to respiratory acidosis and deficient oxygenation, but not all. It is in this sphere that further investigation is required to improve the management of poor risk patients beyond the best of skill and knowledge now available.

It is impossible to administer any form of clinical anesthesia that does not have the potentiality of a deleterious influence upon respiration. The good clinical anesthesiologist can minimize both the frequency and the severity of these changes.

The administration of anesthesia is intimately concerned with effects upon the circulation. These consist of the function of the heart with respect to mechanical activity and rhythmicity. There are also alterations in the maintenance of normal arterial pressure and normal perfusion of blood to the various organs, particularly the brain, the heart and the kidneys. There is much knowledge and also many gaps in our understanding of the circulatory effects of anesthetic agents and methods.

There is almost no anesthetic agent that under certain circumstances will not effect some changes in the circulation. Most of the potent inhalant agents, for example, cause an initial increase in cardiac output. Spinal anesthesia produces a reduction in cardiac output. We do not understand enough at the present time to know whether or not these changes are desirable. Our position is one of gathering the facts and trying to interpret them in the light of practical experience. It appears reasonable, however, to strive for as little change in cardiac activity from the normal as is possible. The maintenance of normality appears to be concerned, in part, with a gradual presentation of an anesthetic burden to the heart in preference to sudden changes in depths of anesthesia or flooding of the coronary circulation with anesthetic drugs.

Although it is true that irregularities of rate and rhythm are more commonly associated with halogenated drugs and with cyclopropane than with others, it is still possible to produce arrhythmias with any anesthetic agent if meticulous care is not exercised for the preservation of adequate oxygenation and freedom from respiratory acidosis. The alterations in arterial pressure are found in either direction and with all the drugs. Unfortunately, much remains to be learned about the nature of the circulatory responses to anesthesia. However, much can be done in the administration of anesthesia with the knowledge now available. The treatment of changes in arterial pressure requires some understanding of the mechanisms involved. Falls in blood pressure may be concerned with blood loss or shock or trauma. These must be corrected by the anesthesiologist with whole blood or with plasma expanders. Changes in arterial tension are frequently associated with visceral manipulations. These can be corrected by blocking the nervous pathways which mediate such "traction reflexes" or by the administration of suitable drugs which will elevate peripheral resistance in the vascular bed. It is a common clinical error to inject a compound like epinephrine or nor-epinephrine to increase peripheral resistance and raise arterial pressure in the presence of anesthetic agents like cyclopropane. This combination can produce a serious cardiac arrhythmia, even to the point of ventricular fibrillation. Neosynephrine and ephedrine are safer and equally effective.

Another problem of importance in the provision of good clinical anesthesia is the maintenance of the function of vital but "silent" organs. Renal function is perhaps of primary consideration in this connection. The renal circulation carries approximately one-third of the cardiac output. Furthermore, the kidney is intimately concerned with the maintenance of normal acid base and fluid balance. Despite these extensive activities, the kidney does not provide signs or symptoms of abnormal behavior in a gross sense during a surgical procedure. It is of the greatest importance, therefore, to understand that anesthetic agents and methods have a significant effect upon renal activity both in its filtration and reabsorption functions and in its role in the circulation.

Most anesthetic agents that produce loss of consciousness, however administered, have a profound and sudden effect upon renal activity. It has been shown that the role of the kidney as a circulatory organ is considerably impaired.[4] A significant reduction in blood flow occurs to the kidney during all forms of general anesthesia. The kidney's ability to filter and its normal pattern of reabsorption are also considerably changed under the influence of anesthetic agents. Unfortunately, this response of the kidney appears to be a stereotyped one to most anesthetic agents and methods. The influence these effects produce on subsequent satisfactory recovery from anesthesia and operation must be considerable. The conduct of good clinical anesthesia involves the knowledge that such changes do occur and the avoidance of technical errors which may produce a further burden upon a functionally damaged kidney in the presence of surgical anesthesia.

These illustrations of physiological changes which must be considered in the carrying out of good clinical anesthesia are described for one major purpose. It is necessary to realize that such changes in physiological activity do occur, that they may be of great magnitude and that present knowledge directed toward their control is limited. It is necessary, in order to reduce these physiological penalties, that the administration of anesthesia include technical skill and the best possible understanding of the effects produced upon body function. The requirement, therefore, is that the skillful anesthesiologist and his associates have a healthy respect for the work of the hands and an appreciation of the work of the brain. Improvements in good clinical anesthesia, as in other branches of medicine, will come from the laboratories and from the careful and intelligent gathering of clinical experience which can be transferred to problems in the future. These aims may be summarized in the same manner as the goal of any science. Bacon put it this way: ". . . we seek the history of nature constrained and vexed, that is to say of nature thrust from her original state mastered and modified by the art and agency of man."[1] This is the future of anesthesiology as well as the other sciences. It is the wisdom that is concerned with the mastery of the effects of drugs upon the body of man. It is not pessimistic to look upon this development as one that can never achieve complete control and complete understanding.

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MSMS

FEDERAL, STATE MEDICAL STOCKPILES MAY EXCEED $80 MILLION BY MID-YEAR

Latest Civil Defense Administration figures indicate total federal and state stockpiles of medical supplies on hand or on order by July 1 may amount to $80.5 million. Of this, CDA has committed nearly all of the $50 million voted by Congress for exclusively *federal regional stockpiles*. In addition, CDA already has given states $10.5 million which they in turn have matched on a 50-50 basis for *local supplies*. CDA has on hand about $9.5 million from the original matching fund appropriation which Congress has said may be used for the *federal* stockpile, provided it's committed by June 30.

CDA explains it has the $9.5 million left over because (a) five states containing critical target areas are not yet participating in the federal-state program, (b) market prices of some supplies have dropped, effecting savings, and (c) additional savings were achieved through simplification of specifications of some items. The states that did not join in the program by the March 15 deadline are Alabama, Georgia, Texas, Louisiana and Illinois.

Civil Defense Administrator Millard Caldwell, meanwhile, had informed Chairman Brien McMahon of Joint Committee on Atomic Energy that medical stockpiling is "unsatisfactory both in volume and quantities of supplies available." Caldwell estimates funds voted by Congress so far would provide enough supplies for only one week of emergency care for 2 million atomic bomb casualties.

For its fiscal 1953 program, CDA is asking Congress for $193 million for *federal* medical stockpiling. No matching funds for *local* stockpiling are requested for next year.

Then and Now

By Neal R. Moore, M.D.

Bay City, Michigan

TONIGHT marks the completion of the officially designated year of activity of our society. There is a custom among the Chinese, centuries old, that directs the head of the family to make periodic pilgrimages to the tomb of his forefathers; there, to sit for a time, in reflection, analyzing his accomplishments of the recent past and weighing the good thereof against the evil, contemplating the future and, in communion with the spirits of his ancestors praying for a continuance of their faith in him, and pledging to them renewed effort toward the doing of good and to the advancement of his ideals. It is in this spirit that I ask you to join me tonight—in reviewing the advances of the medical profession in the past fifty years, in bringing into focus for a moment of consideration some of the issues at hand that are presently unsolved, and to give thought to certain positive measures that will assure to us continuation of the present high standards of the practice of medicine.

The present-day physician, the doctor of medicine who has earned his income in 1951, lives and practices in a relative paradise. This paradise is of his own making, created by him with the aid of those organizations whose continued existence is dependent, wholly or in large part on the fact that he is a practicing physician. It is through the efforts of the medical profession and its allied services that the armamentarium of today's doctor is so vastly superior to that available to the man of medicine of even a half century ago. This fact I would emphasize. To better appreciate these advances, let us consider for a moment a few of the principles of practice, the procedures, and the technological facilities extant in the year 1901, and compare them with those existing today.

Pneumonia

In that earlier year, in the field of internal medicine the treatment of pneumonia was rational but entirely supportive. The patient was treated symptomatically until either his own body resistance overcame the infection or, the severity of it overwhelmed him and he died, usually in dramatic fashion. The mortality rate was appaling. The day of specific pharmacals had not yet dawned. The attending physician was saddened by the knowledge that the measures at hand to treat this disease were so pitifully few and inadequate.

Typhoid

Typhoid fever was rampant. Its incidence in sporadic and endemic proportions was accepted as a matter of course, inevitable. Each spring thaw meant that the children could be cut out of their winter underwear, that mother could think of planting the garden, and that father could pull on his short boots and begin plowing his untilled and untiled acres. But this season of the year also brought the dread of typhoid fever, of cholera morbus, of ptomaine poisoning, of milk fever and those other infections caused by contamination of the water, milk, and food supplies. The spring and summer were times of concern, or of terror depending on the incidence of these diseases. All hoped to escape the dread maladies but no one knew what measures to take to avoid them. Ignorance of even the simplest principles of water decontamination and food preservation lay at the bottom of this sad state of affairs and, even if there had been enlightenment in these matters, proper facilities to safeguard public health were not then available.

Diabetes

The mild diabetic of that time lived in apprehension. His prayer was that his affliction would not increase in severity since the only known measures of treatment were "alkalinization" and an unstandardized dietary regime. Scientific dietary control and insulin were not to appear upon the scene until two more decades had passed. The adult who suffered with severe diabetes could but resign himself to his certain fate and to hope that his tenure of life would be a bit longer than in the average case. Establishment of the diagnosis of diabetes in the child or young adult was accepted as a sentence of death.

Surgery

In the field of surgery, preoperative care, support of the patient during operation, and postoperative care were such that we of today would

The President's Address delivered at the annual meeting of The Bay County Medical Society, December 12, 1951.

consider them primitive, indeed. The average patient who faced operation first saw his lawyer to have his will drawn up, next saw his priest to have his spiritual affairs set in order and, then went to the hospital, resigned but hopeful. He frequently entered the institution on the morning of operation and, after having been relieved of his clothing was placed on a wheeled cart and taken, immediately, to surgery. And, so arrived, was, without further formality other than casual preparation of the operative site, started on his way to temporary oblivion. Open ether was the anaesthetic of choice with chloroform being administered if "piles" were to be removed with cautery or if an abscess cavity were to be "burned out." Other anaesthetic agents were either unknown or had had such limited use that they were not then accepted as being safe or reliable. The anesthetist would have viewed the standard gas inhalation apparatus of today with as much curiosity as would have any lay visitor to the surgery.

The anesthetist sat at the patient's head, in his street clothes, minus his coat and, sometimes, with his outer shirt removed, sans cap and mask. Traffic in the operating room was free and, usually, abundant. Referring physicians frequently wandered in, dressed in street attire, to either discuss with the surgeon some point regarding a case in which they were interested or, merely, to watch him operate. Such a visitor to that arena would have been mortally insulted if asked to don cap, mask, and gown before entering.

It was under these conditions, then, that the surgeon did his work. He operated swiftly and deftly—necessarily so because there was nothing available to support the patient during the operation. Intravenous fluids, immediate transfusions, and currently used drugs were unknown to him. His technique was limited by the then unavailability of electrocautery and electrosurgery, by poor lighting, by lack of suction and, in many instances, by the enforced use of primitive instruments. Surely, it is a tribute to the surgeon of that day that his work was of such high quality and that his mortality rate was as low as it was.

On completion of the operation the patient was taken directly to his room and placed in a preheated bed, the foot of which had been elevated in correct anticipation of his state of shock at that moment. Postoperative treatment was mainly anticipatory. Loss of fluids incurred during operation could not be combated until the patient had regained consciousness and was again able to swallow since, as has been stated, there were no intravenous fluids to maintain or to restore fluid balance. An additional three years were to pass before the patient was able to view the propped crutch at the foot of his bed that supported the Murphy drip container. On regaining consciousness, the pititful cries for water were answered by intermittent wetting of the lips with ice water, interspersed with occasional sips of chilled brandy. And, frequently, when the abdomen became distended in the days following surgery, turpentine stupes were applied—that is, of course, if the site of operation did not interfere. The rectal tube was used, freely. The patient did not know the benefits of or enjoy the relief afforded by the Levine and Miller-Abbott tubes and the Wangensteen apparatus. Such was the accepted and standard regime of treatment of the postoperative patient in the year 1901. Incidcnce of postoperative peritonitis was high. Treatment of this complication was simple since antibiotics were unknown and other measures in common usc today had not then been developed. It consisted of elevation of the head of the bed that there might be dependent drainage into the pelvis. Beyond this point treatment was limited to the fervent prayers of the relatives and of the surgeon. Mortality in postoperative peritonitis was about 60 per cent.

Gynecological operations were infrequently done, the doughnut pessary being relied on to keep the sufferer on her feet. The accepted principle seemed to be that it was far better to let mother live in a state of half invalidism than to expose her to the liklihood of prolonged morbidity or, even, the possibility of fatality, the two eventualities that all too frequently followed such elective procedures. The incidence of postoperative sloughing of perineal tissue was high and this was a deterring factor in performing operations on the female perineum.

Medical Research

Medical research was at a low ebb—not because of paucity of constructive thought but because the many factors named earlier negatcd efforts in this branch of medicine. The chief ones retarding progress in this field were inability to adequately combat shock and to control postoperative infection, lack of knowledge of proper methods of sterilization of milk, decontamination of water and preservation of foodstuffs, and unavailability of ade-

quate facilities for this type of endeavor. This led to a continuing sense of discouragement and futility. Many of the procedures and measures, standard today were brilliantly conceived before the turn of the century, but their practical application perforce awaited refinements that we accept as commonplace. Surmounting these major obstacles has resulted in the development of, among other things, the entire field of thoracic surgery, modern genito-urinary surgery, much of orthopedic surgery, total gastric resection, the combined abdominal-perineal operation, brain surgery, operative procedures in which metallic or other foreign material is placed in the patient's body, there to be retained permanently, and skin grafting in its present state of refinement.

Obstetrics

It appears that only in the field of obstetrics can a favorable comparison be made. The principles and practice accepted as standard in that earlier year are generally those prevailing today. Recognition of puerperal sepsis as an infection, an exact description of its clinical characteristics and mode of transmission, and an outline of measures necessary to prevent its occurrence and to control its course had been given to the profession in the nineteenth century by Doctor Oliver Wendell Holmes. And those principles that he had so clearly enunciated had been common practice in that specialty for many years. Obstetrical procedures which are routine now were likewise in common use in 1901. And the various forms of the obstetrical forceps were employed then, as now.

Economic Status

A brief review of the contrasting economic states of that day and this may be in order. At the dawn of the twentieth century, the annual cash income of the average physician was in the neighborhood of $3,500.00. And, while the purchasing power of the dollar was higher then, income was disproportionately less than that which we enjoy. The above-stated income did not truly represent the doctor's total income since he frequently accepted payment in kind for his services—hay and oats for the horse, cords of slabwood, garden produce and potatoes, a dressed hog or a quarter of beef, or even, services. This method of payment was considered proper because of the very real dollar shortage.

Also, it must be remembered that virtual guarantee of at least part-payment for services rendered was unheard of. A prepayment health insurance plan existed then, only in the mind of the visionary. This, to us, primitive economic state was not limited to the medical profession but involved all fields of human activity.

An additional adverse factor in the economic picture was the wholly inadequate transportation system. Highways that were poor, at best and nearly always impassable in the winter and spring months and the slow speed of the average "hay burner" reduced the doctor's working time per day, shamefully. Further waste of time and effort were occasioned by a poorly operating and sparsely distributed telephone network. One telephone per two city blocks and one telephone per square mile in the rural areas were the ratios of that time. The speaker can attest to the reality of the difficulties of transportation from his own personal experiences, on two occasions having helped unhitch the faithful horse after she had slipped and fallen while pulling a two-wheeled cart through the springtime morass of a country road, in the dead of night and, on three occasions having been unceremoniously dumped from a cutter that overturned in near zero weather on roads that had never seen and would not, for many more years, see a snow plow. May I hasten to state that on none of these occasions was I the physician but was merely the juvenile who accompanied his father, for companionship only. As may well be imagined, these untoward incidents were a bit time-consuming and certainly were not conducive to clear thinking and a pleasant outlook on life.

Who among us would feel at ease or even adequate to face the treatment of patients under these conditions? What man here would have the courage to ride miles to a farm home in a sleigh, there to perform a curettment or, possibly an appendectomy, with the patient lying on a kitchen table; or, to walk a mile or more over impassable roads to that same home to do a version, by lamplight, with only a teakettle of boiled water and Bichloride tablets to safeguard against childbed fever and with a half hysterical husband or a questionably clean neighboring housewife to administer chloroform anaesthesia? Would we be willing to go into practice under such circumstances knowing what we do now? Let us reflect for a moment on the blessings we enjoy today. Also, let us pause in tribute to those hardy souls who lived and prac-

ticed thusly but who were still able to face the future with determination and in the sustained hope of better things to come. Is there not somewhat of a parallel between the hardships endured by these men and those suffered by the apostle Paul, in his travels—"In weariness and in painfulness, in watchings often in hunger and in thirst, in fastings often, in cold and nakedness."

Notwithstanding these real and grave handicaps, a surprisingly high standard of practice was maintained. The reasons for this were twofold, one being the physician's slavish devotion to his patients, regardless of his own comforts or even welfare and the other, an inspiration arising from the conviction that he was standing on the threshold of a new period in the practice of medicine.

Medicine Today

From the above recital, it may be seen that we who are currently practicing medicine are doing so in a comparatively golden era. Let us now ask ourselves how we have arrived at this happy state of affairs, how these improved conditions have been brought about.

Of those factors operating to effect this change, I would name first, the improved economic status of the country, as a whole. This has resulted in the development of valuable technological aids and in vastly improved communications systems and transportation facilities; second, increasing public education, whereby detailed knowledge of medical precepts has been more widely disseminated and, hence better understood and more generally accepted; and, last and most important, that driving force within the medical profession itself that has not only vigorously rejected maintenance of the *status quo* but has inspired, encouraged, and even urged its members to broader and more forward thinking; and has continually goaded its ancillary services to the study of problems that, at first hand appear to have no plausable solution and, later, to demand of those services rational solutions for them.

Organized medicine has provided the individual physician rich opportunities to improve his talents and to advance his medical knowledge through refresher courses, panel discussions, scientific meetings, supervised residencies and other forms of regulated postgraduate training. Organization of the several colleges and of the academies in various specialties has proven a powerful stimulus to deeper broader thinking. The activity of these groups has resulted in much good through the interchange of progressive thought, the establishment of higher standards of practice and through wider knowledge of detailed phases of a particular specialty, gained by study of particular problems of that specialty by members designated to make such study.

Before passing on to other considerations, I feel a few additional remarks should be made regarding the role that education of the public has played in bringing about the general advancement of medicine. In the preface to his book, "Understandable Psychology," Leland E. Hinsie has pointed out the benefits to be derived from some degree of pre-knowledge by the patient. Quoting from this preface:

> "The practice of medicine is the partnership between the person seeking information and the physician, qualified by training and experience, who gives it. Years ago the patient aware only of his distress and having no knowledge of the possible meaning of it, stood by mutely, while the physician examined and treated him. Moreover the former seldom imparted any information about the disease to the patient. While this relation remained thus, neither gained as much as could have come out of the situation had each given freely to the other.
>
> "Today the situation is quite different because the value of co-operation is well established. People know more about medicine in the first place, because much more is known in general, but particularly because what is known is made available to people as facts to be acted upon in the interest of health, not as mere intellectual acquisitions. In the practice of medicine, the patient is the central figure, not only because he or she is ill, but also because he or she is the first one to become aware of the earliest signs of disorder."

The thoughts expressed in the above quotation reveal a healthy attitude toward public enlightment on the part of the modern practitioner. They also reveal the extent to which the public has become educated in matters medical.

These, then, are the influences that have operated throughout the past fifty years to enable us to enjoy the present excellent state of the practice of medicine. And, for the beneficent effect of these influences we stand eternally grateful.

The presentation just made, within the scope of the limited ability of the speaker to do so has outlined the conditions prevailing in the practice of medicine in the year 1901 and contrasted them with those under which we practice today; and, has given a brief explanation of the forces that

have brought about the significant changes recorded in the profession in the past fifty years.

However, in spite of the excellent facilities we enjoy, the ease and comfort in which we practice and the broadened concepts in force today, let all be sobered by the realization that there is much left undone, that many fields remain unexplored in the profession. Those who have gone before builded well. They opened new vistas to us. They broadened our horizons. Truly, they have given us a noble heritage. It is for us, then to be inspired to continue their search for greater truths. Who can deny the challenge that lies in the unsolved mysteries of malignancies, the virus infections, blood dyscrasias and in the host of other obscure, little understood diseases. Surely, such are an inspiration to forward thinking, to a broader vision, to determination to make some effort toward progress in medicine. A sense of self-assurance and complacency is a harbinger of retrogression, of a state of degeneration. It has been well said that where there is no vision, the people perish.

It is felt that this paper would not be complete or have served its best purpose if it did not bring into the limelight for a moment a few of the vital issues that face us today and for which there have not yet been provided satisfactory solutions. And, to make recommendations for certain positive actions that may lead to further advances in our chosen profession. The unresolved issues I shall name and the recommendations I shall make are based on personal observations, inquiries, and on expressed, unsolicited opinions of many fellow practitioners, both locally and throughout the state. In order of importance I would name first, the patient-doctor relationship; then, the threat of governmental intrusion into those rights and privileges now enjoyed by the doctor of medicine; and, finally, the double standard of the practice of medicine in this state.

Patient-Physician Relationship

In various quarters, some lay and some professional, positive opinions have been expressed concerning the current relationship that exists between the patient and his physician. From these opinions the definite impression is gained that there is a disturbance in that relationship as we have known it for many years. It is felt that this change is not great and certainly not universal, but its occurrence is too widespread to be ignored. The underlying cause of this imbalance is a bit difficult to determine—many factors seem to have had a hand in bringing about the change. Among these are the impact of the recent war on many of us who were exposed to a necessarily socialistic type of practice for from three to five years, an increasing desire to seek further knowledge and training in one specific branch of medicine, rather than to continue on in general practice or, in other words, the growing trend toward specialization, and a certain sense of futility, engendered by the existing chaotic economic state and by a mounting tax rate that threatens to reach confiscatory levels. Which one of these is predominant as a causative factor is immaterial. The fact remains that, in response to the influence of one or more of them the patient, as an entity, has been placed in a shadow; that he is being regarded less as a fellow human being who is agitated in spirit whether he be physically or mentally ill than as a clinical condition; to be treated intelligently and to the full satisfaction of a normal conscience and, then, sent on his way, forgotten. However, the consensus is that this relationship is improving, not degenerating; that the pendulum has passed its extreme and is returning toward normal, and that soon, there will again be the happy blending of "The Old Humanities and The New Science."

Again, quoting from the preface to Dr. Hinsie's book:

> "The patient is the central figure in the practice of medicine because he or she constitutes the only reason for the existence of the physician."

It is for us, then to enhance this most human bond between us, the physician on the one hand and that other being, the patient, on the other. We must strive to keep uppermost in our minds an awareness of the real soul agony of the patient during his illness and to instill in him the certain knowledge that we are not only his personal physician but his friend, as well.

Threat of Governmental Intrusion

Little need be said of the seriousness of this menace, of the danger inherent in the continuing and increasing pressure to take away from us the privilege to practice medicine, within the bounds of conscience, unfettered by stifling ukase. Several years ago I was privileged to read a copy of a resolution introduced into the United States Senate by the then senator from Illinois, J. Ham Lewis. The first paragraph proposed that all phy-

sicians in the United States be made federal officers and be placed under direct governmental control. "Thus ended the reading of the word." That was all I could take. Needless to say, that bill was not enacted into law. However, in the ensuing years many resolutions and bills of similar intent—subjugation of the doctor of medicine, have been introduced and all have failed of passage. But who can tell when, by some evil chance one may slip through the legislature and become the law of the land.

I would urge, therefore, that we take a more personal interest in this question. I would urge that it be included in our daily thoughts and be discussed freely and factually with those with whom we converse. It is only by this method, augmented by the concerted efforts of organized medicine that this specter of socialism can be driven into oblivion. We must be unremitting in our efforts, explaining to all who would listen the deadly significance of this evil plan of compulsory health insurance. For this is the entering wedge of socialism, this the cornerstone of the socialistic state. This is the rock that either we smash or upon which we shall be broken. Ours is the responsibility to stay strong and to lead the fight; if we fail, all is lost. How infinitely better to press the issue with a militant attitude, and to at least hold our own than to be passive and, then, when the deluge will have come to say as did the king in his garden, "God be merciful to me, a fool."

Double Standards of Practice

The third issue I would call to your attention is the double standard of the practice of medicine in the state of Michigan. This is an issue wholly unresolved; an issue that demands prompt decisive action to effect a satisfactory solution. And I urge that appropriate action be taken in the immediate future.

My remarks on this question will be brief and, I trust, to the point. I challenge all within the sound of my voice, or anyone in this state, of good faith and capable of intelligent thought to justify or even rationalize the existence and continued functioning of two separate and distinct boards of licensure, each empowered, in effect, to grant the privilege of practicing medicine and surgery in this state. How ridiculous! How incongruous! What a travesty on common sense and reason! The situation might even be ludicrous, were it not for the fact that the unsuspecting patient is the victim.

Gentlemen, whosover undertakes to treat the physical and mental ills of mankind is, in fact, practicing medicine. And the practice of medicine is an indivisible whole, a single entity, incapable of being broken down into parts or phases. It has but a single standard. It is not a set of parallel or collateral practices, and to so regard it means that the patient who is the only excuse for its existence suffers.

Therefore, let me again urge that we abolish the superfluous board that the above truth may be brought into its full realization. With these remarks I close my tenure of office. To those who have served with me, my heartfelt thanks for work well done. To my successor a hearty wish for an even better year than that presently past. My sentiments on stepping down are best expressed in the words of Kipling's "Galley Slave"—

> And tonight I leave the galley,
> And another takes my place,
> There's my name upon the deck beam,
> Let it stand a little space.
>
> And tonight I leave the galley,
> Shall I curse her service then,
> God be thanked, whate'er comes after,
> I have lived and toiled with men.

MSMS

NEW PAMPHLET ON COST OF SICKNESS

To create a better understanding of one of the major causes of patient-doctor misunderstanding—the cost of illness—a new pamphlet has been designed for public distribution. Entitled "Your Money's Worth in Health," the booklet stresses the various aspects of patients' medical bills and the cost of illness in relation to the national income. The pamphlet shows graphically that the cost of illness has not risen as much or as rapidly as other consumer goods. This illustrated eight-page pamphlet soon will be made available to AMA members and medical societies for distribution to the general public.

* * *

AMA EDUCATION FOUNDATION

Dr. Donald G. Anderson, secretary of the council, reports that contributions to the American Medical Education Foundation are gaining in momentum. During 1951, contributions totaling $745,000 were received from 1,811 individual physicians, thirty-three organizations and thirty-three lay friends of the medical profession.

Vertigo

Diagnosis and Treatment

By J. Lewis Dill, M.D.

Detroit, Michigan

THE TERM "vertigo" may be defined as a subjective sensation of rotational or linear movement or displacement of oneself in relation to environment, or of external objects in relation to the individual. The word "dizziness" has a different meaning for different people, but the sensation can be more correctly described in such terms as "light-headedness, giddiness, faintness, unsteadiness, confusion" or even as "specks before the eyes." The two words "vertigo" and "dizziness" are often used synonymously, but this is of little actual importance when the physician correctly understands and interprets the symptoms and their significance. It is difficult for the average patient to clearly describe symptomatology, and as difficult, at times, for the physician to establish the diagnosis, since the vertigo may be so mild as to be scarcely noticeable or again so severe as to incapacitate the patient. The physician might use as a standard of comparison in these varying degrees of vertigo the recollection of his own sensations when as a child he whirled around and around and said he was "dizzy." But whatever the degree of dizziness the physician should take the time, as well as have the knowledge, to clearly and carefully evaluate each case.

Various ophthalmological conditions may occasionally produce vertigo. In this category, muscle imbalance, which usually produces very mild symptoms, is the most frequent in occurrence. In neurological conditions producing vertigo the lesion is most frequently centered in the brain stem in the form of abscess, tumor, various vascular conditions associated with hypertension and arteriosclerosis, as well as posttraumatic changes. It is usual for lesions of the central nervous system to have other signs and symptoms associated with the vertigo. That of central origin is usually not severe, is often positional and generally transient.

In the majority of cases the inner ear or labyrinth is the site of origin and this labyrinthine or peripheral vertigo is usually severe with associated auditory phenomena of tinnitus and deafness. A regular, horizontal nystagmus is present and the "whirling" sensation is accompanied by nausea or vomiting.

The peripheral origin must be investigated, but one must not assume that the ear is responsible for all the vertigo. This vertigo may be produced by:

1. labyrinthitis associated with acute or chronic disease of the ear or mastoid
2. labyrinthine irritation or toxic labyrinthitis due to drugs, infection or allergy
3. Ménière's disease
4. tumors of the 8th or acoustic nerve
5. fractures involving the temporal bone
6. concussion of the ear
7. cases of sudden vertigo and deafness of uncertain origin, including possible vascular spasm

Keeping these causes in mind, a careful detailed history and thorough physical examination are essential when proceeding with the diagnosis and treatment. In taking the history, special note should be made of the outline of the attack, its duration, the frequency and pattern of recurrence, and if any, the accompanying symptoms. Specific questions should be asked regarding postural vertigo, headaches, tinnitus, deafness, gastrointestinal disturbances and dietary and other habits. Labeling the patient with vertigo as a psychoneurotic is a common tendency, but while the functional element may be present either as a cause or as an adjunct of the vertigo, one must not assume that because of it vertigo is solely of neuropsychiatric origin.

As soon as it is decided that the patient does have a true vertigo, one must look for the cause. Physical examination must be complete. Special tests and laboratory studies must be run as indicated. It may be necessary to later have consultations with neurologist, otologist or psychiatrist.

In doing a thorough neurological examination one must include study of the function of all the cranial nerves, examination of eyegrounds for papilledema and vascular changes, and notation of eye movement. If nystagmus is present its character, duration and direction should be noted. When a lesion of the central nervous system is suspected the neurologist may determine the site of the lesion and further evaluate it.

The ear, nose and throat examination should determine the presence or absence of infection of

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the ear or mastoid, with x-rays to substantiate the findings. A hearing test, with tuning fork, is a valuable aid and should include both air and bone conduction and a comparison of the hearing in both ears. Infection of the nose and sinuses should be eliminated and the nasopharynx inspected for disease involving the eustachian tubes. A caloric test should be done. In this the patient is asked to describe his symptoms and to compare these thus produced with those of his complaint. Tests for positional vertigo should complete the examination. If it is felt the ear is the site of the vertigo an evaluation by a competent otologist is indicated to substantiate the diagnosis.

In the majority of patients the cause of the vertigo will be determined. However, there will be a percentage of cases in which it is not. Repeated examinations will be of value if the generally overlooked conditions of recent but mild upper respiratory infection, possible influenza, a mild gall bladder disease, fluctuating blood pressure or food allergy are kept in mind as a possible cause.

The treatment must first control the attack and secondly remove when possible the cause. Reassurance must be given to all patients, many of whom fear the onset of cerebral hemorrhage or that their symptoms are the initial warning of brain tumor. Symptomatic treatment must be given to all patients; in the severe cases to control the severe symptoms until a complete examination and diagnosis may be made, in the mild cases as a palliative, and in surgical cases until surgery can be undertaken.

Rest in bed with sedation such as sodium phenobarbital by hypo, gr 2 to gr 4 i.m. is indicated. Dramamine in doses of 50 to 100 mgm q.4.h. may help control the vertigo. If vomiting persists an intravenous injection of 500 to 1,000 cc. of 5 per cent glucose can be given.

When severe, prostrating vertigo is present a quick examination to elicit its cause if possible, admission to the hospital, and a slow intravenous injection of histamine is recommended. The vertigo of central origin frequently requires surgery. Central vertigo due to hypertension requires reassurance and mild sedation with control of the blood pressure, but in many cases the therapy is often unsatisfactory.

Specific therapy can be given in many cases. In otitis media, a paracentesis of the ear drum and administration of antibiotics will relieve the vertigo. In chronic otitis media and mastoiditis vertigo is a dangerous symptom. A radical mastoid operation here is necessary. Vertigo is a late symptom of an eighth nerve tumor and treatment requires surgery. In concussion of the ear and fracture of the temporal bone expectant treatment, mild sedation and rest are indicated. Psychotherapy, of course, is indicated in all cases of functional vertigo.

Ménière's disease is due to a hydrops of the labyrinth or an increase of the fluid endolymph within the ear. True Ménière's disease must not be confused with those Ménière-like symptoms which are often as confusing. The treatment of true Ménière's disease is primarily medical, surgery being reserved for those patients who fail to respond. The low sodium salt diet of Furstenberg may be tried, but I personally prefer intravenous histamine treatment which has given relief in practically all our cases after three to six daily injections. The treatment as indicated by Horton is the slow drip method of intravenous injection of 2.75 mgm of histamine diphosphate in 250 cc. of 5 per cent glucose, commencing at the rate of about 10 drops per minute, increasing as tolerated. This may be followed by hypodermic histamine injections in small doses to maintain the desensitization. Nicotinic acid, in doses of 50 to 100 mgm t.i.d. may also produce relief.

Summary

Vertigo is a complex symptom of multiple possible origins. That of labyrinthine origin is usually severe, generally associated with deafness and with tinnitus. That of central origin is generally more mild, is positional and usually has associated signs of a central lesion. Toxic vertigo or dizziness may be due to systemic disease, metabolic disorders, drugs or be of psychogenic origin.

The primary point in the diagnosis of vertigo is the determination of the patient's definition of his symptoms of "dizziness." Complete physical examination, a thorough ear, nose and throat examination, and evaluation of the auditory and labyrinthine functions are necessary before the final diagnosis may be made.

The few cases in which the cause cannot be determined may be relieved by symptomatic treatment. Certain specific treatment is helpful in the majority of cases, and the therapy may be medical or surgical.

Headaches

Etiology and Treatment

By Russell N. DeJong, M.D.
Ann Arbor, Michigan

A HEADACHE, like any other pain, is a symptom and not a disease. Consequently, the diagnosis and attempts at treatment of a headache, as such, are not sufficient. The physician, if possible, must diagnose the type and etiology before attempting to institute therapy. The presence of a headache, especially if severe or frequent, should always warrant a complete investigation of the patient, by both history and examination, in order to recognize or exclude one or another of the possible serious causes.

A headache is said to be one of the most common ills to which the human race is heir. It is one of the most frequent presenting complaints of patients who seek medical help, not only from the neurologist, but also from the ophthalmologist, otolaryngologist, gynecologist and other specialists, and especially from the general practitioner of medicine. The symptom may be of minor significance in many instances, but it also may be the first symptom of a grave organic disease; it may be of either organic or psychogenic origin.

Anatomy and Physiology

In order to understand why and how headaches occur, it is of value to review briefly the anatomic and physiologic backgrounds of head pain, including the mode of production and the structures involved.[8,19,21] The scalp, galea aponeurotica, fasciae and muscles of the head are all sensitive to painful stimulation such as cutting, crushing and tension. The periosteum of the skull is sensitive only low in the temporal, frontal and occipital regions. The cranial bones, including the diploe, are insensitive. The extracranial arteries are very sensitive, especially to distention and especially in their larger divisions, and the pain is referred to the region of distribution of the artery. The extracranial veins are only slightly sensitive. Of the meninges, the dura over the cortex is insensitive except along the sinuses and arteries. The basal dura, however, is extremely sensitive; if that of the anterior fossa is involved, the pain is referred to the homolateral eye, and affection of that in the posterior fossa causes pain to be referred to the homolateral ear. The falx is sensitive only along the margin of the superior longitudinal sinus. Traction on or distention of the dural sinuses causes severe pain; this is referred to the vertex if the superior longitudinal sinus is involved and to the eye or ear if the transverse sinus is affected.

The pia and arachnoid are insensitive, as are the cortex and parenchyma of the brain. Of the intracranial vessels, the cerebral veins are sensitive only to traction. The vessels of the pia and arachnoid are insensitive. The intracranial arteries, however, are extremely sensitive to pressure and trauma. The choroid plexus and walls of the ventricles do not react to stimulation, but distention of the ventricles, if followed by severe pain. Distention of the lateral ventricles causes pain which is referred to the frontal area, and distention of the third ventricle causes generalized pain. In summary then, the skull, dura and brain are insensitive except for the dura along the base and the dural sinuses. The vessels are sensitive to pain, especially the extracranial and intracranial arteries. The scalp and its muscles are pain-sensitive.

Dr. Harold Wolff and his co-workers, through detailed experimental studies, have summarized six basic mechanisms for headaches. These are as follows: (1) traction on or displacement of the venous sinuses or their contributing veins; (2) traction on the middle meningeal artery; (3) traction on the large arteries at the base of the brain and their main branches; (4) distention or dilatation of the intracranial arteries (both extracerebral and intracerebral); (5) inflammation in or about any of the pain-sensitive structures of the head: the muscles, tendons, fasciae and basal dura; (6) direct pressure, as by tumors, on the cranial or cervical nerves carrying pain afferent fibers from the head. Traction, distention, displacement or inflammation of the cranial vascular structures is chiefly responsible for intracranial pain, and involvement of the muscles, tendons and fasciae, or direct affection of the sensory nerves, for extracranial pain. Almost all, if not all, causes of headache can be explained by one of the above mechanisms.

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History and Description

An adequate history and description of the headache is essential to diagnosis. Patients often think that they have given sufficient information if they merely mention the symptom, but an accurate characterization of the headache is necessary. It is important to recall that a headache is a pain and therefore it is entirely subjective, and one must rely upon the patient's description of the pain in order to arrive at a diagnosis. The following features of the pain should be considered.[3,22]

1. *Localization and Paths of Radiation.*—The pain may be frontal, vertical, occipital or temporal; it may be unilateral or bilateral, or localized or diffuse. In *migraine* the pain is most frequently of the hemicranial type, starting in the supraorbital area and radiating back to the occiput on the same side. It may vary from side to side in attacks, and occasionally is bilateral. The headache in *sinus disease* is frequently in the frontal area or behind the eyes. The headache of *ocular disease* is either frontal or occipital. In *brain tumors, brain abscesses* and *ear disease* the pain is often unilateral. In *uremia,* it may be frontal or occipital. The pain associated with *myalgia of the muscles of the neck and cervical arthritis and fibrositis* is in the occipital region, radiating to the temporal areas bilaterally. *Psychogenic headaches* may be in this same location, or they may vary in site or type. Frequently, they are band-like in distribution, or may be characterized by a pressure sensation at the vertex.

2. *Character of the Pain.*—It may be steady, paroxysmal, or intermittent; dull, throbbing or boring; or sharp or laciniating.

3. *Intensity of the Pain.*—This is often difficult to evaluate. The physician must depend largely upon his interpretation of the patient's reaction to pain. Some individuals may complain bitterly of a pain that to others may be minor in significance. One can often get some clue regarding the intensity by inquiring whether the pain interferes with work or sleep, and whether it incapacitates the patient for his routine duties. It is often of value to determine whether it interferes with pleasurable activities as well as with work.

3. *Incidence, Mode of Onset, Duration and Frequency.*—Here one inquires about the periodicity of occurrence, time interval during the day or month, seasonal factors, and the relationship to food, movement, exercise, position, coughing, mental effort, use of the eyes, temporal or jugular compression, rest and sleep, emotional stress and strain, or changes in mood. Migrainous headaches are often noted on arising in the morning, or may come on at periods of stress or strain. Other causes of morning headaches may be poor ventilation, the presence of fumes in the room, sensitivity to feathers, and slight degrees of astigmatism or hypermetropia. Headaches that occur early in the morning and awaken the patient are often due to organic disease of the brain or meninges. This is especially true of so-called hypertensive headaches which frequently awaken the patient early in the morning and leave shortly after he arises. Persistent morning headaches may be due to nephritis. Headaches that come on in the evening are often due to mental overwork, fatigue and eyestrain. The *mode of cessation* is also important. The headache may cease gradually or abruptly; it may be relieved by rest in a dark room, a frequent manifestation of migraine. Hypertensive headaches are relieved with activity. Headaches on toxic and febrile bases are often relieved by rest. Response to therapeutic measures may be a valuable diagnostic aid.

4. *Localized Tenderness.*—In sinus disease, there is often tenderness to pressure over the paranasal sinuses; in brain tumors and subdural hematomas there may be localized tenderness on the side of the lesion. In the so-called clavus hystericus, there are localized areas of tenderness within the scalp. These may be so acute that even movements of the hair may cause the pain.

5. *Associated Phenomena.*—Nausea, vomiting, and other gastrointerestinal symptoms are often found in migraine. On the other hand, vomiting also occurs in headaches due to increased intracranial pressure, but here the vomiting is often precipitate or projectile and not associated with nausea. Ocular manifestations such as burning of the eyes, smarting of the eyes, photophobia, diplopia, hemianopia, blurred vision, or sleepiness or fatigue with the use of the eyes may be of significance. The burning and fatigue on use of the eyes might indicate ocular origin of headaches. Diplopia, photophobia, hemianopia, hyperacusis and hyperosomia may be present during migrainous attacks. Photophobia is also an early symptom

in meningitis. In vascular disease and organic brain disease there may be vertigo, syncope, lowering of consciousness, confusion, aphasia, paralyses and paraesthesias. With headaches due to increased intracranial pressure, or due to toxic or febrile causes, there may be drowsiness and confusion which may terminate in convulsions and coma. In infectious processes, there is fever with elevation of the pulse and respiratory rates, while in headaches due to increased intracranial pressure there may be a bradycardia and decreased respiratory rate. In meningeal irritation and subarachnoid bleeding, there is marked stiffness of the neck. In arteriosclerosis and hypertension, there may be vertigo and tinnitus. In allergic headaches there may be vasomotor changes with lacrimation and flushing.

The history should always be followed by a thorough examination of the patient. A complete physical evaluation, of course, should be carried out to eliminate any systemic cause for the symptoms. A neurologic examination is necessary. In many instances, examination of the eyes, paranasal sinuses and ears is essential. Allergy studies may be of value. Auxiliary examinations, such as biochemical tests, skull roentgenograms, basal metabolic rate determination, blood and urine studies, or spinal puncture, may be necessary. On occasions, special diagnostic procedures, such as electroencephalography and pneumoencephalography, may be indicated. Sometimes the diagnosis can be made by provocation of the headache by means of histamine or other vasodilators, or therapeutic tests with ergotamine tartrate or epinephrine.

Differential Diagnosis

In discussing the differential diagnosis of headaches, one may classify them into three groups: the acute, the occasional, and the chronic, periodic or recurrent headaches. In the first group, the diagnosis is usually not too difficult, and, of course, treatment follows determination of cause. *Acute headaches* are frequently associated with febrile diseases such as typhoid, pneumonia or malaria. They may occur with exposure to toxins, or with acute ear or sinus disease. They may be present in uremia, in grave illnesses such as meningitis, and with cerebral or subarachnoid hemorrhage. *Occasional headaches* may be associated with excessive fatigue, unusual eye strain, or may be emotionally precipitated by tension, mental overactivity, emotional strain, worry, anger, excitement, frustration, or resentment. They are sometimes brought on by excessive eating, excessive drinking, omission of meals, or lack of sleep; in fact, they may be precipitated by either organic or psychologic variations from the normal life routine. Also in this group we should probably include the not unusual hangover headaches and spinal puncture, post-convulsion, and acute post-traumatic headaches. These are all relatively simple, as far as diagnosis is concerned. Some respond to the usual analgesics, but for others more prolonged therapy is necessary.

The headaches that present the major problem in regard to both diagnosis and treatment are the *recurrent, periodic* and *chronic headaches.* It is in these that we are obliged to carry out complete diagnostic studies. One must always bear in mind that even though brain tumor is not one of the common causes of headaches, many patients with chronic, undiagnosed headache seek help because they have either a conscious or unconscious fear that they may have such a lesion, and it may be of value to carry out certain additional diagnostic studies which the physician, himself, may not think entirely necessary, just to help to reassure the patient that such a lesion is not present.

In a complete discussion of the etiology and treatment of headaches, one should include those of ocular origin; those associated with diseases of the ears, nose, throat and paranasal sinuses; those of allergic origin; and those associated with toxins, infections, systemic disease, hypoglycemia, temporal arteritis, diseases of the cervical spine and muscles, intracranial lesions, and endocrine or metabolic disturbances, among others. In this large group, however, specific treatment must be directed toward the primary etiologic factor, and the headaches, themselves, are treated symptomatically with analgesics. In the present discussion, however, I would like to concentrate on a few of the most common causes of chronic and recurrent headaches. It has been found from a review of large groups of patients that the most frequent causes for chronic and recurring headaches are migraine and atypical migrainous syndromes, hypertension and other vascular diseases, trauma and the posttraumatic state, and psychogenic disorders. These will be discussed individually.

Migraine

A migraine headache is a specific type of recurrent headache which occurs in individuals who are otherwise well. It is oftentimes severe and

incapacitating, and may last from half an hour to three or four days. It has been estimated that 5 per cent of the population are subject to this type of cephalalgia. It occurs in both sexes, although two to three times as frequently in women as in men, and in women the attacks frequently occur at the time of the menstrual periods, and may be absent during pregnancy and after the menopause.

The headache is dull, throbbing or piercing in type, and is frequently restricted to one half of the head. It often starts over one eye and radiates backward, although it may start at the back of the head and proceed forward. It may alternate from side to side in attacks. There is frequently a family history of migraine. The attacks are often accompanied by visual symptoms such as scotomas, blurred vision, or even hemianopia, and by gastrointestinal manifestations such as nausea, vomiting or anorexia. The individual attack may be preceded by an aura characterized by drowsiness, depression, a feeling of exhaustion, nervousness or irritability. Other accompaniments such as vasomotor changes, paresthesias, or even pareses have been described. It is known at the present time that a migraine headache is a vascular phenomenon, and the pain itself is caused by dilatation of certain extracranial arteries, especially the branches of the external carotid. The dilatation may be preceded by spasm, which accounts for the preceding visual phenomena.

Various etiologic factors have been hypothesized, and it is known the allergic, endocrine and metabolic changes may be at the basis of a certain percentage of migraine, but the individual attacks are in most instances precipitated by psychologic factors. It has been found that the patient who is subject to migraine has certain personality characteristics. The attacks, while they may occur in individuals of all walks of life, are more frequent in the "thinkers" than in the "doers"; that is in the professional and semiprofessional groups. Patients subject to migraine are likely to be tense, nervous, worrisome, overly conscientious individuals who work hard but fatigue easily. They are sensitive to criticism and are subject to doubts and fears. They react strongly to all stimuli. The woman who is subject to migraine is likely to be a meticulous, fastidious housewife, and the man is often overambitious and exacting, with an exaggerated sense of responsibility and a perfectionistic attitude toward himself and everyone else. In people of this type, any change from the normal may bring on an attack; fatigue, overwork, loss of sleep, worry, hunger, anger, frustration, or excitement may be the precipitating or contributing factors.

In treating migraine, two objectives are to be borne in mind. First, treating or shortening the individual attack, and, second, the prevention of recurrence or lengthening of the intervals between the headaches. The first principle in treating the attack is to start the moment the first sign of trouble appears. The earlier the treatment is started, the more successful it will be. If the attack is mild, aspirin or some allied analgesic often accompanied by a mild sedative or by caffeine may bring about adequate relief, and the patient may be able to continue with his normal activity. If the attack is more severe, he may have to rest in a darkened room for a period of time. Sometimes, the application of cold packs to the head may give relief. Occasionally, the patient notices relief from the pain following vomiting, and some individuals even induce vomiting.

It has been found in recent years that ergotamine tartrate or gynergen is specific in some seventy to ninety per cent of patients with migraine.[5,6,15,18] It is so successful that it may be used as a therapeutic test. Standard ergotamine tartrate is given either by mouth or parenterally. Tablets of 1 milligram are available for oral or sublingual use; one or two to four or five tablets may be taken at the onset of a headache and additional tablets may be taken at half hourly intervals. Ampules of one half milligram given subcutaneously or intravenously will bring about more dramatic relief. Ergotamine sometimes causes gastrointestinal disturbances, especially if it is taken after the headache is at its peak. These, on occasion, may be relieved by the use of atropine. Dihydroergotamine has been found to be somewhat safer and less likely to produce gastrointestinal upsets.[2,13] This is administered parenterally in doses of one to two milligrams. Recently, a new compound, cafergot, which is a combination of one milligram of ergotamine together with 100 milligrams of caffeine, has been found to be more effective than ergotamine alone; possibly the added caffeine works synergistically with the ergotamine.[10,14] Suppositories of cafergot are now available experimentally and these have been found to be even more effective in some cases than the oral cafergot. The suppository works more quickly than the oral preparation,

and it may be given to individuals who cannot take oral medicine because of nausea. Many other drugs, including nicotinic acid, thiamin, histamine (see below), octin,[16] endocrine products and calcium, have been reported to be of value in individual cases of migraine, but the above preparations are the most important and the most specific. They are safe when used in therapeutic doses, but must be avoided in hypertension and coronary and peripheral vascular disease. Dihydroergotamine can be used during pregnancy. Narcotics should be strictly avoided in migraine.

The second objective in the treatment of migraine is the prevention of the attacks or the lengthening of the intervals between them. It is important to review the patient's case thoroughly, and to remove all possible precipitating causes or underlying mechanisms, including allergic factors, toxins, infections, endocrine changes, et cetera. The most important measure, however, in relieving the disorder, is to treat the total personality, to help the patient to understand why he is having the attacks and to avoid the precipitating causes. Personality readjustment, correction of erroneous ideas of living, and elimination of undesirable environmental factors are the most important parts of the therapy.

Atypical Migrainous Syndromes

Atypical migrainous headaches and migraine equivalents and variants may include many variations and *formes frustes*. Many of these are difficult to differentiate from the psychogenic headache to be discussed later. In some instances they respond to therapy with drugs of the ergotamine group, although often they require more individual therapy.

One specific type of the atypical migraine is the so-called *histamine cephalalgia* of Horton, also known as erythromelalgia of the scalp.[11,12] The pain here is also unilateral, but it is restricted to the eye or supraorbital area. It is briefer in duration than migraine, and the individual attacks often last from only twenty minutes to an hour. The pain frequently comes on at night and awakens the patient. He gets out of bed and sits in a chair, and in a short period of time the pain leaves and he can return to sleep; he may, however, have two or three such recurrences during the night. This type of headache is very rarely accompanied by vomiting, but there is usually congestion of the conjunctive on the affected side, with lacrimation and unilateral rhinorrhea. The manifestations are frequently periodic, and the patient may have daily (or nightly) attacks of pain for a period of six weeks to two months and then be free from symptoms for six months or so, followed by a recurrence lasting for six weeks to two months. While the attacks occur most frequently in the spring and fall, no seasonal relationship is definitely observed.

These headaches may be precipitated by the subcutaneous injection of 0.3 to 0.5 milligrams of histamine phosphate (0.3 to 0.5 cc. of a 1:1000 solution) and relieved by the subcutaneous injection of 0.2 to 0.3 milligrams of epinephrine (0.2 to 0.3 cc. of a 1:1000 solution of epinephrine hydrochloride). This headache is probably also of vascular origin, and the pain probably results from dilatation of branches of the internal carotid artery. Histamine desensitization has been recommended for relief of the syndrome. This is carried out by the subcutaneous injection of increasing doses of histamine, starting with 0.025 milligram of histamine base and working up to 0.1 milligram, giving this amount twice daily for eight days, then every other day, and finally once a week as a maintenance dose. It has also been treated by the intravenous administration of 2.75 milligrams histamine acid phosphate in 250 to 500 cubic centimeters of saline solution given daily for three or four injections. This latter ode of histamine injection has also been recommended in the treatment of migraine.[1,17] While the histamine cephalalgia is very probably a result of sensitivity to histamine, the above procedures are not uniformly successful in relieving the headache. The attacks themselves are often helped by the use of ergotamine tartrate or related drugs, and recently very good results have been obtained in some cases by the use of the cafergot suppositories.

Hypertension and Other Vascular Diseases

Chronic vascular disease, either arteriosclerosis or hypertension but usually the latter, is a common cause of headaches, especially in elderly individuals. It is stated that 45 per cent of the patients with hypertension have headaches. There is often associated tinnitus and vertigo and there may be vomiting, transient paralyses or paresthesias, periods of aphasia, confusion, memory loss, emotional liability, and general evidence of loss of cerebral function. The typical hypertensive

headache comes on about four or five o'clock in the morning. It awakens the patient and may go away when he gets up. It is associated with increased intracranial pressure, but not relieved by decrease of such pressure. It is interesting that the hypertensive headache is sometimes relieved by splanchnicectomy even though the blood pressure does not remain low after such an operation. Severe headaches may occur with either cerebral hemorrhage or subarachnoid bleeding. Increasing severity of headache may precede an intracerebral ictus, but in subarachnoid hemorrhage the pain may come on precipitously. The latter diagnosis should be borne in mind if there is a sudden onset of severe nuchal or occipital pain with resulting meningeal signs, retraction of the neck, photophobia and confusion. The diagnosis can be confirmed by spinal puncture.

Posttraumatic Headaches

Posttraumatic headaches often constitute a difficult problem in both diagnosis and treatment. The pain which follows immediately after a head injury is not difficult to treat and usually responds to analgesics and sedatives; sometimes the intravenous injection of hypertonic sucrose or the removal of cerebrospinal fluid by the lumbar route is of value. It is important in the immediate posttraumatic headache to reassure the patient and minimize his symptoms, and to encourage early ambulation. The headaches that persist long after injury or gradually become worse constitute a more challenging problem.[20] They may appear singly or in association with such symptoms as dizziness, difficulty in concentration, nervousness, and insomnia. The headaches are often localized or bursting in type; they are sometimes increased by increasing the intracranial pressure as in coughing, sneezing and stooping. They are aggravated by mental or physical exertion. They may be absent in the morning or on lying down, and come on when the patient is up and about. They are relieved by rest. They may be associated with irritability, emotional outbursts, mental or personality change, and decreased tolerance to alcohol.

There are many theories regarding the pathophysiology of posttraumatic headaches. Some authors consider them to be entirely physiologic, some entirely psychologic, and others feel that both factors are important. The physiologic mechanisms involved include distention of cranial blood vessels, sustained contractions of the muscles of the scalp and neck, and scarring of the extra- and intracranial soft tissues, Psychogenic factors include the immediate emotional effect of the injury, that is, anxiety, depression, resentment or frustration; pretraumatic neurotic ideas or tendencies; and psychic conflicts due to environmental stresses incident to the injury. If no organic changes are found in the neurologic examination, electroencephalogram, pneumoencephalogram, or spinal fluid examination, one must feel that organic factors are absent or minimal, and may, in most instances, assume that psychogenic factors are the more important ones. The treatment, of course, is the treatment of the whole person, and is mainly a psychotherapeutic problem.[4,7,9] Reassurance is important. Habit-forming drugs should be avoided, and every attempt should be made to explain the situation fully and truthfully to the patient. In general, the treatment must be similar to that in the next group, the psychogenic headaches. In a few isolated instances procedures such as pneumoencephalography, probably to free meningeal adhesions, or even neurosurgical intervention, is indicated. One must always be sure, however, in the treatment of the posttraumatic headache, that he is not dealing with a subdural hematoma or some other grave intracranial condition.

Psychogenic Headaches

By far the largest group of headaches are the so-called psychogenic ones.[4,7,9] The pathophysiology of some of these is understood. Some are on a vascular basis associated with relaxation or dilatation of arterial walls; some are associated with tension and spasm of the extracranial muscles and related structures. Psychogenic headaches may be of various types. Sometimes the pain is an occipital or low cervical one with radiation of the temples, sometimes it is at the vertex, sometimes it is band-like in distribution. In many patients the headache varies from time to time as to location, type and severity. Fatigue, mental strain, emotional conflict, frustration, and resentment are often precipitating or underlying factors, and the headaches may be made worse by emotional stress and inner conflicts. Patients with headaches of this type represent a challenging therapeutic problem to the practitioner. Many patients have already consulted many different physicians and have had various treatment regimes

advised, including analgesics, sedatives, vitamin preparation, hormones, et cetera. Often we get the history that there is temporary relief with every new physician and with every new therapy, but still the headaches persist and interfere with the patient's work, his home life, or his domestic or marital duties. In these patients symptomatic treatment should be limited as much as possible, because they soon become dependent upon analgesics and sedatives, and require increasing doses of them. On the other hand, there are some patients with psychogenic headaches who get no benefit from analgesics and even narcotics, and occasionally a diagnostic criterion for psychogenic headaches is that the pain is not relieved even by large doses of narcotics.

It is important that the physician gain the patient's confidence; that he understand his background, his early development, and his home and work situations, so that he may comprehend the factors which bring on the pain. It is essential to help the patient to understand that anxiety, fear, depression and frustration may cause physiologic changes that may bring on the headache. One may explain, for instance, that tension of the posterior cervical muscles may irritate the afferent cervical nerves and cause pain in the temporal and occipital distribution; that anger and resentment may cause vascular changes within and without the skull, similar to the vasodilatation which occurs with blushing and the vasoconstriction which occurs with fright, and that these vascular changes within the skull can bring on the pain. The important part of the treatment, however, is the treatment of the total personality, helping the patient to understand his conflicts and to overcome his anxieties and tensions.

Conclusion

Headaches may be caused by many different factors and processes. They may be a result of localized intracranial disease, they may be a symptom of systemic illness, or they may be a result of trauma or of emotional conflict and psychogenic disturbances. The etiology must always be determined before treatment is undertaken. It is important to bear in mind, however, in the therapy of all types of headaches, that a two-fold approach may be necessary. Analgesic drugs may be used for the symptomatic treatment of headaches due to systemic disease and for transient relief in those of psychologic origin or posttraumatic in onset, and drugs of the ergotamine group for migrainous headache and atypical migraine. Secondly, psychotherapy should be instituted in order to relieve emotional tensions and help the patient to cope with difficult life situations. The results of the latter are often quite gratifying, even when only simple supportive psychotherapy is given.

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Chronic Intestinal Disease

Diagnosis and Treatment

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CHRONIC DISEASE of the gastrointestinal tract constitutes a large segment of the general practice of internal medicine. Furthermore, chronic symptoms referable to disturbance of function of this physiologic system are frequently encountered in pathologic conditions of other organs and systems. Consequently, diseases of the digestive tract frequently enter prominently into many problems of differential diagnosis. It follows that reasonable familiarity with the more common diseases of the intestinal tract is as important to the practitioner of internal medicine as to the specialist.

The fact that symptoms may be primary, or secondary to pathologic conditions in other regions of the body which cause remote functional disturbances, emphasizes the need for a detailed and complete history before attempting to evaluate physical findings or the planning of laboratory and x-ray examinations. The history when taken with careful attention to complete description of the individual symptoms will frequently provide strong presumptive evidence that the condition under consideration is or is not primary in the gastrointestinal tract.

The clinical phenomena which the patient may note may be classed in three general categories: cardinal symptoms, associated symptoms and cardinal signs. The cardinal symptoms of gastrointestinal disease are: abdominal pain, nausea, vomiting, diarrhoea, constipation, cramps and tenesmus. All of these, however, may be the expression of pathologic conditions in other parts of the body.

Pain may be highly significant and its description and localization of the utmost importance. Thus pain in the epigastrium is usually due to lesions in the stomach, duodenum, gallbladder, or pancreas. When it is due to peptic ulcer, the patient may be able to localize it sharply at a point between the xiphoid and the umbilicus. Gallbladder pain is usually more diffuse in its localization and is generally referred to the right upper quadrant. In duodenal ulcer, in addition to the anterior abdominal pain, there may be pain in the back at the level of the eighth to the tenth thoracic vertebrae, and more rarely back pain may occur alone. In esophageal lesions pain is generally substernal corresponding to the level of the lesion. However, it may be accompanied by substernal pressure and may radiate to the left shoulder and arm strongly suggesting angina pectoris. Pain originating from disease of the small intestine generally is localized in an area just above and just below the umbilicus. When produced by lesions in the colon, except in the region of the points of fixation, pain is usually referred to the midline at or below the level of the iliac crests. When it originates from the areas of the fixed points of the colon as the hepatic and splenic flexures and the sigmoid, pain is usually localized in the area of involvement. Pain resulting from lesions of the rectosigmoid is also referred to the midline in the suprapubic area or to the midline of the sacrum. Similarly, pain originating in the rectum is commonly suprapubic or sacral and only rarely when the disease process is in the ampulla is it perineal in its localization.

Nausea is far less useful as a sign of intrinsic gastrointestinal disease since it is a frequently encountered symptom in a variety of conditions in which the primary process lies outside the gastrointestinal tract. Vomiting, likewise, is seldom helpful in localization since it is a frequent symptom in a wide variety of disease conditions.

Diarrhoea, also, occurs in many conditions both systemic and gastrointestinal. Constipation, on the other hand, may have definite significance especially if it occurs in an individual who previously has had normal intestinal function.

Low abdominal cramps are strongly suggestive of a pathologic process in the colon especially the proximal portion. Tenesmus, on the other hand, is indicative of irritation of the descending and pelvic rather than the proximal colon.

Associated symptoms such as belching, flatulence and meteorism may or may not have considerable weight in the primary diagnosis. Belching is a frequent complaint but it seldom has diagnostic significance. However, chronic flatulence and especially meteorism in the presence of certain of the cardinal symptoms may strongly suggest

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the possibility of an obstructive lesion of the intestinal tract involving the lower small intestine or the colon.

Certain objective phenomena which the patient may have noted may have considerable importance in arriving at a primary diagnosis and determining the lines of further investigation. These cardinal signs include the type of stools, the frequency of evacuation, the color of the dejecta, and the presence of gross blood, pus or mucus.

The type and frequency of evacuation may give an indication of the nature of the pathologic process and of its severity. Clay colored stools suggest obstructive jaundice or steatorrhoea. Stools which are abnormally dark in color point to bleeding in the upper portion of the intestinal tract, while red blood, mucus and pus are commonly indicative of a lesion of the colon. While none of these symptoms or cardinal signs is pathognomonic, when taken together, the history frequently permits accurate interpretation and immediate choice of the additional diagnostic methods necessary to reach definitive diagnosis.

The following discussion of clinical conditions is restricted to certain of the more important chronic diseases of the small intestine and the colon. Peptic ulcer is excluded because of its frequent occurrence and familiarity. The conditions under consideration may be classified in four general categories: congenital malformations, the results of infection and inflammation, benign and malignant tumors, and primary and secondary nutritional defects. While it is obviously impossible to discuss all of these conditions in detail, the attempt will be made to emphasize the salient features which are of assistance in definitive diagnosis, and to indicate the general lines of therapy.

Congenital anomalies of the small intestine are not particularly uncommon. Bands producing varying degrees of obstruction of the duodenum occur in about five per cent of patients. The most common variety probably represents persisting foetal structures binding the duodenum to the liver, gallbladder or hepatic flexure of the colon. A second type which is responsible for partial obstruction of the second and third portions of the duodenum is produced by the structures normally crossing this portion of the tract and the obstructive phenomena result, apparently, from abnormal mobility of the proximal colon. The third and least common anomaly is non-rotation of the duodenum which may or may not be associated with non-rotation of the colon.

These congenital defects may not be accompanied by symptoms. When clinical phenomena are present, they are the expression of irritation or obstruction, or both. The characteristic symptom of duodenal irritation is hunger pain; those of obstruction are pain shortly after eating, nausea and vomiting. Considerable if not complete relief of symptoms may be obtained in some cases by assuming the knee-chest position or the right lateral position. While the symptomatology may be highly suggestive, definite diagnosis depends upon the findings at x-ray. Treatment whenever possible should be by conservative medical measures.

Diverticula of the duodenum occur in 1 to 2.3 per cent of individuals.[9] They are located most frequently in the second portion, in the vicinity of the papilla of Vater and may be single or multiple. They are usually asymptomatic but may be accompanied by pain. Treatment when required is purely symptomatic.

Duodenitis, as the name implies, is a localized inflammatory process which is accompanied by symptoms closely resembling those of ulcer. However, the pain is apt to be more diffuse and relief from food or alkali is less complete. Hemorrhage occurs not infrequently, but uncomplicated duodenitis is not associated with gastric retention or other evidence of obstruction. The treatment is that of ulcer.

Primary tumors of the duodenum, benign or malignant, are extremely rare.

The jejunum and the ileum are subject to a much greater variety of pathologic conditions. Diverticula are rare and generally asymptomatic. Meckel's diverticulum, however, the persisting remnant of the normally obliterated omphalomesenteric duct, occurs in about 2 per cent of adults. It is located on the antimesenteric border of the intestine within a meter of the ileocecal valve. Hemorrhage beginning in childhood and recurring intermittently, obstruction and perforation are the more common expressions of this anomaly. Five clinical syndromes are ascribed to it.[6] In the first, peptic ulcer of the ileum occurs. This may cause severe hemorrhage, perforation and peritonitis. The second group is characterized by obstruction resulting from intussusception, volvulus, hernia or adhesions. The third, which clinically may resemble acute

appendicitis, is the result of inflammation of the sac. In the fourth group fecal fistula or prolapse of the small intestine into an umbilical hernia may occur. And finally, the diverticulum may be the site of benign or malignant tumor formation of various types. In almost all instances diagnosis must be made on clinical grounds. In all cases of obscure bleeding this condition must be kept in mind. Treatment is surgical excision.

The most important chronic inflammatory diseases of the small intestine are tuberculosis and regional ileitis. Primary tuberculosis of the intestine is rare and has decreased in prevalence with the widespread adoption of pasteurization of milk and the control of tuberculosis in dairy cattle. Diagnosis of this condition is very difficult. Secondary tuberculosis is not uncommon. It is the most frequent complication of advanced pulmonary tuberculosis and lesions can be demonstrated in over half of the fatal cases coming to autopsy. Diagnosis is not difficult when chronic intestinal symptoms develop in a patient with advanced pulmonary disease, especially if a tumor mass is present in the right lower quadrant. X-ray examination will usually demonstrate one or more of the significant signs: abnormal filling and emptying of the terminal ileum and a filling defect of the cecum.

Until comparatively recently there has been no specific or effective therapy. With the advent of streptomycin and the less toxic dihydrostreptomycin the prognosis has been greatly changed. It has proved to be most effective in relieving symptoms and producing corresponding regression of the radiographic evidence of pathology.[15]

Regional ileitis was first described by Crohn and his associates in 1932.[4] It is a non-specific inflammatory process usually involving the terminal ileum but often affecting other areas of the ileum or jejunum, the so-called "skip areas." It is characterized by mucosal ulceration, fibroblastic proliferation and thickening of the intestinal wall and of the mesentery with secondary lymphatic obstruction. Adhesion occurs to adjacent loops with the formation of a mass and internal and external fistulae are frequent complications. The disease commonly affects males more often than females. It is usually observed in individuals between the ages of twenty and forty.

It runs a chronic course with exacerbations and remissions with progressive risk of obstruction, perforation and peritonitis. During the periods of activity there is low-grade fever, abdominal pain, distention varying with the degree of obstruction, diarrhoea, weight-loss, anemia and progressive malnutrition. Diagnosis in the well-marked case is not difficult since a mass in the right lower quadrant is usually palpable, and x-ray examination will reveal the characteristic deformities of the affected portion of the intestine together with disturbance of motor function.

Treatment is not entirely satisfactory. In the presence of definite obstruction surgery is, of course, required. Extensive resection, formerly recommended, has been largely replaced by short-circuiting procedures. Medical treatment at times is relatively effective in the milder cases. Although certain of the sulfonamides and certain of the antibiotics appear to induce a remission in individual cases, there is no uniformity of response. In all instances the individual must be kept under long observation with recognition of the probable ultimate necessity for surgical intervention.

Tumors of the small intestine are as rare as those of the colon are common. They are frequently the cause of intussusception, obstruction or hemorrhage. There is no characteristic clinical picture on which diagnosis may be based.

Idiopathic steatorrhoea is a clinical syndrome characterized by abnormal amounts of fatty acids and soaps in the stools, progressive malnutrition and anemia. Clinically, it closely resembles and may, in fact, be identical with the three conditions: tropical sprue, non-tropical sprue and celiac disease. In the typical case the patient gradually develops morning diarrhoea, the stools becoming more bulky, light in color and acid in reaction. Usually abdominal distention is prominent. More or less coincidentally, the tongue becomes red, inflamed and sore, with inflammation of the papillae followed by atrophy ultimately producing the characteristic smooth tongue. Aphthous ulcers of the tongue and buccal mucosa are usual, and dysphagia may be a troublesome symptom in acute cases. There is progressive loss of weight, development of hypochromic anemia and other indications of progressive malnutrition. The disease is characterized by remissions, but with each exacerbation it tends to become more severe and ultimately macrocytic anemia appears.

The etiology is unknown. There is no specific pathology and the lesions are merely those of atrophy, probably an expression of the malnutrition. The gastric acidity may be normal or

anacidity may be present. Pancreatic function is normal on secretin stimulation and, consequently, dysfunction of this organ cannot be a factor.[1] The large amounts of free fatty acids in the intestinal contents bind calcium provided by the diet to form insoluble soaps. This mechanism in turn produces chronic calcium deficiency which in long-standing cases may be manifested by osteoporosis. The presence of split fats in the stools together with the absence of undigested starch granules and meat fibers suggest failure of absorption rather than failure of digestion. This is confirmed by the different results given by oral and intravenous glucose tolerance tests. The former yields a low flat blood sugar curve, while the latter gives a normal curve indicating normal carbohydrate metabolism. The light color of the stools is due to the presence of leucobilirubin.

Advanced multiple nutritional deficiencies have been shown to be associated with characteristic changes in the x-ray pattern of the small intestine after ingestion of the standard barium meal.[12] Similar changes occur in the small intestine in sprue indicating further the extensive dysfunction of this portion of the gastrointestinal tract.[13]

The diagnosis of idiopathic steatorrhoea and sprue is not difficult in view of the characteristic clinical picture, the character of the stools, the results of oral and intravenous glucose tolerance tests and the findings on x-ray examination of the small intestine.

Treatment, except in the far advanced case, is usually effective in producing remission and controlling progression and relapse. Until comparatively recently, the most effective regime consisted of a diet high in protein and low in fat together with adequate amounts of crude liver extract administered parenterally. Recently, vitamin B_{12} and folic acid have been shown to be effective therapeutic agents in certain cases.[18] Further studies of these preparations have shown that there are some patients with megaloblastic anemia who respond well to liver extracts, vitamin B_{12}, and folic acid; others, however, respond to folic acids but not to parenteral liver extracts or to vitamin B_{12}.[8]

Redundancy of the colon is one of the most frequent of the congenital anomalies of the lower bowel. It is said to be associated with approximately 22 per cent of cases of chronic constipation. As the name implies, the colon is unusually long and frequently dilated, particularly the pelvic colon. It is accompanied by abdominal pain, constipation and flatulence. Treatment should be conservative and directed to restoration of normal colonic function without the use of cathartics.

Diverticula are more common in the colon than in any other portion of the intestinal tract. They are found in from 3 to 10 per cent of all patients x-rayed. Generally they are multiple, occurring predominantly in the iliac and pelvic areas but they may be present in the proximal colon and even in the cecum.

The pouches develop at the site of a congenital weakness of the wall usually between the leaves of the mesentery. Less commonly they occur on the antimesenteric border or in the appendices epiploicae. In some instances all four coats of the bowel wall are involved; in others only the mucosa, submocosa and serosa.

This condition, diverticulosis, is observed most frequently in stocky individuals past middle life. In uncomplicated cases they are no symptoms or merely some degree of functional instability of the colon. Constipation is frequent. Perhaps the most important aspect of treatment is recognition of frequency with which this condition occurs, the rarity of significant pathology and symptomatology, and the lack of indication for radical dietary or other treatment.

Chronic infections of the colon are likewise frequently encountered. They may be classified as bacterial, protozoal, helminthic, and nonspecific. The prevalence of the different types varies in different parts of the world in accordance with local conditions of sanitation as these affect the possibility of fecal contamination of food, water and soil. The most important bacterial agents are the *Shigella dysenteriae,* the etiologic agents of bacillary dysentery, and various members of the Salmonella group. When these infections become chronic, the clinical results are little if any different from those of chronic ulcerative colitis.

Of the protozoa, the *Endamoeba histolytica* is by far the most important. Chronic infection by this organism occurs in at least 10 per cent of the population of the United States.[5] In certain rural and institutional groups the prevalence has been shown to be as high as 38 per cent and 55 per cent, respectively.[2,3] The writer has found this infection in over 30 per cent of veterans in North Carolina.[14]

Chronic amebiasis is rarely manifested by dysentery or acute diarrhoea. Much more common

is the syndrome of occasional brief periods of mild looseness followed by constipation or normal bowel function. These patients frequently are below par physically, often underweight and unable to gain weight. Vague abdominal pain and discomfort with flatulence are common complaints, and there is often intolerance of excess fat in the diet. It is not uncommon for such patients, after the possibility of chronic gallbladder disease is eliminated, to be labeled as instances of psychoneurosis; whereas, in fact, they are handicapped individuals who can easily be restored to normal health. Unfortunately, the diagnosis of intestinal amebiasis can be made only by the demonstration of the *Endamoeba histolytica* in the stools and this organism is frequently missed even by laboratory workers highly competent in other fields.

Ideally, treatment of this infection is by the combined use of emetine hydrochloride and diodoquin over the same eight-day period. Emetine, however, should not be administered to ambulatory patients because of its cumulative toxic action which is demonstrated by the not infrequent changes in the electrocardiogram during the period of therapy.

Parasitic worm infections producing significant chronic disease of the colon are fortunately rare in this country although frequently encountered in tropical regions.

Chronic ulcerative colitis is a distressing condition both for the patient and the physician because therapy is unsatisfactory in so many individuals. The etiology remains a matter of debate. Many microorganisms have been advanced as etiologic agents but none have met the criticisms levelled at them. Similarly, the high prevalence of psychoneurotic characteristics have led to the concept that emotional factors may play a primary role. Bockus and his associates[16] found that all of the patients whom they studied revealed neurotic traits but concluded that there is no direct or specific etiologic relationship.

The disease is characterized by long chronicity, of course, with periods of exacerbation and remission, in many instances occurring spontaneously. Each period of activity is usually accompanied by further extension of the pathologic process and by progressive damage leading ultimately to extensive and permanent destruction of the mucous membrane, fibrosis of the bowel wall, polypoid degeneration, and shortening and narrowing of the colon. One of the important late complications is the development of carcinoma which occurs in approximately 5 per cent of cases.[17]

Irrespective of the primary mechanism of the disease, studies of a group of patients continuing over a period of years have led the writer to the concept that in many instances, once the pathologic process is established, a complex set of actors become operative which act together to maintain the chronicity and to produce recurring periods of activity. These factors include secondary infection, primary or secondary malnutrition states and sensitization of the affected colon to foreign proteins originating from certain foods and certain micro-organisms.[11]

It is inevitable that lack of certainty concerning the etiology should lead to the recommendation of a variety of therapeutic regimes. The extremes are represented by too long adherence to medical measures on the one hand, and immediate iliostomy on the other. A middle course is unquestionably the wisest one. In the absence of serious complications, these patients should be handled medically and carefully studied through at least one full cycle of the disease. The regime should be directed to the maintenance of optimal nutrition and to the attempt to identify certain of the etiologic factors which may be operative. Sensitization to specific food proteins plays a most important role in some cases. Identification of this mechanism, however, is difficult since skin tests are completely undependable and misleading. It is necessary to utilize the elimination diet technique applied with meticulous accuracy. When satisfactory evidence of food allergy is obtained, dramatic and long-standing improvement may follow, provided the necessary diet restrictions are followed permanently. In certain instances, also, autogenous vaccines seem to give some temporary benefit. It is doubtful that this is related to an immunity mechanism. It seems more probable that any improvement should be attributed to a temporary desensitization to certain bacterial proteins.

In advanced cases there is frequently dissociation of colonic motor function with prolonged delay in the proximal colon despite numerous evacuations which the patient may describe as diarrhea, but which, in fact, consist principally of mucus, pus and blood with little fecal matter. This condition is best handled by daily small doses of a mild saline, which, when properly adjusted,

will relieve spasm and pain and reduce the total number of evacuations.

Definitive surgical treatment may be required when medical measures fail. In the usual case, it implies permanent iliostomy and resection of the affected portion of the colon. The ideal management of chronic ulcerative colitis is, therefore, a complicated problem requiring the best judgment of the internist and the surgeon. The wisdom of ultimate surgery is pointed up by the incidence of carcinoma in long-standing cases.

Diverticulitis, fortunately, is as rare as the diverticula are common. It appears to be the result of the formation of fecal concretions in one or more diverticula, with ulceration and secondary infection. The symptoms and signs are those of an acute or chronic inflammatory process and may range from localized pain and tenderness with the presence of a mass, especially in the left lower quadrant, to abscess formation or to perforation and peritonitis. In the chronic recurring type fibrosis, thickening of the bowel wall and stenosis may be produced and require resection. Similarly, the acute form may urgently call for operative intervention. In the milder cases the primary indication for treatment is the control of constipation. The condition variously designated simple colitis, irritable colon, spastic colon or mucous colitis is one of the most common conditions encountered in the whole field of gastroenterology. It is seen in approximately 40 per cent of all patients having abdominal disorders.[9] It is a functional disturbance and not an inflammatary disease. It is characterized by abdominal discomfort or pain frequently appearing immediately after eating and due, apparently, to an abnormally active gastro-colic reflex mechanism. Diarrhea or constipation with abnormal amounts of mucus in the stools is usual, and there is frequently the complaint of faintness at stool. The severity of the symptoms tend to vary directly with fatigue and emotional strain.

One of the most striking features of this condition is the disparity between the subjective phenomena and the objective findings. Apart from variable tenderness over the colon, physical examination of the abdomen commonly reveals nothing of note. X-ray examination, however, is both useful and important. The essential findings are hypermotility with the barium meal reaching the pelvic colon within nine hours, and demonstration by barium enema of exaggerated haustration, or narrowing with loss of haustra in the descending colon.

One of the most important aspects of treatment is continued reassurance of the patient and re-education to control the anxiety and neurotic factors. Of equal importance is the establishment of normal evacuation without catharsis and insistence upon discontinuing the frequent practice of high irrigations and repeated enemas.

The colon is one of the most important sites of tumor formation in the body. Benign tumors, usually adenomatous polyps, are relatively common. Approximately 45 per cent of them occur in the sigmoid and rectum.[7] They are frequently asymptomatic but may be responsible for rectal bleeding, prolapse, or obstruction. More important, however, is the fact that about 10 per cent undergo malignant degeneration.

Carcinoma is the most common malignant tumor, and carcinoma of the rectum is said to be fifth in the list of frequency of primary carcinomas. It is somewhat more common in males than in females and there is a tendency for it to appear before the "cancer age." About 5 per cent of rectal carcinomata occur in patients under the age of thirty.

There are no characteristic or pathognomonic symptoms prior to the advanced stages of the disease when metastasis has almost certainly occurred and when cure is improbable. Generally, the clinical picture is that of slow and insiduous alteration of bowel habit which may not attract particular attention. With enlargement of the tumor mass, narrowing of the stools may be noted; and as ulceration occurs, blood in variable amounts appears in the stools. When relative obstruction of the colon develops, there may be pain, nausea and vomiting. It is important to remember that more than 75 per cent of all rectal cancers can be felt by digital examination of the rectum when the patient is in the left lateral position with the knees drawn up.

In no other form of internal cancer can such good results be obtained, if only the diagnosis is made before the process has extended beyond the bowel wall. Thus, Lahey[10] has reported that 90 per cent of cases of rectal carcinoma were free from disease five years after operation when no metastases were demonstrable at the time of the resection. When the lymph nodes were involved, the five-year prognosis was reduced by almost two-thirds.

Too frequently obvious hemorrhoids are accept-

ed as adequate explanation of rectal bleeding and, consequently, thorough examination is omitted. In such instances tragedy frequently results. Too much emphasis cannot be placed on the axiom that the passage of blood by rectum is an imperative indication for the application of all the diagnostic measures which are of use in establishing with certainty the exact nature of the underlying pathology.

Patients with gastrointestinal disease commonly consult the family physician rather than the specialist, particularly in the early stages. The variety of pathologic conditions affecting the intestinal tract and the differing prognoses in many of these diseases, when diagnosis is delayed, emphasize the responsibility resting upon the practitioner of internal medicine. The complicated and often atypical symptomatology too frequently are ascribed to emotional factors, and the resulting diagnosis of psychoneurosis may cloak the progression of organic disease until cure becomes impossible. The numbers of patients seeking assistance for the relief of symptoms referable to this physiologic system emphasize the necessity for an adequate working knowledge of the mechanism underlying symptoms arising from the intestinal tract, and of the more important methods of examination upon which final differential diagnosis must be based.

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HEADACHES

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FEDERAL LEGISLATION

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tion laws. The bill (H.R. 5678) introduces a high degree of "selectivity" in choosing between applicant immigrants. The first 50 per cent of the quota of each country annually would be made available to qualified quota immigrants whose services are determined by the Attorney General to be needed urgently in the United States because of the high education, specialized experience, or exceptional ability of such immigrants, and to be substantially beneficial to the national economy, cultural interests, or welfare of the United States. This group of skilled persons (including physicians) and their families would be given preference over alien parents of citizens of the United States and qualified quota immigrants who are spouses or children of aliens lawfully admitted for permanent residence in the United States. Unfilled quotas from other than the skilled person group could also be used to admit persons in the skilled category.

Acute Abdominal Conditions

By Charles R. Doyle, M.D.
St. Louis, Missouri

ACUTE ABDOMINAL conditions are of diagnostic and therapeutic interest to almost the whole field of medical practitioners, and there are no limitations or boundaries for specialists alone. General practitioners, internists, surgeons, even dermatologists and neurologists may be concerned with the diagnosis and often with the treatment of an abdominal emergency.

There is nothing new, startling or dramatic about this subject. Great practitioners of the past have written volumes about it. Now there are new and more accurate laboratory tests which tend to play a more and more important part in the differential diagnosis. However, keeping in mind certain anatomical and physiological facts will simplify reaching the proper diagnosis and expedite the indicated treatment.

The term "acute abdominal condition" embraces a great many clinical entities, but ordinarily only a half-dozen or so are confused with others.

An acute abdominal condition is the most important everyday disorder requiring early diagnosis so that the proper treatment may be implemented. This is true because an incorrect diagnosis and plan of treatment may result in complications which unduly prolong the illness, permanently incapacitate the patient, or even cause death. In any event, there is frequently an economic, as well as a physical, catastrophe if the diagnosis is wrong.

The exact cause of an acute abdominal condition is not nearly as important as deciding what should be done. Valuable time may be lost in trying to be too exact, which results in prolonged indecision and vacillation so that, literally, the patient is examined to death. It is true that incomplete investigation may cause a wrong diagnosis, but it does not follow that it is necessary or desirable to order every laboratory examination which possibly could apply. This is not only time consuming but often the determinations are overlapping, and the cost is no small item. Other causes of wrong diagnoses are: preconceived ideas (a pitfall of the inexperienced), failure to think anatomically and physiologically, incomplete history taking and poor physical examination.

This subject cannot be discussed without repeating the oft-stated fact that the history and physical examination are most important. Laboratory determinations, including x-ray examinations, are important, too, but their value in the majority of acute conditions is chiefly corroborative. There is too often the tendency of some to approach the problem of the abdominal emergency by ordering many laboratory tests and various x-ray examinations in the hope that the correct answer will be forthcoming automatically.

The foregoing statements are not intended to depreciate the value of these important ancillary procedures in any way, but rather to condemn the practice of abusing the laboratories by overloading them with requests for emergency determinations which frequently have little bearing on the immediate problem and, too often, are completely ignored when reported.

There is no substitute or shortcut for the information obtained through the careful bedside examination of the patient. The thorough clinician gains his facts by observation, palpation, percussion and auscultation of the abdomen—also, by that oft-neglected, digital rectal or vaginal examination. The consideration of these findings with the history and the results of the indicated laboratory tests constitutes the only sound basis for a correct diagnosis. The proper evaluation of all information, particularly the exclusion of "red herrings" depends on the very significant faculty called clinical judgment.

Pain and changes in bowel activity are practically always present where there is an acute abdominal condition. Study of these two factors will very often clearly indicate the probable diagnosis.

The type of onset, character, location and referred distribution of the pain must be determined.

Changes in bowel activity can be obtained from the history and by listening to the abdomen with the stethoscope. The stethoscope is a very important diagnostic instrument in abdominal, as well as in pulmonary and cardiovascular, conditions.

The application of this information is indicated by the following outline, which, of course, serves only as a general guide:

Presented at the eighty-sixth Annual Session of the Michigan State Medical Society, Grand Rapids, September 26, 1951.

I. ABDOMINAL PAIN

A. Sudden Onset
 1. Producing fainting
 (a) Men: Perforated peptic ulcer
 (b) Women: Also ruptured ectopic gestation
 2. Not producing fainting
 (a) Colics (associated with restlessness)

Intestinal	Ureterorenal
Biliary	Uterine-tubal
Pancreatic	

 (b) Hemorrhage

Spleen	Kidneys
Liver	Bladder
Intestines	Ruptured aneurysm

 Cysts (ovarian, pancreatic, mesenteric)
 (c) Emboli, thrombosis and infarction

Mesentery	Liver
Spleen	Iliac vessels

B. Insidious Onset
 1. Inflammatory lesions
 (a) Becoming obstructive

Appendicitis	Salpingitis
Cholecystitis	Regional ileitis

 Acute hydronephrosis or pyelitis
 Diverticulitis (Meckel's or colon)
 (b) Not obstructive

Acute gastroenteritis	Acute cystitis
Ulcerative colitis	Pancreatitis
Mesenteric lymphadenitis	Peritonitis

 (Movement increases pain)
 2. Neoplasms
 3. Post-trauma
 4. Abscesses

C. Location
 1. Usually over the affected organ
 2. Radiation to top of shoulder (either supraspinous fossa, over acromion, over clavicle or in subclavicular fossa)
 (a) Cholelithiasis (radiating from right subscapular area)
 (b) Ruptured spleen (left)
 (c) Subphrenic abscess
 (d) Perforated peptic ulcer
 (e) Diaphragmatic pleurisy
 (f) Acute pancreatitis (radiates from mid-line back)
 (g) Liver abscess
 (h) Appendicitis with generalized peritonitis
 3. Colics
 (a) Small intestinal
 Epigastric and umbilical (T_9 to T_{11})
 (b) Large intestinal
 Hypogastric (T_{11} to L_1)
 (c) Biliary
 Right subcostal radiating to subscapular area (T_8)
 (d) Renal
 Loin, radiating to corresponding testicle (L_1, L_2)
 4. Referred cutaneous hyperesthesia
 (a) Present in one-half the cases of acute abdominal condition
 (b) May be referred to skin level of same spinal nerve innervating the pathologic organ

II. BOWEL CHANGES

A. Peristaltic sounds usually decreased or absent, with obstipation
 1. Peritonitis (paralytic ileus)
 2. Intra-abdominal hemorrage

B. Peristaltic sounds usually increased, without diarrhea
 1. Mechanical obstruction (tinkles and rushes sometimes audible)

C. Peristaltic sounds usually increased, with diarrhea
 1. Acute gastroenteritis
 2. Dysenteries

D. Hypogastric pain and diarrhea followed by hypogastric tenderness and constipation are suspicious of a pelvic abscess and/or pelvic appendicitis

E. Bloody or tarry stools with acute abdomen indicate intragastrointestinal hemorrhage

There are a few generalities which should be kept in mind:

In a previously well patient, severe abdominal pain of more than four hours' duration usually indicates surgical intervention.

If the temperature is 104° to 105° early, the pathologic process is probably not in the abdomen.

An acutely inflamed appendix lying in the pelvis causes little, if any, abdominal wall rigidity.

Movement and pressure increase pain in peritonitis.

Laboratory procedures are diagnostic aids which must be used intelligently by the clinician.

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GOVERNMENT COSTS

Why does Government cost more? Here's a clue:

The Declaration of Independence contains 300 words; the Ten Commandments contain 297 words; the Lord's Prayer contains fifty-six words; the two Commandments that comprise the whole law of God contain twenty-three words.

But despite the examples of simplicity and brevity set by these masterpieces of wisdom and literature, the OPS order setting the price of cabbage contains 26,911 words.

Diabetic Coma

Prevention and Treatment

By Alexander Marble, M.D.
Boston, Mass.

IN THE twenty-nine years which have elapsed since the introduction of insulin into clinical use, the morbidity and mortality from diabetic coma have decreased markedly. Prior to 1922, from 40 to over 60 per cent of diabetics who died, did so in diabetic coma.[5] At present, less than 2 per cent of deaths among diabetics are in coma.[4] However, this means that significant numbers of patients still acquire, and still die from, this acute complication which is the end result of poorly controlled diabetes. Further improvement is possible and is urgently needed.

In certain hospitals in recent years a zero or near zero mortality has been achieved over many months of time. Harwood[3] reported recently that at the Massachusetts General Hospital between November, 1944, and July, 1951—over six and one-half years—there were only two deaths from diabetic coma among seventy-five consecutive cases. This contrasts sharply with a mortality of 20 per cent among thirty-five cases at the same hospital from January, 1942, to November, 1944. Harwood ascribes this remarkable improvement to changes which can be made in any hospital: constant stimulation and training of the house staff to give more aggressive treatment, including truly large doses of insulin, beginning immediately upon admission to the hospital; insistence upon the active and personal interest of the visiting staff with immediate consultation when coma cases appear; and arrangements so that complete laboratory service may be had at any hour, day or night, Sundays or holidays. From another institution, the Pennsylvania Hospital, Duncan et al[2] reported no deaths from diabetic coma in two and one-half years. Our own experience at the New England Deaconess Hospital has been much the same. From April, 1945, to May, 1948, there were ninety-two consecutive cases without a death. Pride came before a fall, however, because in 1948 within a five-month period there were four deaths. However, from November, 1948, to July 1, 1951, there have been sixty-seven consecutive cases with only one fatality.

In Table I are summarized data regarding 805 cases treated at the New England Deaconess Hospital from May, 1923, to July 1, 1951. In all patients the carbon dioxide content (in earlier years the carbon dioxide combining power) of the blood plasma was 9 m. eq. per liter or less (20 volumes per cent or less). It will be noted that the average patient was 29.3 years of age and had had diabetes for 6.2 years at the time of coma. There were sixty-six deaths making an over-all mortality of 8 per cent. However, in the 342 cases of coma since January, 1940 (Series III and IV), the mortality fell to 3 per cent.

The five deaths in 1948 and 1949 were needless insofar as diabetic coma was concerned and certainly demand explanation. In Table II is given certain information regarding these five patients. It is evident that three of the patients had serious complications.

Case 1.—A man, aged seventy-two years, whose diabetes had been discovered less than three weeks before admission in coma, received 1800 units of insulin within the first sixteen hours in the hospital but died thirty-nine hours after admission. An electrocardiogram suggested a posterior myocardial infarction. During the first few hours in the hospital he developed a right hemiplegia. Permission for a postmortem examination was not obtained.

Cases 2 and 3.—These two patients each died in about thirteen hours after admission despite a total of 992 and 2300 units of insulin respectively. On admission the former had a blood sugar of 1075 mg. and the latter of 1525 mg. per 100 cc. This patient Case 32266 had been in the New England Deaconess Hospital for over two months earlier in the year because of profound and long-continued hypoglycemia due to insulin overdosage from which irreversible cerebral damage resulted. Case 23088 had been unconscious for fourteen hours prior to admission. On admission 50 cc. of urine were obtained by catheterization but during the entire period of thirteen hours in the hospital she was almost totally anuric. In neither of these patients was permission for a postmortem examination obtained.

Case 4.—A woman, aged 59.3 years, with diabetes of 8.3 years' duration, was found at postmortem examination to have a chronic and acute pyelonephritis of severe grade with numerous cortical abscesses and peri-

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TABLE I. DIABETIC COMA
805 CASES

Series	No. of Patients	Date	Age of Patient* Years	Duration of Diabetes* Years	Fatal Cases	
					Number	Per Cent
I	179	May 1923 to Aug. 1931	30.9	3.2	27	15
II	284	Aug. 1931 to Jan. 1940	29.1	4.6	28	10
III	188	Jan. 1940 to Jan. 1946	27.9	6.3	6	3
IV	154	Jan. 1946 to July 1, 1951	31.1	9.3	5	3
Totals and Averages	805		29.3	6.2	66	8

*Average figures at time of diabetic coma.

TABLE II. SUMMARY OF DATA REGARDING FIVE FATAL CASES OF COMA

Case	Clinic Case Number	Sex	Age at Coma Yrs.	Duration of Diabetes Yrs.	Findings on Admission				Insulin		Survival in Hosp. Hrs.	Complications
					Blood Sugar Mg./100cc.	Plasma CO_2 m.eq./l.	B. P. mm. Hg.	Blood NPN Mg./100cc.	First 3 hrs. Units	Total 24 hrs. Units		
1.	32877	M	72.0	0.4	835	9	104/54	65	200	1800	39	Rt. hemiplegia ? myocardial infarction
2.	32266	F	27.1	7.2	1075	4	76/20	45	400	900	13	—
3.	23088	F	47.3	14.3	1525	4	70/54	105	1200	2300	13	—
4.	33704	F	59.3	8.3	400	7	92/58	49	200	230	10	Chronic and acute pyelonephritis
5.	20454	M	40.8	8.7	790	8	90/50	66	500	1050	26	Extensive bronchopneumonia

nephric infection on the left. It will be noted from Table II that she received only 200 units of insulin in the first three hours after admission and a total of only 230 units during the ten hours of life in the hospital. Prior to admission she had received at home her usual dose of 20 units of protamine zinc insulin at 8:00 A.M. and had been given an additional 30 units of unmodified insulin at 11:00 A.M., three and a half hours prior to admission. The blood sugar on admission was 400 mg. per cent and the plasma CO_2 7 m.eq. per liter. With the amount of insulin given, the blood sugar fell quite satisfactorily to 222 mg. per cent at three hours after admission and a similar value was obtained at six and a half hours after admission. On the latter occasion the urine was found to be free from diacetic acid and the plasma CO_2 had risen to 13 m. eq. per liter. Although the patient continued to be confused and irritable, her progress seemed reasonably satisfactory and her sudden death ten hours after admission was unexpected. In reviewing this patient's history it was noted that her present illness had actually begun fourteen days before, at which time she had been admitted to another hospital because of nausea, vomiting and fever. She had been treated for pneumonia with penicillin and streptomycin. She had been discharged from this other hospital two days prior to admission to the New England Deaconess Hospital but had not been well, had had a poor appetite and had gradually become worse, developing back pain. In retrospect it would appear that this patient died from long-continued and overwhelming sepsis. Studies regarding the potassium content of the blood were not made, but it appears unlikely that these would have been revealing or helpful.

Case 5.—A man, aged 40.8 years, died twenty-six hours after admission despite 1050 units of insulin. Postmortem examination confirmed the diagnosis of bilateral bronchopneumonia and showed this to be so extensive as to leave very little functioning lung tissue. A second complication during the course of coma was oliguria progressing to anuria. This patient prior to hospital admission had been markedly drowsy for sixteen hours and in the latter ten hours of this period had been totally unconscious.

* * *

In retrospect, it is difficult to state what change in treatment might have brought about recovery in these five patients. Study of the case histories does not suggest that the deaths were related to potassium deficiency. As has been described, they were all patients who had serious complications or who had been totally unconscious in diabetic coma for many hours. One must concede that eventually irreversible changes are brought about in the central nervous system in diabetic coma and there comes a time eventually when therapy, however energetic, will be of no avail. Experiences such as this lend emphasis to the teaching that diabetic coma must be prevented if possible but that if it occurs, it must be diagnosed and treated early and vigorously.

Prevention of Diabetic Coma

Prevention of diabetic coma is all-important and may be accomplished by early and continuous education of the patient, his family and the general public. At the very start of treatment the patient should become familiar with the nature of diabetes, the important points in treatment and the prevention of complications, including acidosis. The patient should be imbued with the ideal of

the sugar-free urine and taught so effectively that he will not later fall a prey to those who advocate free and easy methods of treatment. To condone hyperglycemia and glycosuria is to tolerate a condition only one step removed from acidosis. The patient should be taught to test the urine frequently and to report difficulties and illnesses promptly to his physician. He should learn never to omit insulin, even when nauseated and vomiting, unless the urine is free from sugar at tests taken every few hours. The patient must appreciate that in the presence of infection, particularly with fever, and in the presence of certain other complications, the insulin requirement may be increased temporarily. Therefore, in infections, urine tests must be done at frequent intervals and additional insulin taken if necessary. All too often patients omit insulin during times of acute illness when food intake is scant or nausea and vomiting are present. Fearing hypoglycemia from overdosage with insulin, the patient reasons that if he is not eating, he should not take insulin. The consequence may be increasing hyperglycemia with later the development of ketosis and eventual coma.

Development of Diabetic Coma

There is great variation from patient to patient but in general the symptomatology of well-marked diabetic coma develops along the following lines:

1. Early symptoms such as polydipsia and polyuria due to inadequately controlled diabetes;
2. Digestive symptoms, including anorexia, nausea, vomiting and later abdominal pain.
3. Respiratory symptoms with air hunger (Kussmaul) type of respiration characterized by long, deep, rapid breathing.
4. Central nervous system involvement with drowsiness progressing to unconsciousness.
5. Circulatory involvement leading to collapse with weak, rapid pulse, low blood pressure, subnormal body temperature and cold, mottled extremities.

It must be emphasized, however, that the symptoms of diabetic ketosis, particularly the early and the terminal symptoms, may be vague, variable and atypical. The physician must be ever on his guard when confronted by any abnormal turn of events in a diabetic.

The developments noted above take place because of an acute deficiency of insulin. This arises not only in the patient who omits his insulin or breaks his diet or both but also innocently in the individual with hitherto unrecognized diabetes. Furthermore, coma may be precipitated by influences outside the pancreas, such as infections, thyrotoxicosis and menstruation, but the end result is the same, namely, gross inadequacy of insulin effect for the individual at the time concerned. Because of insulin lack, carbohydrate stores become low and utilization is impaired. Greater recourse is had by the body to fats. Consequently, acetone bodies are formed in amounts larger than can be used peripherally and therefore accumulate in the blood and body fluids and are excreted in the urine.

The body can withstand a certain increase in the ketone acids by excreting them as free acid in highly acid urine or by neutralization with ammonia followed by excretion. A considerable amount of the ketone acids may yield to the buffer action of the blood bicarbonate and the blood proteins, thereby preventing significant change in the blood pH. However, if these natural defenses are overwhelmed, the body must resort to neutralization of the ketone acids with fixed base, chiefly sodium, and excretion in the urine. Other electrolytes lost from the body either by vomiting or by excretion in the urine include potassium, phosphates and chlorides. The end results are: (1) depletion of fixed base, chloride and phosphate of the body; (2) lowering of the plasma CO_2 content and shift in the pH of the blood toward the acid side; (3) hemoconcentration and dehydration and (4) depletion of glycogen stores in liver and muscles.

Treatment of Diabetic Coma

In planning treatment one must keep in mind the following objectives: (1) to replace the insulin deficit promptly; (2) to correct dehydration; (3) to prevent or treat chemical abnormalities such as a low serum potassium, low plasma chloride and blood nitrogen retention; (4) to discover and treat complications.

It is the physician's serious responsibility to make the diagnosis early and to institute vigorous treatment promptly. In a known diabetic with a classical history, given by relatives, the diagnosis may be easy. In an unconscious, unidentified patient brought without relatives or friends to the emergency ward of a large city hospital, the recognition of the condition may be more difficult.

However, diagnosis will depend chiefly on keeping the condition in mind. At times in the known diabetic there may be difficulty in differentiating between unconsciousness due to hypoglycemia and to diabetic coma. Consequently the differential diagnosis between these two conditions must be familiar to the physician and, in case of doubt, laboratory aid must be sought without hesitation and at once. A few minutes or an hour or two may make the difference between life and death.

The patient in diabetic coma belongs in a hospital. Success in treatment depends upon attention to details and upon close continuous attention of physicians and nurses. Immediately upon arrival an adequate history and physical examination should be made expeditiously. The urine, obtained by catheter if necessary, should be tested at once for sugar and diacetic acid. Blood should be drawn for the determination of sugar, CO_2 content, nonprotein nitrogen and such other constituents as may appear indicated. A trained technician always on call in the laboratory should begin the analyses at once and be prepared to give a report regarding the blood sugar and CO_2 in at least an hour and preferably in forty-five minutes. However, one does not wait to learn the results of the blood analyses before starting treatment. If the history, physical findings and urine tests are characteristic, one should proceed without delay with the giving of insulin and fluids.

Diabetic coma is primarily a state of acute deficiency of insulin. Other measures in treatment, however admirable, will be futile unless enough insulin is given. Moreover, to insure maximum success, large amounts must be given early, that is, within the first two or three hours of treatment. In the adult patient with full-blown coma, often several hundreds of units of insulin will be necessary. The initial dose given a few minutes after admission may well be 100 units subcutaneously with an additional 100 units intravenously with patients in circulatory collapse. At one hour after admission when the results of the blood sugar and CO_2 determinations are available, additional insulin may be given as follows:

If the initial blood sugar is—

300- 600 mg. per 100 cc. give 50 to 200 additional units
600-1000 mg. per 100 cc. give 200 to 300 additional units
Over 1000 mg. per 100 cc. give 300 to 400 additional units

Often more insulin is indicated at the second hour after admission. It must be emphasized that treatment cannot be made routine but must be individualized and altered to suit changing needs. The blood sugar should be obtained at first every two to three hours.

The first three to six hours of treatment must be viewed as an attempt to stage an overpowering onslaught in the battle against the acute acidosis. In the presence of acidosis, insulin must be regarded as one does paper money in times of inflation, gauging the amount used not according to normal standards but by the effect secured. Following the giving of large amounts of insulin initially, subsequent needs during the first eighteen to twenty-four hours may be judged by blood and urine tests at appropriate intervals.

It goes without saying that care and judgment must be used in deciding as to the amount of insulin to give in any individual case. Children usually require much smaller doses than adults. Patients with diabetes of recent onset who have never received insulin before may respond more readily than those with well-established diabetes who have been taking insulin. Finally, those patients with less severe acidosis usually require less insulin.

The second important matter in the treatment of diabetic coma is the overcoming of dehydration with fluid and replacement of lost electrolytes. During the development of acidosis various electrolytes have been lost from the body: sodium, chloride, potassium, phosphorus, calcium, magnesium, et cetera. Some have tried and are trying complex solutions containing varying proportions of these elements.[1] These attempts to improve therapy are to be encouraged since the thought is logical and sound. However, although everyone recognizes that physiological solution of sodium chloride does not offer complete replacement of lost electrolytes and may provide a temporary excess of sodium and chloride, in practical usage it works out very well indeed to use this solution for intravenous administration during the first few hours of treatment. For most physicians this readily available solution is at present the best and safest to use. One may start an intravenous infusion of salt solution shortly after admission and continue this until 2,000 to 5,000 cc. and occasionally more have been given, gauging the amount by the degree of previous dehydration and the general condition of the patient.

Other points in treatment deserve mention. Since the stomach is often dilated, it is well to

carry out gastric lavage routinely shortly after admission, thereby relieving distention and paving the way for the early institution of oral feedings. The patient should be kept warm but this is better done by means of blankets rather than by hot water bottles or electric pads because of the danger of burning the patient. Blood transfusion is only occasionally indicated. Stimulants such as adrenalin and caffeine rarely are of real value. Of prime importance, however, is the beginning of oral feedings as soon as possible. This can often be done within 5-6 hours after the beginning of treatment although at times nausea and vomiting may continue and preclude such. Continued vomiting suggests the need of repetition of gastric lavage. When oral feedings are begun, these are at first of water and this is followed by broths, gruel, orange juice, tea with sugar and gingerale. By this means, valuable electrolytes, including potassium, are automatically offered to the body.

In recent years much has been said and written regarding the behavior of potassium in diabetic coma.[6] Although when the patient is first examined, the blood potassium may be high, it is artificially so because of hemoconcentration. As hydration proceeds and as recovery takes place the blood potassium falls and may reach a truly low point 8 to 18 hours after treatment has been started. If it reaches a certain critical level, 2.5 to 3 m. eq. per liter or below, weakness progressing to muscular paralysis, including respiratory paralysis, may take place and rarely cause fatal issue. The level of the blood potassium may be followed by actual determinations using the flame photometer if such is available. If not, a rough idea may be obtained from serial electrocardiograms although these are by no means infallible. Rarely will clinical symptoms of hypopotassemia develop if one avoids the use of glucose intravenously during the first hours of treatment and if one starts oral feedings early as described above. Potassium solutions may be given more safely by mouth than by vein. Particularly if they are given intravenously, one should be certain that renal function is adequate because hyperpotassemia may prove fatal by causing cardiac arrest. For a discussion of types and concentrations of solutions for intravenous use, see the articles by Butler[1] and Martin, Hillier and Wertman.[6]

Glucose should not be given during the early hours of treatment. The glucose which is already flooding the blood and body fluids is just as serviceable as any glucose which one can inject. To inject still more is to add insult to injury. Glucose is metabolically inert until it can be normally phosphorylated and this cannot take place until adequate amounts of insulin have been given. As noted above, the overgenerous use of glucose may favor the development of a low serum potassium since in the deposition of glucose as glycogen, potassium accompanies glucose and goes from the blood into fixed tissue cells. If glucose is being infused it is difficult to use the blood sugar level as a guide to the amount of insulin to be given. Finally, the use of glucose detracts attention away from the all-important matter of giving enough insulin. However, after large amounts of insulin have been given and the blood sugar has fallen satisfactorily, glucose may then be given parenterally if necessary, though rarely is there need.

The use of sodium bicarbonate is unnecessary and in some cases potentially harmful. The use of alkalies attempts to treat acidosis by striking at the effects rather than the cause of the abnormal condition and by decreasing rapid breathing may lead to a false sense of security. Sodium lactate offers certain advantages but with it, as with sodium bicarbonate, there is danger in overdosage.

In the successful treatment of diabetic coma, constant personal attention of the physician and the fearless use of insulin in adequate dosage are all important. No patient should die in or from diabetic coma unless there exists an acute complication which in itself is fatal. Deaths due to the fact that patients are not brought for treatment until they are moribund can in time be reduced in number or avoided by continuous education of the patient and his family from the day of diagnosis. A death in diabetic coma is a needless death.

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The Treatment of Alcoholism in an Out-patient Clinic

By Frank A. Cellar, M.D., and
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THE Outpatient Clinic of the Detroit Committee on Alcoholism was established in April, 1950. It was anticipated that this facility might serve as a model for a statewide approach to the wider treatment of this disease. The purpose of the present paper is (a) to review the history of the organization of the Clinic; (b) to outline the rationale of the clinical treatment of alcoholism; (c) to describe the treatment methods currently used, and (d) to suggest a tentative evaluation of the results obtained with the first 444 patients.

The Clinic was started through the efforts of public spirited individuals and with funds contributed by the Detroit United Foundation. The Detroit Committee on Alcoholism has two major functions: education and treatment. Although we realize the great importance of the educational program for prevention as well as treatment, we are limiting our present discussion to the treatment aspects of the problem. (The educational program of the Detroit Committee on Alcoholism is supervised by an educational director who is responsible also for administrative duties at the Clinic).

The treatment program, which is a function of the Outpatient Clinic, is headed by a medical director. The staff consists of a psychiatrist and an internist who work on a part-time basis; and a clinical psychologist and a psychiatric social worker who serve full time. Only since January 1, 1951, has the staff been complete.

The Clinic deals primarily with a group in which drinking has interfered with social, economic, or marital adjustment. Since we treat individuals on an outpatient basis, we do not deal except in a limited way with psychotic or other severely disturbed groups, nor do we treat nonambulatory patients.

From the Departments of Psychiatry and Medicine of Wayne University College of Medicine, Detroit, Michigan.

Study based on the first year's experience of the Outpatient Clinic of the Detroit Committee on Alcoholism.

The alcoholic group treated here uses alcohol to allay anxiety and tension, and in an attempt to solve their own emotional problems. Because of the personality structure implied by this behavior, and because of possible physiological disorders which are not well understood at present, the individual's life pattern becomes organized—and disorganized—in terms of his drinking.

Therapeutic procedures are based upon the conception of alcoholism as a syndrome consisting of a prodromal phase, a critical phase, and a chronic phase.[2] The prodromal phase includes excessive drinking without loss of control; individuals in this stage may have had brief retrograde amnestic episodes as a result of drinking ("blackouts"), and liquor has assumed increasing importance in their lives. The critical phase includes the loss of control over how much is drunk at a given time, and at what time the drinking will occur; this loss of control is apparently thereafter permanent, so that the individual cannot again drink in a controlled, socially acceptable manner. During this phase "dry periods" (i.e. going on the wagon) which represent remissions of the behavior pattern are common. Further, it should be understood that loss of control is not absolute for a brief period. However, the alcoholic who persists in drinking one or two drinks at a time will certainly soon end up drunk. The chronic phase includes the complications of alcoholism, such as alcoholic polyneuropathy, portal cirrhosis, delirium tremens, Korsakoff's psychosis, Wernicke's syndrome, and cerebral atrophy. Ambulatory individuals with certain of the above complications who are able to come to the clinic receive treatment.

The treatment of the alcoholic represents a coordinated effort of the different skills of the staff. The first interview, which is conducted by the clinical psychologist or the psychiatric social worker, is utilized to obtain pertinent historical information regarding the patient's drinking and social problems. An attempt is then made to resolve the immediate stresses so that the individual can devote his energies to working with his main problem.

Handling the immediate situation often involves requesting the help of social agencies to provide necessities for his family on an emergency basis. It may be necessary to contact his employer or public employment agencies to secure employment. Family counseling may prevent disruption

of the family, and strengthen family unity of purpose in dealing with the immediate stresses related to alcoholism. Referral of the patient to Alcoholics Anonymous has been of great value during this stage as well as in the later stages of treatment. The patient's physical condition may present an emergent problem which, if possible, is treated at our clinic, but, if necessary, hospitalization is arranged. We do not have a direct connection with any hospital, but have received splendid co-operation from hospitals in the community for this purpose.

If the patient wants treatment at the clinic, arrangement for a physical examination is made to evaluate presence of organic disease. Necessary laboratory work is then ordered. If any organic diseases are discovered every effort is made to correct these, utilizing whenever possible the services of the patient's private physician. It has been found that medical or surgical problems present may require a priority in treatment, and undoubtedly the general improvement of the patient's health increases the amount of energy he can use to work with his alcoholic problem.

If it is discovered that the patient is psychotic, is suffering from organic brain disease, or requires in-patient care for other reasons, he is referred to other available facilities. While there are few agencies that deal with the problem of alcoholism specifically, there are many resources that can be mobilized to help answer the individual's needs.

The emergency situation having been handled, treatment continues mainly through the psychotherapeutic relationship of one therapist with the patient. In addition, through staff conferences, or as special needs may arise, a co-ordinated effort of all the skills of the clinic is maintained.

Where supportive medical care is needed certain drugs have been used. These include Mephenesin which is frequently useful for the relief of tremors and tension states associated with alcoholism; Benadryl has been of value in certain cases because of its soporific action, and is used in preference to barbiturates or other sedatives to which the alcoholic is prone to become "addicted." In this connection it should be mentioned that considerable caution is advisable in prescribing habituating or addicting drugs to an alcoholic. Care should also be taken not to prescribe medication containing alcohol to a problem drinker. Vitamins and special diets are prescribed when necessary, especially for the malnutrition one often sees in alcoholics. Adrenal cortical extracts have been used in some cases in conjunction with the other supportive treatment outlined. Antabuse is administered in selected cases only after the patient has been referred to a hospital where Antabuse therapy has been started.

Tentative Evaluation of Results

From April, 1950 through June, 1951, 444 patients were seen at the clinic. Because of the chronic nature of the disorder, and the many variables involved, and since no method of treatment has been developed which enables the alcoholic to drink in a controlled manner, it is advisable to think in terms of a remission and a readjustment rather than a cure.

In evaluating treatment results we have used the criteria suggested by Jacobsen and Martenson-Larsen,[1] as follows:

1. *Socially recovered*—designates a patient who can competently perform his work and live in harmony with his family. He may have relapses, but they are few, do not last more than twenty-four hours and do not influence his work or his family life.
2. *Much better*—designates a patient who can perform his work with integrity and who has had a few relapses that have not disturbed his social status.
3. *Somewhat better*—designates a patient that is somewhat improved but is subject to attacks which influence his work and/or his family life.
4. *Unchanged*—designates a patient in whom no real improvement has been noted.

To the above we have added a group labelled *Unknown* (5), to indicate that follow-up has not been possible. These we are listing as failures, although we realize that some of this group may actually have received some benefit from treatment. The results to date are shown in the accompanying table:

Socially recovered	Much better	Somewhat better	Unchanged	Unknown	Total
(1)	(2)	(3)	(4)	(5)	
128	93	31	12	180	444
29%	21%	7%	3%	40%	100%

Thus 50 per cent have shown substantial improvement, and another 7 per cent slight improvement, while 43 per cent are presumed to be unchanged.

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Doctors' Fees and the Wage Earner's Dollar

By Norman E. Clarke, M.D.
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THOSE WHO speak or work for socialization of the medical profession claim that doctors' fees have increased beyond the paying ability of the average American wage earner. Our total medical costs, like taxes and other living expenses, necessarily have increased with the passing years and our cheapened dollar, while the increased use of hospitals and modern diagnostic facilities, if there were no other reasons, would make higher sickness costs inevitable. However, the people who advocate socialized medicine mention softly, if at all, these new and now major parts in the cost of treating illness. They quote the obvious increase in total medical costs as supporting their assertion that high fees charged by physicians is the major cause of it all.

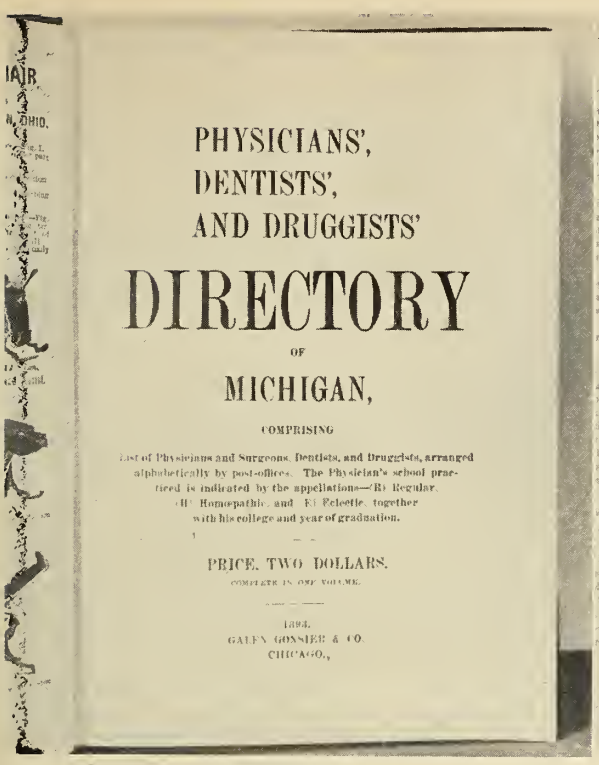
It is painfully obvious to anyone who has to work for a living that today's dollar has to cover numerous expenses that did not exist even several years ago. Our government takes prior lien on the employe's pay check and abstracts many dollars for his old age pension, social security and other deferred benefits. This involuntary contribution for a possible future security is part of the living cost, though of no personal current value. When the wage earner has made the payments on his automobile, refrigerator, television or radio set, and numerous other modern conveniences, he does feel cramped financially. With his pocketbook deflated by high taxes, alluring advertising and easy credits, his feeling of financial insecurity conditions a sympathetic attitude to the false dogma of something for nothing. The cost of unwanted, unexpected and unplanned-for illness makes the doctor and his fee an easy target to blame for financial embarrassment, and it becomes just an easy step for many people to believe the self-serving claim that doctors' fees are excessive.

This argument has gone on for years, so it is time to look at the record. The question is: are present-day doctor fees beyond the paying ability of the people with average incomes or, putting it in a provable manner, have doctors' fees increased out of proportion to the average wage earner's income? To answer this question we must first go back to a period when taxes were reasonable and the temptation to mortgage income for luxuries did not exist.

For determining the real cost of a physician's fee, its variation in cost at different times, or the ability of wage earners to pay for such a service, we must compare the fee with the number of hourly wages a man needs earn to pay for it. For example, how many industrial hours' pay were required in 1893 to pay for a specific doctor's fee as compared to the present-day hourly wages required to pay for the same service. With this yardstick applied to a sufficient variety of medical fees over this period of almost sixty years, we can learn whether doctors' fees have become excessive and beyond the paying ability of working people. We must assume everyone's willingness to consider reasonable ability to pay as being confined to the purchase of life necessities without considering the obligations of unnecessary luxury purchases or excessive taxes.

The fact that industrial workers income has increased progressively during the past sixty years is presented in the book by Paul H. Douglas entitled "Real Wages in the United States—1890-1926." For the years after 1926 we find continuing information in the "Statistical Abstract of the United States," published by the United States Department of Commerce in 1949, and the later "Industry Report" of the United States Department of Labor. These compiled records show that the average hourly wage rate for all industry in 1893 was 21.6 cents; by 1910 it had risen to 28.8 cents, and in August, 1950, the average hourly earnings in manufacturing were $1.46 an hour and, of course, are still higher today.

During this same period of years the standard work week in all industry gradually declined. In 1893 the industrial wage earner worked 58.2 hours a week; by 1926 this had fallen to 49.8 hours, and in 1946 it was 40.1 hours. With this reduction in hours worked per week, the average weekly earnings of all employed in industry rose from $10.93 in 1893 to $32.39 in 1926, and in August of 1950 they had risen to $60.32. So over a period of fifty-seven years the average wage earner employed in industry increased his earnings from $10.93 for a work week of 58.2 hours to $60.32 in 1950 when working 40 hours per week. The industrial workers weekly income, therefore, in-



PHYSICIANS',
DENTISTS',
AND DRUGGISTS'

DIRECTORY

OF

MICHIGAN,

COMPRISING

List of Physicians and Surgeons, Dentists, and Druggists, arranged alphabetically by post-offices. The Physician's school practiced is indicated by the appellations—(R) Regular, (H) Homeopathic, and (E) Eclectic, together with his college and year of graduation.

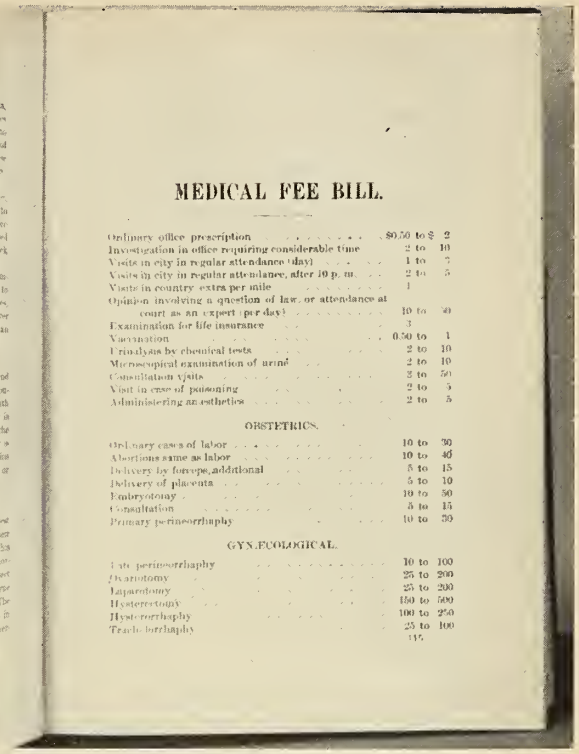
PRICE, TWO DOLLARS.

COMPLETE IN ONE VOLUME.

1893.

GALEN GOSSIER & CO.
CHICAGO.

Fig. 1



MEDICAL FEE BILL.

Ordinary office prescription	$0.50 to $ 2
Investigation in office requiring considerable time	2 to 10
Visits in city in regular attendance (day)	1 to 3
Visits in city in regular attendance, after 10 p. m.	2 to 5
Visits in country, extra per mile	1
Opinion involving a question of law, or attendance at court as an expert (per day)	10 to 50
Examination for life insurance	3
Vaccination	0.50 to 1
Urinalysis by chemical tests	2 to 10
Microscopical examination of urine	2 to 10
Consultation visits	3 to 50
Visit in case of poisoning	2 to 5
Administering an esthetics	2 to 5
OBSTETRICS.	
Ordinary cases of labor	10 to 30
Abortions same as labor	10 to 40
Delivery by forceps, additional	5 to 15
Delivery of placenta	5 to 10
Embryotomy	10 to 50
Consultation	5 to 15
Primary perineorrhaphy	10 to 30
GYNÆCOLOGICAL.	
Late perineorrhaphy	10 to 100
Ovariotomy	25 to 200
Laparotomy	25 to 200
Hysterectomy	150 to 500
Hysterorrhaphy	100 to 250
Trachelorrhaphy	25 to 100

Fig. 2

creased 550 per cent in fifty-seven years although working eighteen hours less.

There are no inclusive records of physicians earned income or hours worked for the years 1893 to 1950, but these are not necessary, and income alone could be misleading, for a doctor's cash earnings will vary with the hours worked and the amount of his fees collected. Doctors' incomes have increased, but there has been no reduction in the number of hours worked each week by practicing physicians. It is a certainty that the average practicing physician of today devotes as many hours to his practice as did the physician of sixty years ago, and it seems equally certain that the average present-day physician's income does not exceed by 550 per cent that earned by doctors sixty years ago.

The Michigan State Medical Society published in 1893 a book entitled "Physicians, Dentists and Druggists Directory of Michigan," which lists the medical fees charged by physicians of that day, giving the minmuim and maximum fee for specific medical and surgical services (Figs. 1 and 2). As the advocates of socialized medicine have chosen to base much of their propaganda on doctors' fees, the argument can be met by comparing the present-day fees of Michigan physicians, which are representative of the same in other states, with those charged sixty years ago and, similarly, comparing with the hourly earned wages of the two periods.

A few representative medical services with corresponding hourly wage incomes will give the facts. The preliminary to medical care is a general physical examination which usually is performed in the physician's office. The Michigan doctor of 1893 charged an average fee of six dollars for this service so the average industrial workman earning 21.6 cents an hour was required to work 27.8 hours to pay for this service. Today the general medical practitioner in an industrial city like Detroit charges ten dollars for a general physical examination, and the medical specialist charges fifteen dollars. The present industrial wage earner, paid $1.46 or more an hour, can purchase his general medical examination from a general practitioner for 6.2 hours' work. He can have a physical examination by a specialist for 9.4 hours' work. Such examinations occasionally are followed by laboratory or x-ray studies which have been mentioned as increasing the cost and which might support the alleged inability to pay. It should be emphasized that these additional studies are not a part of most physical examinations but,

where necessary, today's wage earner still has 21.6 hours wages to spend before the actual cost of his modern over-all examination equals what his fellow paid in 1893. If he spent the same time, 27.8 hours, that the earlier worker did, he would pay $40.58 for his general physical examination, and this is more than most people have to pay for this service.

When consultation was required in the nineties, the consultant's fee averaged $26.50 and was paid by the industrial wage earner with the wages of 122.6 hours' work. Today, in cities like Detroit, the average specialist consultation fee is $25, so the wage earner worked but 17 hours to pay for this medical service. This uncommon medical expense, therefore, can be purchased for less than one-seventh of that paid by the industrial worker of 1893, and with this great saving the present medical consultant gives the benefit of sixty years' advance in medical knowledge.

A necessary medical service is child delivery, and there were few obstetrical specialists in 1893, when the average fee was $20, which did not include before-and-after delivery service. The fee of present obstetrical specialists varies, with some being high, but for people of average income, exclusive of before-and-after delivery care, an average fee is not more than $100. When an industrial wage earner's wife had a baby in 1893, he worked 92.5 hours to pay the doctor's fee, but today his wife can have the services of a specialist and the fee be paid with only 69 hours' work. The modern general practitioner is a competent obstetrician, and his child delivery fee averages $50, which permits this important service to be purchased for only 35 hours' work. Much has been said about catastrophic illness, meaning, usually, the expense of major surgery, as the cost of prolonged chronic illnesses like tuberculosis and mental disease is now assumed largely by government. One of the commonest surgical operations is hysterectomy, or removal of the female womb. The average fee for this operation in 1893 was $325, which was paid by the wage earner with 1,504 hours' work. Today, qualified surgeons charge $200 for this operation, which the wage earner can pay for with only 137 hours' work. Again he gets the superior skill of the modern surgical specialist and at a saving of 1,367 hours' work, or he pays less than 10 per cent of its former cost. Another common operation is for correction of uncomplicated rupture or hernia. Sixty years ago the average surgical fee was $100, or it cost the industrial wage earner 485 hours' work, and the present-day surgeon charges $125.00 for this operation, which costs the wage earner only 86 hours' work.

Various fields of surgery have become subspecialties, and the fees charged by these doctors usually are larger than those of general surgeons, but they must be included in today's over-all medical cost picture. Rectal surgery is such a subspecialty, and hemorrhoid removal sixty years ago cost the average fee of $21.50, which the wage earner paid with 99 hours' work. The same operation today, performed by a surgical specialist, costs $100, which is paid by the wage earner with 69 hours' work. Surgery of the eye is another special field, and when they operated for removal of eye cataract sixty years ago, the average fee was $112.50 or the equivalent of 520 hours' work by the wage earner. The modern eye surgeon charges $200 for this operation, which is paid with 138 hours' work by the wage earner. The present-day wage earner purchases this operation for about one-fourth of what it cost sixty years ago. The fitting of glasses is required sooner or later by most people, and in 1893 the doctor's fee averaged $6 or 27.7 hours' work of a wage earner. The fee for this same service today averages $10 and can be paid with the wages of seven hours' work.

The specialty of orthopedics is one of the smaller specialty groups and their fees, generally, have increased more than in other surgical fields. In 1893 the average fee for setting a fracture of the humerus or a broken bone in the upper arm was $17.50, which was paid with 80 hours' work by the wage earner. This same service today, when performed by a qualified orthopedic specialist, costs $100 or 69 hours' work by the wage earner. If the leg was amputated at the thigh in 1893, the average surgical fee was $87.50, which cost the wage earner 405 hours' work, but today the fee for this operation is $200, which costs the wage earner only 138 hours' work.

One could multiply these examples, and all would show the same decline in the real cost of physicians' fees. This true yardstick of cost reveals clearly that physicians' and surgeons' fees today are not excessive or beyond the paying ability of working people and remain as the only essential

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Poliomyelitis and Injections

By Mario S. Cioffari, M.D.

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THIS YEAR something new has been added: the question of whether there is any connection between all types of hypodermic injections and the incidence and severity of poliomyelitis. The importance is obvious; we have been trying for years to convince people of the necessity of immunization, and now considerable doubt has already developed in the minds of parents, whether to have the injections during the summer, or whether to have them at all, which is very regrettable.

It is with this thought in mind that the present study was undertaken. The shadow has been cast on all inoculations, therapeutic or otherwise. Writers presenting more recent data have been trying to exonerate allergic or therapeutic injections, but still blaming the others. Even here the general consensus is that injections *per se* do not bring on an attack of poliomyelitis but that the infection will tend to localize in the injected limb and be more severe. Some have theorized that the child may have a dormant infection which is aroused by the serum.

It is our purpose to prove these points: that an injection will not induce poliomyelitis and that it is rash to postpone necessary protection and treatment on the remote possibility of making an acquired infection worse.

Guy Bousfield[1] gave 293 children two injections each, one month apart during a severe epidemic of polio, with no resulting paralyses. Two other English investigators, A. Bradford Hill and J. Knowelden,[4] are not convinced of any relation. They state that with the available data the relative risk of poliomyelitis after inoculation, either at different ages or with different antigens, cannot be assessed.

B. P. McCloskey[5] has a series of thirty-one cases of paralysis within three months in a group of 340, with emphasis on pertussis vaccine as the main culprit. He states, "The parents of children were naturally inclined to blame the inoculations for the development of the disease."

In another series,[6] fourteen cases out of 495 under ten had been immunized within one month. Even admitting abnormal types of paralyses, the percentage here is also too low to be completely free of doubt about chance localization. This investigator deduced, "There appears to be no relationship between the substance inoculated and the paralysis." He also gives a word of warning: "It is admitted that any measure affecting the immunization campaign must be given most careful thought lest more harm than good ensue," and, "In any case when the number of inoculations given is considered, these complications are obviously rare."

In preparing this report, we have closely examined the records in our private practice. These are all children of middle class families, residing in Wayne and Oakland Counties, Michigan, from the age of six weeks to fifteen years. We were not primarily concerned with the number of children involved, but rather with the location, type, number of inoculations, and the type of serum used.

The following serums are involved in this series: alum precipitated pertussis, diphtheria-tetanus, and diphtheria-pertussis-tetanus, with fluid diphtheria or tetanus for those over ten years of age, catarrhal vaccine, influenzal vaccine, Schick and Dick tests, smallpox vaccine, precipitated scarlet fever serum, and gonadotropic hormone. By far the largest number were immunizing antigens; penicillin, adrenalin, or allergy injections were not included.

The survey covers four years, and this year only was the advisability of summer injections discussed with the parents. There were none who, having come to the office, considered the risk so great as to postpone the injections. For our purpose, the period was limited to the time from May 1 to November 1, 1948-1950 and May 1 to September 1, 1951, as being representative.

Within these boundaries there were given 3,200 injections to 1,601 children; of these, 1,664 were in 785 boys and 1,536 in 816 girls; 401 children under six months received 949 injections, and 1,260 children over six months received 2,251 injections. The breakdown is shown in Tables I and II.

The smallest number of injections per child was one, and the largest nine, each of which would have been a separate contamination if any virus were introduced at the time.

This representative series of children produced not one case of site-correlated polio within three months of injection. The longest interval that is

TABLE I. INJECTIONS IN BOYS

Age	1948	1949	1950	1951	Cases of Polio
1-5 mo.	75	73	142	165	0
6 mo.-1 yr.	151	127	176	145	0
2-5 yrs.	48	80	171	114	0
6-10 yrs.	40	38	54	41	1
11-15 yrs.	1	7	4	10	0
Totals	315	325	547	475	1

TABLE II. INJECTIONS IN GIRLS

Age	1948	1949	1950	1951	Cases of Polio
1-5 mo.	84	105	139	166	0
6 mo.-1 yr.	105	141	170	134	0
2-5 yrs.	69	80	86	112	0
6-10 yrs.	41	47	20	22	0
11-15 yrs.	2	3	2	8	0
Totals	301	376	417	442	0

now claimed to have any bearing is thirty days. There was only one child who developed polio within four weeks. He was nine years old, had had injections in both triceps, and developed slight weakness of the soft palate, left gastrocnemius and anterior tibial muscles within two weeks of inoculation.

During this period of observation 1948-1951, we have had quite severe epidemics in this area, the incidence rate of children under fifteen years going up to .88 per 1,000 in 1949. Many of our children were undoubtedly exposed without contracting the disease.

The severity of the reaction from the inoculation is thought by some to have a bearing on the resulting paralysis. We have noticed in our series that the child will have a progressively increased reaction in relation to age, starting at about one year of age, irrespective of the brand of serum; children from five to ten years of age, for instance, will regularly have a severe local and sometimes a systemic reaction, so much so that we don't give triple vaccine from four years up and only fluid serum from ten years of age and up. The factor of local reaction is therefore too common to be taken into consideration.

L. S. Goerke,[3] following his survey in the Los Angeles Health Department, is convinced that we are doing more harm than good by the summer ban. He states, "It appears inadvisable to permit the chance occurrence of poliomyelitis following injections to interfere with the continued mass elimination of diseases equally crippling and fatal." His observations do not show any marked difference between the recently immunized and the controls.

Somewhat in the same vein is an editorial[2] revaluating our present stand: ". . . Now we turn and say avoid them (injections) during the polio season. It will be a difficult task to make the public understand that the immunizations and injections do not predispose a child to polio. . . . We must not lose what has been gained over the last twenty-five years because of the hysteria engendered by the recent polio campaign. . . . The final responsibility rests on the judgment of the physician in determining the relative importance of the risks."

Discussion

In this article we have shown that there is no relation between an injection and the inciting of poliomyelitis. The chance of reactivating whooping cough or diphtheria epidemics is real, but of acquiring paralytic polio at all, is slight. That an infection may be worse and may localize in the injected limb is still debatable.

In our series, by far the largest percentage of school children came for their inoculations in the warm months: toward the beginning or end of the school year, and through the summer. When an older child comes in for a booster injection, or what is more serious, if he comes in without any previous protection, in May or June, it does not seem reasonable to postpone antigens until November (30 per cent of polio cases occur October through December).[6] There will be an additional lag of three to four months to produce immunity in virgin territory.

Are we to let that child be a potential hazard to himself and community for six months to a year longer? The problem must still be left to the discretion of the individual doctor. We do not stop athletics, national sports and strenuous children's games during the summer, though there is more evidence about the evil effect of exhaustion in polio.

The summer vacation is the logical time for immunizing older children; they are in better health, they are out of school, and are coming in for check-ups anyway. Many have not had boosters since infancy and are, therefore, very susceptible to communicable diseases.

The question of whether the paralysis will localize in the left arm or right leg seems almost academic, but it would be a more serious decision to make between bulbar type and an extremity.

We know very little about poliomyelitis; we are

continually stabbing in the dark or grabbing at straws as to how it may be spread. Once a child has acquired the disease, it is easy enough to blame anything that came before and find a relation to it.

The only thing that we are sure about polio is that it is a very unpredictable disease; that, like a tornado, it will affect one child in a family and none of the others, or it may affect all four or five siblings; one year the individual cases of an epidemic are very mild, and the next will bring severe paralyses and a high mortality; in some areas the case incidence will be high, and just as unexpectedly the next visitation will give a very low incidence. We shall, therefore, need many more thousands of severe paralytics, immunized within the previous month, before we stop immunizations for six months out of the year. Even that would not change the relative risks. Statistically, the chances of getting severe paralytic polio are infinitesimal as compared to the millions of injections of all types given each year.

We have nothing tangible to offer parents on the prevention of poliomyelitis, and not much after paralysis has occurred, but we do have something very tangible for prophylaxis of whooping cough and diphtheria. Mortality has been reduced from 7.4 per 100,000 in 1900 for the former, to 0.4 per 100,000 in 1950, and from 29.1 per 100,000 in 1900 for the latter to 0.0 per 100,000 in 1950. This was not done by spasmodic campaigns, but by very persistent efforts by all concerned. We feel, therefore, that immunization against the communicable diseases should be carried out the year around. You cannot turn them on and off like a faucet; you cannot make the public immunization conscious one minute, and distrusting the next.

Summary and Conclusions

1. In the four years 1948-1951 we have given 3,200 injections in our private practice during the months in question—1,664 in boys and 1,536 in girls from the age of six weeks to fifteen years.

2. The serums and vaccines included were pertussis, diphtheria, and tetanus—single and in combination, fluid and alum-precipitated—smallpox, scarlet fever, influenza, and catarrhal vaccine, Schick and Dick tests.

3. In this series there was only one very mild paralytic polio case within three months of injection, not related to the site of inoculation.

4. We feel that there is no relation between the incidence rate of polio and injections of any kind. If there is any relation to severity, the proof is still forthcoming; the weight of evidence thus far presented does not warrant the postponement of protection and treatment by injection for a period of six to eight months out of the year.

5. It would be advisable, for the present at least, to finish the first series of immunizations by six to seven months of age, and to give the occasional booster when necessary.

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AD—Two (2) Mono Tables

MSMS

THE TREATMENT OF ALCOHOLISM IN AN OUT-PATIENT CLINIC

(Continued from Page 723)

Because of the brief period of follow-up of many of the patients, it should be emphasized that the results are only tentative. They show that, given constructive aid, alcoholics will react favorably. How effective the help is can be evaluated fully only after the patient has been observed for a sufficiently long period of time.

Summary

The clinic represents the first attempt in this State to treat alcoholism at a community level. It is felt that the results obtained have justified the efforts and money expended. An extension of this program through similar agencies on a state-wide basis should be contemplated.

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Detroit Physiological Society
and the
Society of the Sigma Xi

JOINT MEETING OF APRIL 24, 1952

Radioisotopes, Their Properties and Applications to Chemistry

R. B. Hahn
Department of Chemistry, Wayne University, Detroit

Radioactive substances emit three types of radiation: positively charged alpha particles, negatively charged beta particles and gamma rays. These radiations can be measured with an electroscope or Geiger-Mueller counter. Thus, very minute amounts of radioactive isotopes can be detected.

Since radioactive isotopes have the same chemical properties as the inactive isotope, they can be used as "tracers" in studying various chemical reactions. By the use of C^{14}, the mechanisms of various organic reactions have been determined. The efficiency of various methods of chemical separations can be studied by using mixtures of radioactive isotopes. By activating certain elements with neutrons, minute quantities, undetectible by any other method, can be measured. Radioactive isotopes have become an important tool to the chemist.

Some Applications of Radioisotope to Engineering Problems

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College of Engineering, Wayne University, Detroit

The properties and characteristics of radio isotopes which make them valuable tools in industry may be listed as follows:

The radiation from isotopes penetrates containers and opaque walls of any material; the radiation is absorbed in logarithmic proportion to the thickness and density of any material it passes through; radiation destroys bacteria; radiation ionizes gases and dust particles; radiation is scattered by liquids and solids; minute quantities of radio isotopes are detectable; chemically identical atoms may be differentiated because of radiation; fast neutrons are slowed down by moderators such as parafine or water; and slow neutrons striking some atoms make them radioactive.

Each of these properties is useful in the application of Radioisotopes to the solution of industrial and engineering problems.

Radioactive Isotopes in Biochemical and Metabolic Studies

Ralph M. Johnson
Detroit Institute of Cancer Research

Direct chemical analyses of animal tissues for elements or metabolites have failed to provide many of the details of metabolism of the substances. "Tagging" of the element or metabolite, however, has facilitated following its course of utilization. Radioactive isotopes have found by far the widest use of any of the labelling substances that are introduced into the body for the purpose of making biochemical and metabolic studies.

One of the greatest fundamental contributions made by this tool in biochemical research has been in the study of transfer of materials across membranes within the organism. Factors affecting absorption of nutrients from the intestine may be cited as an example of this. Another field investigated with the aid of radioactivity has concerned the production of secretory and excretory products by the various specialized tissues and organs of the body. Factors influencing, or concerned in the utilization of, vital metabolites have been elucidated using radioactive isotopes, and in general, it is now known that there is a constant renewal of most of the body constituents. In the mature animal, for example, most of the materials in the body remain at a fairly constant amount, the continuous degradative processes corresponding closely to the formation of those substances.

Examples were given of the use of P^{32} in biochemical studies. Its employment has provided evidence that a phosphoprotein exists which is important in the intermediary metabolism of phosphate. In another instance it was shown that there is an increased phosphorylative activity in acid

soluble organic phosphoprotein, and nucleic acid fractions within cells during the period of cell growth and immediately prior to cell division. Phospholipid phosphorylation appears to be more closely associated with cell division.

Diagnostic and Therapeutic Use of Radioisotopes in Medicine

R. W. Smith, Jr., M.D.
Henry Ford Hospital, Detroit

Attention was called first to the historical significance of radium. From extensive experience with this natural radioactive element has come much of our understanding of the biological effects of radioactivity in man. The value of radioactive phosphorus (P^{32}) in treating polycythemia vera and leukemia was discussed. Its use diagnostically in suspected brain tumors, in differentiating breast tumors, and in hyperparathyroidism was then reviewed. Considerations were given to the use of P^{32} in determining blood and plasma volumes, circulation times and peripheral diffusion rates. The role of radioactive iodine (I^{131}) in the diagnosis and treatment of thyroid disorders, including carcinoma, was then reviewed. Both the assets and debits were acknowledged. Attention was given to its use in locating intracranial tumors when the isotope was incorporated into the fluoroescein and albumin molecules. I^{131}-tagged albumin has been used to determine circulation times and plasma volumes while the inorganic I^{131} has found a limited place in treating certain refractory heart problems. Radioactive sodium (Na^{24}) has been proven of value in measuring peripheral diffusion rates, circulation times and extracellular fluid volume. The recent uses of radioactive gold (Au^{198}) in treating effusions arising secondarily to malignancies were then reviewed, as were its applications to the direct treatment of uterine cervics and prostatic carcinomas. The increasingly important role of radioactive cobalt (Co^{60}) in medicine as an inexpensive substitute for radium was noted, brief attention being given to the reasons why Co^{60} is threatening to replace radium as a source of therapeutic radiation. Finally, brief mention was made of the limited experiences reported with gallium[72], strontium[89], bromine[82] and arsenic.[71] It was stated, summarily, that the radioactive isotopes were of growing importance to medicine but that in no sense could they be considered as revolutionary.

DOCTORS' FEES AND THE WAGE EARNER'S DOLLAR

(Continued from Page 726)

living cost that has been greatly reduced over the years.

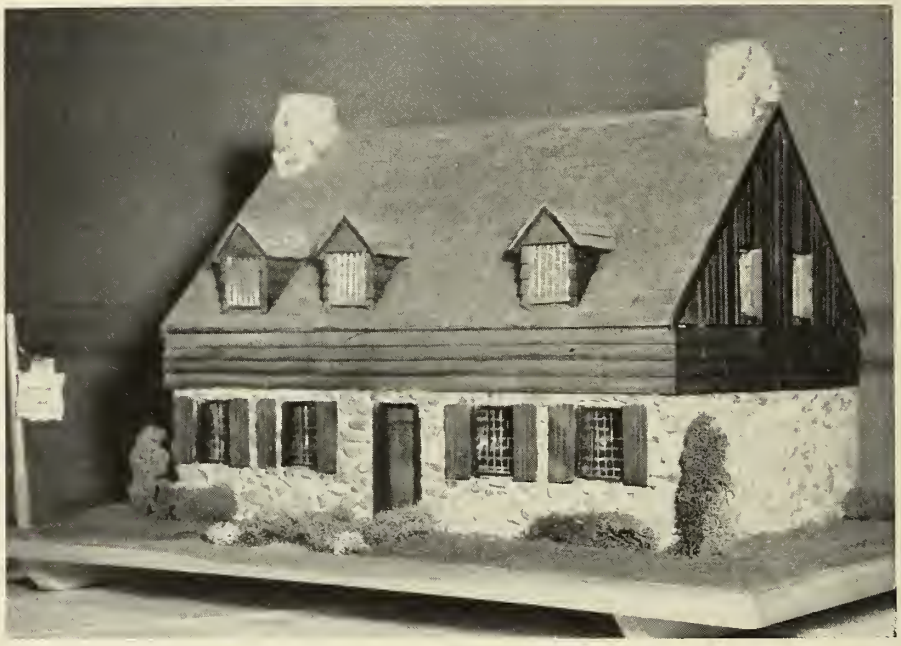
This can be further demonstrated by taking an average wage earner and his family in 1893 and assuming that in a year's time the father required a general physical examination and a consultation of physicians, his wife was delivered of a child by the family physician, a son was operated for rupture and another child had an eye examination for the fitting of glasses. Such combined medical expense in one year is unusual, and in 1893 it cost the wage earner $158.50 in average doctors' fees, which he paid with 734 hourly earnings or about 12.5 weeks' work. If this same series of medical and surgical experiences occurred in the family of a wage earner today, the average fees would total $220, which could be paid with 150 hourly earnings. The wage earner in 1950 could purchase with three and three-quarters weeks' work the medical services that cost his fellow 12.5 weeks' work in 1893.

There can be no dispute about the rise in living costs over the past sixty years but the present wage earner can purchase his doctor's services, in general, for less than one-third of what it cost sixty years ago. The past generation of Americans did not think of socializing medicine nor is there reason to believe that they considered their doctors' fees high. The new methods for diagnosis have increased the over-all cost of medical care, but the greatly increased purchasing power of the present wage earner's dollar allows him to pay these additional diagnostic fees and still get his medical care for less than such service cost sixty years ago, because the medical profession has not advanced the size of its fees in proportion to their patients' earned ability to pay. The prudent worker must accept the responsibility of paying for necessities before purchasing luxuries.

OPHTHALMIC MINIATURE

Having been informed the night (of) the death of a poor man in the hospital, that he had a cataract in one of his eyes, I removed the eye a short time after death, and carried it home. On opening it, I observed that the cataract occupied the place of the crystaline, and appeared to be that badly.—A. Martre, Jan. 1707.

President's Page



Model of Beaumont Memorial Restoration

The Beaumont Memorial Fund has reached one third of its goal. One hundred per cent contribution has been received from the membership of the Genesee County Medical Society. The Woman's Auxiliary of the Wayne County Medical Society has sent in a substantial sum. This is a good beginning for a project which has special interest to all doctors of medicine in Michigan, for it was in Michigan that Doctor William Beaumont made his pioneering observations.

Join your fellow doctors of medicine in recreating this historic medical shrine.

Otto O. Becke

President, Michigan State
Medical Society

Editorial

MICHIGAN STATE MEDICAL SOCIETY ANNUAL SESSION
SHERATON-CADILLAC HOTEL—DETROIT
September 24-25-26, 1952

WE ARE PROUD TO REPORT

FOR MANY YEARS the social planners who are always suggesting some change in our economic or sociologic outlook have been giving their attention to the practice of medicine. This situation started with Bismarck in our near modern times. He was ambitious for the German "Kultur," and by offering hard to get health servives to the bulk of the serfs and working people built up a following, an army, and ultimately the German Empire. His ambition was POWER.

We have had social planners in the past couple of decades, with the same ambition, and the same technique. They wish to control large groups of people and their economy and are willing to offer scarce and much needed benefits for the sake of gaining the plaudits, the gratitude, and the following of these beneficiaries. Again they selected the medical profession, probably because that profession has universally the respect and confidence of friends and patients. The medical profession was composed of highly individualized persons, used to working alone, to being their own best advisers. They consulted and fraternalized in matters scientific, but shunned all appearance of being economic minded. They were, as a profession, ideal sitting ducks for the attention of the social planners.

Suggestions were made that the costs of medical care were high—too high. It was suggested slyly that government might do a better job of distribution of our services. It was claimed a considerable number of our population, 40 per cent, were not getting what they called adequate medical service. Surveys showed that statement to be false, but constant repetition made it bear the weight of truth. It was repeatedly made for many years, and even just recently. Such reiteration has presumably gained the semblance of truth. Communists teach if a statement is made often enough people will believe it. Social planners seem to be of the same brand of thinking.

Plans were made for various forms of government control, and the medical profession promptly opposed. Murray-Wagner-Dingell bill after bill was introduced, and we always opposed, until we ourselves hesitated to be always "opposed." We were asked by our friends and our opponents also, "Why is the medical profession always opposed?" "Why do they never offer some plan of their own?" "Why always *against* and never *for anything?*"

Michigan Medicine accepted the challenge, and proposed a plan to distribute medical care in catastrophic cases so that anyone who wished could be assured of medical services and protection from financial calamity when sickness comes. Michigan medicine is proud of its efforts, and presents in this issue another report to our constituents. The profession has partially stymied the progress of socialized medicine as a grand social upheaval. We doubt if the plan can be put across in one fell swoop as was contemplated by the various Wagner, Murray, Dingell bills, and their successors. The profession is now too alert for *frontal* attack.

FORMULA FOR FREEDOM

OUR FOREFATHERS came to America to escape oppression. They came to find freedom. They built a nation of individualists who were capable and willing to make their own way, to provide for their needs, to protect and cherish their families. They established the basic foundation of Americanism, the ability and intention to earn their own living. In time they banded together to establish a government with limited powers granted by the Constitution, all other powers to be retained. Such a society and such a philosophy was entirely new in the world, but the world was ready and it came into being in America.

Time and more complicated conditions have prompted the assignment of more duties to government. As long as that was voluntary and knowingly done all was well. But for some years there has been a growing assumption of authority and power by government. Government has become our competitor, both by law and by executive regulation and has gone into business. Small or big, business as administered by government is

inefficient. Early the Post Office system was declared a government monopoly, and has it ever run without a deficit? Politics does not produce good businessmen.

Social planners have intruded themselves into government, and are given the guiding hand. A very few determined workers can do great things. Witness the Tennessee Valley Authority. It was established for flood control, but entered the business of power, in competition with the driving out private enterprise. That is just one federal corporation. There are 88 listed, costing us about thirteen and a half billions of dollars annually, just to do business in competition with us. They pay no taxes. If privately owned and operated they would not only *not* have a deficit each year, they would materially aid in carrying our tax burden.

In addition there are over thirty different programs in the government which furnish medical and hospital care to groups of our citizens. These are in competition with each one of us, and with our private hospitals. They pay no income or other taxes, but we who have to compete do pay taxes.

One of the tenets of our Michigan Formula For Freedom is that many persons co-operate—unite their forces and resources and abilities to the end that we may preserve and enjoy our freedom to the best advantage.

About three years ago a group of far seeing citizens of Los Angeles decided to stop opposing the development of big government, and to do something about government. They have proposed the twenty-third amendment reading as follows:

> "The Government of the United States shall not engage in any business, professional, commercial or industrial enterprise in competition with its citizens, except as specified in the Constitution."

Such an amendment would stop the threat of socializing not only business and industry, but medicine.

GOVERNMENT INEFFICIENCY OR INEPTITUDE

SOME YEARS AGO a medical friend was building a picket fence to hide an area containing a garbage can, and to keep out a neighbor's dog. The neighbor without investigation got out an injunction prohibiting the building of the fence, and dragged the friend into court. The case was settled easily after the attorneys had their say, and the fence being proven harmless was allowed. An unnecessary expense, an unnecessary delay, and no redress. The friend was a victim.

Some years ago there was a concerted effort to put the medical man and his profession in a bad light before the public. The American Medical Association was brought into court under the Sherman Antitrust law, and much unfavorable publicity given to the so-called "Medical Trust." Thurman Arnold, the assistant Attorney General of the United States, made trips all over the country telling audiences who would listen what horrible things were being "proven" against the medical trust in the *grand jury*. Finally the case came to trial; the profession had been put to tremendous expense, and had suffered a loss of prestige it has taken years to regain. The American Medical Association was a victim.

Four or five years ago federal executive officers began seeking other ways of embarrassing the profession. They visited the offices of over twenty State Medical Societies and Service Plans including Michigan, ghost hunting, looking for anything which could be used against the profession which was opposing the program of the social planners. In October, 1948, suit was brought against the Oregon State Medical Society, the Oregon Physicians Service, eight County medical societies and eight individual doctors, charging conspiracy in restraint of trade. The trial judge directed a verdict for the society, but the case was appealed directly to the Supreme Court, instead of an intermediary. On April 28, 1952 the Supreme Court of the United States in a seven to one (one not voting) decision dismissed the appeal. A tremendous and unnecessary expense to the Oregon State Medical Society, a great loss of prestige until the final verdict. The Oregon State Medical Society was a victim.

At the beginning of what the Government calls the "Korean Incident" an effort was made to stabilize prices and costs. A program was announced to control and to restrain inflation. Officials were appointed for that purpose whose duty it was to regulate all increases in prices. That group has attempted to function according to its best information and to the limit of its powers.

The Government also set up a board to study and control wages. This latter board when the steel wage dispute came up, without consideration of the effect of its contemplated action, offered a wage raise in excess of what the labor group had

asked, and so far out of line that only inflation could result if adopted. That board's report was tantamount to a complete acceptance. One government group was attempting to restrain and control inflation and the other was boosting inflation by its action in considering the same basic controversy.

The government also double-crossed the industry concerned. The steel companies had been promised a raise sufficient to carry the increased costs of the inflated wages which would be necessary; but this was denied by the President, and industry had no alternative but refuse the strike settlement terms. The result—incalculable loss to our economy, a set-back to our defense program, and wage loss to hundreds of thousands of workers. All this because two government agencies did not try to understand each other's problem, and reach a common decision in the light of the common good.

Other departments of Government are just as apt to do the unaccountable and the unjustifiable thing. Witness the following editorial quoted from *Steel,* December 17, 1951:

REMEDY FOR INJUSTICE

Three years ago the Justice Department obtained indictments against 14 paint manufacturing companies and 21 officials of these companies for alleged violation of the Sherman anti-trust laws. The companies and individuals were charged with conspiracy in fixing paint prices, discounts and allowances.

The story of these cases should interest thousands of metalworking companies because it demonstrates clearly what might have been the rainbow finish of numerous metalworking industry cases had the defendants been willing or financially able to fight for principle.

Here is the story: All defendant paint companies and individuals were confident they were innocent, yet they realized clearly they had two alternatives. Either they could plead "nolo contendere" and get off with a fine of a few thousand dollars or they could fight their cases in court which would cost many tens of thousands of dollars and consume months or years of time.

Twelve companies pleaded "nolo contendere" and were fined $5,000 each. Twenty individuals pleaded similarly and were assessed fines ranging from $1,000 to $3,500 each. The twenty-first individual fought the indictment and the government dismissed its charges against him. The thirteenth and fourteenth companies—E. I. du Pont de Nemours & Co. and Glidden Co.—carried their fight to a federal district court where a jury acquitted them. It cost the Glidden Co. about $100,000 to prove its innocence and it may be assumed that Du Pont spent as much or more. The companies and persons pleading "nolo contendere," although later found to be innocent, paid out more than $110,000 in what amounted to a virtual "shakedown" by their government.

This type of extortion cannot be justified on any score. The reason for it is that the anti-business atmosphere which has pervaded Washington in recent years makes it too easy for the Justice Department to obtain indictments on insufficient or faulty evidence.

One remedy would be to require the government to compensate the defendant for his costs if he is acquitted. This would force government lawyers to prepare their cases more carefully and it would encourage honest defendants—especially small ones—to fight to protect their good names.

E. L. Shamer, Editor-in-Chief,
Steel, December 17, 1952 .

MSMS

RETIREMENT DREAMS TURN INTO NIGHTMARES

Despite the sudden mushrooming of pension plans in recent years, "retirement" is becoming a word of dread to many elderly people. The reason is that inflation has drained it of much of its pleasant connotation.

As the Government's Bureau of Labor Statistics price index has climbed nearly 90 per cent above the 1935-39 average, the word has become more and more synonymous with struggle, hardship and, in some cases, poverty.

A survey of various groups of retired persons shows that a substantial number are being forced to go back to work, often at jobs far less satisfactory than those they left.

Others, less fortunate, have found that even unsuitable jobs are denied persons of retirement age.

The plight of many of Detroit's retired Board of Education employes is typical of persons who are attempting to live on pensions established before the full impact of inflation was felt.

Miss Jennie Fleming, chairman of the pension committee of the Detroit Teachers Association, points out that teachers who retired before 1945 are limited to maximum benefits of $110 a month, set up in the middle of the depression-stricken 1930s.

The Board of Education has attempted to boost the pensions of this group, but has not been able to get permissive legislation through the State Legislature.

"Meantime, the number of hardship cases increases," Miss Fleming points out.

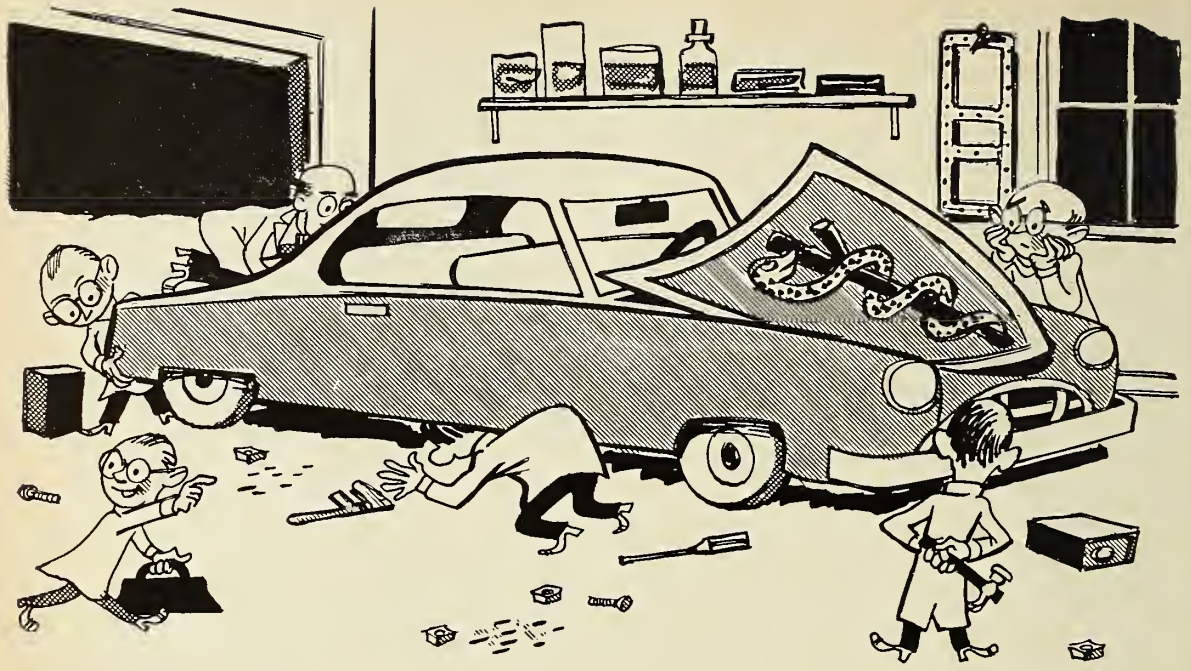
"After teaching thirty years to obtain maximum retirement benefits, many are prohibited from working because of illness or simply because of age.

"A number, plagued by large medical bills or other unforeseen expenses, have been forced to move into dingy, substandard living quarters and get by on a drastically curtailed standard of living."

The inflationary pinch has also been felt by employes enjoying more liberal pension plans.

Robert Schurig, sixty-four, of 9951 Stoepel, retired after thirty years as a Detroit fireman, draws a $177 monthly pension.

Since he is entitled to half the pay currently earned by firemen in the classification he held before retirement, he is partially protected against rising prices. Pay hikes granted firemen since his retirement in 1944 have been reflected in his pension.



YOU BUILT IT !

"Good Morning, Doctor. I represent *your* Blue Shield."

Twelve years ago, you, the Doctors of Michigan, built a vehicle. A means for pre-paying medical-surgical care. The present status of Blue Shield as a social institution was obscure twelve years ago. The vehicle has changed with the times, and is changing each day. Social institutions must keep abreast of the age. The machine is yours. You built it. To merely drive a vehicle these days is not enough. Motors and design are not infallable. A gear is only as strong as its pinion. One must know how the machine works. And when a Professional Relations Representative greets you with "Good Morning, Doctor. I represent *your* Blue Shield." he is bringing the vehicle you designed and built to you.

Shakespeare once wrote, "It is a wise father that knows his child." When this quotation is applied to the thesis here, the father becomes each Doctor of Medicine in the State of Michigan—The Michigan State Medical Society. The child, their child *your* child is Michigan Medical Service.

The environment out of which professionally managed pre-payment plans arose was both factual and theoretical. The first entry on the factual side of the ledger was the depression and the period of economic stagnation during the decade of the thirties. The alphabet agencies of the federal government sprang up over night. The WPA, the CCC, and others became as close to the population of the country as the BVD. Only historians will be capable of judging whether or not the economic burden of the country was alleviated through this means. The point, however, at the time was that the government would and could cure all of the economic and social problems which faced the country as a whole. And one of the most acute problems was the matter of hospital and medical care for millions of Americans who were unable to meet the costs of such contingencies.

For many of the people in the country there was but one answer. There was but one place to seek the refuge they had already found through governmental agencies the federal government, of course. This feeling of dependency on the part of many toward the government prompted the seed for governmental entry into the hospital and medical fields. Social planners were quick to grasp at the opportunity.

Hospitals were the first to feel the rumblings of the storm. Prior to the Great Depression a majority of the hospitals were privately endowed. Citizens of a community who were able to underwrite the deficits of an institution rallied to the appeal of the hospital. The depression ended that. The pressure on the hospital was at a peak. The doctor felt the repercussions directly. He could pull in

his belt. The hospital had no belt to tighten! It needed to do something and quickly!

Without the flurry and confusion that sometimes accompanies the solution to a problem, the hospital merely adopted a gimmick that was prevalent around them. Furniture stores, appliance stores, and almost all types of real goods were being sold on an installment plan. A buyer was able to pay for a commodity a little at a time until the full bill was paid. Why couldn't this same principle be applied to hospital care? The answer, with only one modification, was affirmative: it could. This could be done if people were to *pre*-pay their hospital care. The very nature of the hospital as an institution required such an arrangement. The nature of an illness demanded prepayment and not post-payment. Here was the answer the hospitals themselves gave to government control. Here was the answer the hospital themselves gave the people of the country who realized the probable necessity of hospital care and also realized their difficulty to pay for such care.

Superimposed on this factual achievement of the hospital during the decade were the advances made by the medical profession. The entire population of the country was awakening to the fact that medical care is the only human necessity, the need for which cannot be predicted in advance. Even today, during a period of rising costs, it is easy to estimate with accuracy next month's cost of food, of clothing, of rent and every other necessity, save medical care; and no one can predict this even 24 hours in advance. This idea was emphasized during the early thirties. An idea which affected every human being in the country.

On the factual side, too, the medical profession made advances. The fruits of science are not concerned with price tags. The researcher found more and more an application for the knowledge he was gaining in the laboratory. Where, for example, during the twenties ten diseases out of fifty could be cured, the thirties found forty cures for the fifty specific illnesses. Doctors urged patients to utilize the facilities of a hospital. It was the hospital, and only that institution, which housed the mechanics and progress the science of medicine was developing. Utilization of hospital care doubled, trebled, and in many instances more fantastically multiplied. Where the doctor of the twenties needed the hospital for his work, the doctor of the thirties found his patients asking for hospital care where they knew each facet of the medical sciences would be available.

The medical profession found itself in much the same position as the bear hunter who was being chased by a bear. He finally climbed a tree and as he looked below he saw the bear coming toward him. He was a man not given much to prayer but he thought this was a good time to pray. There is no sacrilege intended in this, but his prayer went something like this: "Oh God, if I ever needed help, I need it now. Come help me and don't send a little angel because this ain't no boy's job."

It was a complex situation. The elements were all so closely interrelated that it was difficult to think of hospital economics without thinking of medical economics. Science advanced rapidly; the people were aware of the advances. The hospitals had done something about meeting the individuals' needs. The rumblings of governmental control were quieted on one front. But on the other front, the medical profession's job was a man-sized one.

Studies, special committees, and an earnest interest from almost every doctor in the country aroused the profession on a national scale. As early as 1931, a survey on the cost of medical care was made by the Michigan State Medical Society. One year later the Hoover Committee Report on the Cost of Medical Care was published. Here were two tangible points of departure. Here was the need for some financing plan made specific. An increasing number of physicians were convinced that it was to their best interests as well as the interests of the nation that some plan be developed. A form was beginning to take shape out of the seemingly endless dark. In 1939, the first statewide medical care prepayment plan squalled its then weak voice at the tremendous job that needed to be done nationally. Was this the solution to the problem, or was it an attempt in the direction of the impossible. Just one year later, in 1940, the Michigan State Medical Society embarked on its prepayment "experiment."

It needs to be emphasized that the "experiment" which began in 1940 was not the result of any one or two doctors in the State of Michigan. On the contrary, this was the result of *all* the doctors in the State . . . this was the result of the Michigan State Medical Society as a whole. The result of a group who faced a common situation.

Ideas need to be crystallized. They need to be tied together, modified and moreover they must meet the need for the situation at hand. Few men are able to crystallize ideas well, but the Michigan State Medical Society members were a lucky lot. Leaders developed. These men were of that vintage of man who are leaders of idealism. They did not work within that framework of fantasy which so many thinkers in the realm of idealism find themselves vaguely and abstractly imbedded. They were not revolutionaries. They were not impractical. These were men who could see at first hand the needs of their patients. These were men who could gauge the reaction of other doctors and the needs of the time.

When the matter began to jell they felt that the people of Michigan needed a complete program.

A program which would guarantee them the cost of medical care whether they needed that care in a hospital, or in a doctor's office, or in the individual patient's home. People needed to be guaranteed the payment for medical-surgical care whether that cost was low or fantastically high.

A sound venture revolves around statistics and actuarial data. The Society was embarking upon a type of insurance program. But there was a difference. Where an insurance company tries to gauge its risk, there was no gauging to be done in the case of medical care. Let's take, for example, a man that dies at the age of forty. The payment from an insurance company does not attempt to pay the beneficiary the total amount of income this man could have earned if he had lived. The devastating cost of medical care must be met. In reality, there is no means of even guessing a partial payment. This needed to be complete coverage. One that did the job and did it in its entirety.

The plan which was put into action in 1940 offered an all-inclusive medical care program. Medical services rendered in the patients' homes, the doctors' office and the hospital were covered. The coverage was complete in every respect. Through sheer speculative calculation, a monthly subscription rate was established.

When one assumes the role of a pioneer, hardships must follow. The two go hand in hand. They are inseparable. And where does pioneering lead? What becomes of it all? These answers are lost in the abyss of time. Look at the visionary who predicted that some day the horseless carriage would be a necessity. Pioneers in automobile manufacturing were ridiculed. The airplane would never be a success. Television was a pipe dream. Today, many of us smile at interplanetary travel as yesterday we laughed at atom splitting. The visionary believes he is not working with the impossible.

Those early years of the Medical Society's prepayment plan in Michigan were not easy ones. Disbelievers jeered and obstructed. The program was hampered by inadequate finances. The subscription rates barely covered half the cost of the idealistic plan. This would never work, people said. It was an attempt toward accomplishing the impossible, others pompously remarked. Yet there were those who did believe. Those of stout heart and keen interest. The struggling years of the early forties are history now. The breath of life many gave the faltering child will never be forgotten. And certainly the impetus, inspiration, and concern from the Michigan State Medical Society marks a brilliant chapter in that Society's history.

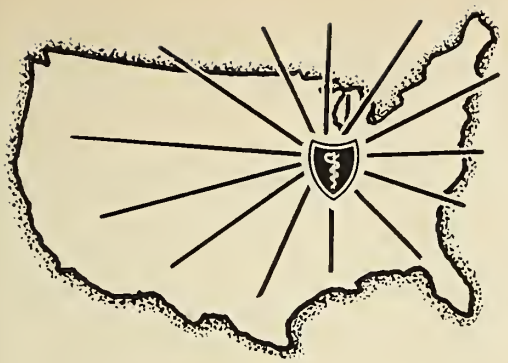
Practical considerations have necessitated change in the basic philosophy of a professionally sponsored pre-payment medical-surgical plan. The public was in dire need of a program that would protect them from the financially disastrous medical bill. The hospitals were aware of the fact that a vast majority of people could meet a small hospital bill. It was the catastrophic bill that would require the mortgaging of a home, the borrowing of money at usury rates that could break the morale of a family. Practical, efficient, business-like principles needed to be adopted by the doctors for their plan to work. And this was done. This was done by the Michigan State Medical Society, by the doctors of Michigan. The necessity was faced and the Doctors joined together to meet it.

During this period of the development of Blue Shield here at home one must not lose sight of the spontaneous reaction that was taking place throughout the country. Some State Medical Societies were slow in recognizing the need for a professionally sponsored program. Where this was true, county societies answered the call. Doctor-sponsored prepayment plans were cropping up all over the nation. They were greeted with public approval. This was no longer an "experiment." Rather, the voluntary prepayment method of medical-surgical care sponsored by the profession was rapidly coming into its own.

Statistics in themselves are usually cold. One seeks to dramatize them as much as possible. If one were to say that well over twenty-two million people in the country today have Blue Shield protection, the fact falls flat. Yet when you can say that more people in the past twelve years have enrolled for Blue Shield protection than have been born in the past six years, then the fact takes on stature. Or when you can say that more than four times as many people enroll for Blue Shield each day—an estimated 23,000—than there are automobiles produced in the country each day, the fact becomes more meaningful. Last year alone more people enrolled for Blue Shield nationally than there are legal residents in eight states in the country. Already seventy-eight separate Blue Shield Plans are sponsored by State Medical Societies or County Medical Societies throughout the country. More County and State Societies realize the need for such a program each year.

Here at home we have something to be proud of. For some time during the period of national development, the Michigan Blue Shield Plan had two-thirds of the total nation-wide enrollment. Ever since its inception, the Michigan Plan has led the nation in the total number of people enrolled when compared with any comparable area.

Why, you may ask, has this seemingly stop-gap measure been perpetuated? Was it not of economic crisis that the idea of pre-payment medical plans evolved? Let us try to find the answers. Just a few paragraphs ago we mentioned the auto-



motive pioneers who tried desperately to come up with a necessity . . . something that the public could not presumably do without. Look at those pioneers who set down their mechanical means of transportation. Was there any way of measuring that someday the automobile would become almost a necessity? Absolutely not. And the refrigeration engineer who dreamed of a majority of the homes in the country having electrical means of refrigeration, was there a way he could judge the realization of his dreams? Again, a resounding no. Granted that the circumstances surrounding the development of hospital and medical prepayment plans were somewhat remote from these other steps, yet there is a definite similarity. Principally, today as twelve years ago, the growth of Blue Shield on the local level as well as on a national scale reduces itself to the matter of a necessity. You, the doctors of Michigan, produced a product which was a hidden need. As the automobile and refrigerator, you found another vital development in social progress.

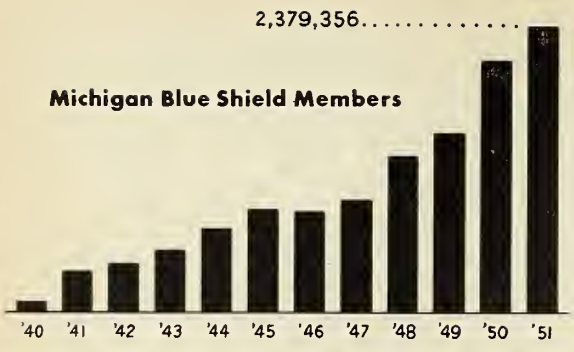
During the 1930's when the problem of economics required thinking in terms of a prepayment plan, the matter of necessity, from the doctor's point of view, was paramount. A method needed to be developed to quiet the social extremist, but more important, a plan needed to be developed because the public wanted it. The reception of the Plan was by no means an accident. Nor is the present-day reception of the Plan merely the coasting of that initial push. In reality, the Plan you developed out of necessity has evolved into a necessity for the entire country. Whether the medical profession realizes it or not, and surely they do, a tremendous educational job has been done on the people of this country. Through the years, and more and more each day, people are becoming acutely aware of the highly specialized and technical advances that are being made in the field of medicine. And at the same time, the people are becoming more aware of the need for protection against the costs involving the progress made in the field. The hospital has become, and rightly so, the workshop for the medical practitioner. As a development is made in the science of medicine, the hospital looms larger and larger as a place to house the mechanics of that science. Whereas the doctors of the thirties developed a plan for the prepayment of medical-surgical cost because of their necessity, today the people of America realize the need for such a plan.

Unknowingly, a social institution was begun when doctors met the needs of the public through Blue Shield. A public trust was established. The late Senator Arthur Vandenberg put it this way: "You have done something in Michigan that you didn't know you were doing. You have established a public trust. . . . You have taken millions of dollars of the people's money and have used it for the benefit of the people. As such you are the trustees of a public trust!" The shifting of the necessity at first seems unbelievable, but in reality it is a fact.

The rumblings of the socializer cannot be overlooked. They have not died. To think that the fight has been won would be fatal. The answer to these "gimme" believers twelve years ago was an experiment; today this answer is real tangible evidence. Your Blue Shield, its present stature, its potential, its constant supervision by each and every doctor in the state, affords the greatest weapon when encountering the social regimentor on the field of battle. Here is a dynamic public necessity operated, sponsored, and governed by the doctors for the welfare of the people. Here is a functioning organization, no longer a nebulous idea, which is meeting the needs of the American public each day. Here is an organization founded on sound business principles. And here is a movement with vision enough to realize that there is still a tremendous job to be done in the field of protection against the cost of illness.

"Good Morning, Doctor. I represent *your* Blue Shield Plan. . . ." This is a Professional Relations Representative seeking to acquaint you with the operations of the Plan, progress of the Plan, and to help you better understand the coverage Blue Shield offers its subscribers. The Representative seeks your counsel, your guidance, your help. He brings your organization to you . . . bringing a child to its father.

Sometimes the most obvious justification for existence is the most difficult to set down. When one asks the question, "Why an entire department of Blue Shield designed to handle Professional Relations?" a flurry of reasons immediately come to mind. Yet there is one obvious and imperative reason which foreshadows the rest: A Professional Relations Department is necessary to form the bridge between Doctor and Plan. Good working relationships with physicians are essential to the success of Blue Shield. Blue Shield belongs to the doctors and to separate the two would be impossible.



It needs to be emphasized again that the Professional Relations Program is essentially concerned with bringing the working of his (the doctor's) Plan to the doctor. In 1947, at the Annual Conference of Blue Shield Plans a statement of principle was adopted which clearly established the dual responsibility for cultivating good relationships between a Plan and its sponsoring physicians. In part, that principle stated:

"It shall be recognized that the responsibility for maintaining physician co-operation must be shared by plan management and the sponsoring medical society; that while plan management shall be held responsible for furnishing full information to the medical profession regarding its operations and development, the responsibility for gaining professional acceptance of the philosophy and principles of prepaid medical care shall rest essentially with the physicians and their organized societies . . ."

One must immediately pose the question, "Why a dual responsibility?" The answer lies in cold logic. The Plan was originated, sponsored, and approved by the medical profession. It was the profession's machine. From its very beginning the operation of the plan needed to comply with certain policies established by the medical profession. Consider an automobile engine, it needs its transmission to function. The transmission of a Blue Shield Plan is each doctor in the area served by the Plan. The machinery of the doctor, Blue Shield, cannot operate without him.

Further, if a medical society assumes the responsibility for establishing a Plan, it should likewise accept a portion of the responsibility for securing the active co-operation of each physician in the Society. This the Michigan State Medical Society has realized. The Society, as a whole, realizes that the essence of their plan lies within each individual doctor and his understanding of the Plan. Such co-operation is essential if the Plan and its subscribers are to exist together.

The physician responsibility consists of a moral obligation to support the economic device he has aided in establishing. And here emerges another important reason for the existence of a Professional Relations Department. Blue Shield, as an organization, does not sell a tangible item. There are no assembly lines or shipping stations in the Blue Shield office. Their product is security. And within this abstraction revolves its functions.

Security is an interesting word. Connotatively the word has a great number of applications, but denotatively, as Webster put it, the word means ". . . A feeling of or assurance of safety or certainty; freedom from anxiety." This is the product Blue Shield sells its subscribers. The millions that have enrolled, and the millions that will enroll for the protection are sold a promise. A promise to each enrolled member that the benefits which are outlined in the Certificate will be carried out when and if he, the member, requires the care You, the Doctors, fulfill that promise; Professional Relations Representatives try to interpret that promise to you.

Perhaps many doctors are saying at this point "Well, all I have to do is read the Certificate issued to subscribers and I'll know what is expected of me!" No truer words were ever uttered. Yes, this acquaintanceship with Blue Shield is imperative But there's just no sense in kidding ourselves; very few people read their own life insurance policy or fire insurance policy, or even their automobile insurance policy. And even if we can honestly say that we've read all of this literature, there is more to your Blue Shield than merely understanding benefits. If we can arrive at one truism in this discussion let us attempt it now: A well-informed doctor means a well-satisfied public.

And this brings still another reason for Professional Relations. How can the physician's organization function properly and effectively unless the physician is there to steer its destiny? Blue Shield needs the advice of the doctor . . . each doctor in the state . . . to make it realize its shortcomings and discrepancies. An artillery commander never knows where his shells are hitting—on target or miles away—without the aid of an observer to direct him. This is Blue Shield without the help of the doctor. An organization which has no way of knowing if it is hitting the bullseye of public approval, and certainly never knowing when it is off target, can in a short while burn itself out. Blue Shield, developed by the doctor twelve years ago, could not have survived the gaff if doctors had not directed. The strength of Blue Shield in the years to come rests entirely with the doctor . . . *you* . . . and the guidance, interest and direction you offer.

Organized Professional Relations was a neglected important cog when the machine was built Of course there were sessions with doctors explaining how the machine they had built was running And of course there were "fires to be put out" all over the state. Fires that threatened the existence of the Plan only because men did not understand

ts function. It was not until a young-looking, lim, ex-Army Corporal began working in the 3lue Shield Claims Department that the tremen-lous problem of Professional Relations was ıpproached.

Few men are able to come upon a situation and ınalyze it. Still fewer men have the capacity of vriting or detailing the prescription that can solve ı problem. John Castellucci was hired by Blue Shield in 1943 and assigned to the Claims De-ɔartment. Here at first hand he was able to see he wheels of the machine in operation. And here ıis keen analytical mind set to work.

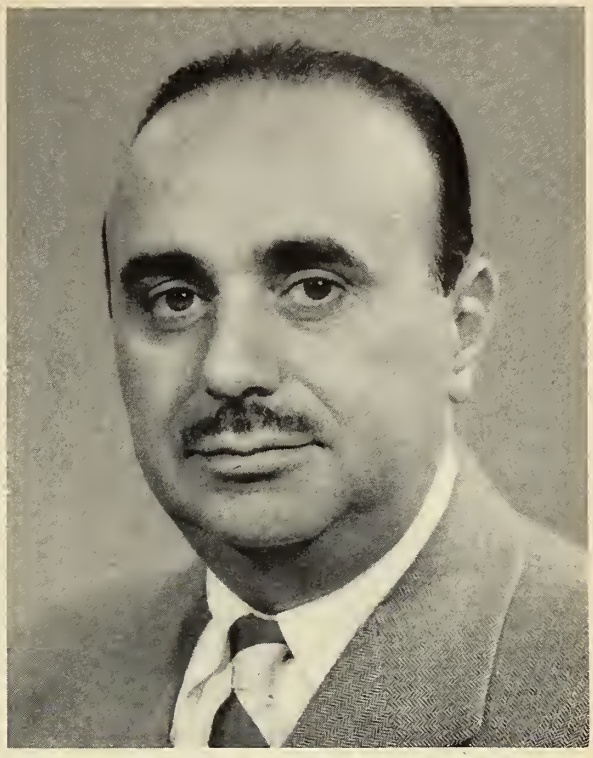
Why was he having so much difficulty process-ng a Doctor's Service Report? Why were the eports improperly filled out? Why were the doc-ors lax in understanding the processing of their ɔayments in the office? And why were the doctors ıot understanding how their organization was vorking? These were the questions that kept both-ring John. They were the questions that needed ınswering from the Plan's point of view. His rea-oning went something like this: These doctors ıre all intelligent men. They have recognized the ıeed of the public through the establishment of method of pre-paying services. The doctors ıeeded someone, something, some real means of ıaving the mechanics of a business—*their* business —explained to them.

The problem was there. To write the prescrip-ion for its solution was difficult. But to compound he prescription in correct proportions was still ınother matter.

Castellucci went to Charles Coghlan, then direc-or of the few field men who were "putting out ires," with the problem, solution, and means for ıctivating the answer. The problem was obvious. The inventors of the machine had lost touch with heir brain child. The machine was running, yet he men who built it were not aware of the diffi-ulties it was having. This could not continue. Without the doctors' knowing more about their Plan the pre-payment method was in serious rouble.

The Plan had to be taken to each doctor in the tate. It was theirs and no one else's. Its existence lepended on them. They built it. They had to now how it worked. Instead of "putting out ires" when they broke out, John proposed a means f averting the blazes. It was all a matter of telling ach doctor of his own vehicle. Explaining to the hysician the vastness of the problem, and, more-ver, seeking the doctor's advice on how to correct roblems.

John likened the situation to the executive ranch of government. "The Plan is the executive ranch. The judicial and legislative branches are ıe doctors themselves. We must get to them and ear them. We're not policemen of the profes-



John W. Castellucci, Assistant to the Director, Michigan Medical Service

sion, nor are we the profession itself, we belong to them and we must understand them. They're the bosses. We must listen to each of them." Here was the essence of the very future of the Plan. To activate this idea would not be a simple matter, yet Castellucci is not of the brand that backs away from a seemingly insurmountable problem.

There was only one way to do the job and do it properly: See the doctor—each doctor in the state, personally—and explain Blue Shield to him. See him wherever one could, in his office, at Society meetings, any place. The point was, see him! John tells of playing eighteen holes of golf with a physician on a blisterong July Sunday afternoon. The doctor was an excellent golfer, measuring each shot and exerting great effort in playing a "scientific" game. It was John's very first experience with golf clubs and a golf course. "I dug up the turf, sweat, strained and had a strenuous day. But the Doctor loved giving me some pointers and we had a wonderful time together. . . . I wasn't able to get out of bed for two days after that. But I had talked to one doctor and he understood Blue Shield. It was worth it!"

The prescription was working. Doctors were contacted, changes were made in office procedures, modifications were made that originated with the doctors themselves. And doctors appreciated the opportunity of being active in their own Plan.

They, of course, were aware of Blue Shield and their relationship to it. But having a Blue Shield Representative visit with them so that they could discuss the Plan in its entirety was something new, and something that the doctor himself was overwhelmingly in favor of. At first, field representatives were looked upon skeptically, yet when their mission in the doctor's office was explained, a warm welcome was apparent.

Just as the Professional Relations Program was coming into its own, another related problem developed. It was 1945 and veterans of the War were beginning to return to their homes. Many of them had service-connected disabilities. Was it impossible for Blue Shield to handle these veterans? The doctors thought it could be done, and after weeks of planning, a task force was sent to Washington.

John went along, assigned the job of trying to reduce the required government paperwork and red tape to a minimum. He found himself in a difficult position. Here was John, an ex-Army Corporal, talking with Colonels, Generals, and Admirals. He remembers distinctly pounding on the table to emphasize a point at one time during the conferences and having a Colonel remark, "My, if those chevrons were only on your sleeve now!" But the task force returned to Michigan with a victory. The paperwork was reduced from eight pages to one page for each report. The plan was much too logical for even the Veterans Administration to refuse.

When that eventful trip was finished, the Blue Shield Plan in Michigan was to handle veterans medical care on a local scale. The program worked beautifully. Blue Shield Plans throughout the country refer to the program as the Michigan Veterans Care Program, and today this Program is still doing a remarkable job as an integrated part of *your* Blue Shield.

With the Veterans Program running smoothly, John was anxious to get back to his Professional Relations work. There was still a large job to be done. The field work program needed to be expanded and new people in the work had to be well grounded in their task. Each of them had to know the internal operations of Blue Shield. They had to know about Blue Cross. They had to realize that they were not salesmen. They weren't selling a thing to the doctor, but rather their sole purpose was to explain Blue Shield to the physician, get a feeling of his thinking about his own prepayment program, and answer questions the doctors had about the status of the Plan. The job was unending.

As John again became engrossed with the Professional Relations Department here at home, the Blue Shield Commission in Chicago flicked a beckoning finger. This matter of contacting physicians was working in Michigan, and other Blue Shield Plans in the country desperately needed a program like it. The eyes of Blue Shield Plans throughout the country were focused on this new idea which was evolving—the idea of the doctor becoming a more integral part of the economic necessity he had created. John was "loaned" by Michigan to the Commission late in 1947 on a part-time basis. He retained his capacity here with the Veterans Care Program and Professional Relations.

He was to visit other Blue Shield Plans throughout the country and explain the Professional Relations Program Michigan had adopted. When he was approached with the proposition the Commission had to offer, he insisted that he remain in Michigan on a part-time basis and only work with the national picture on a split schedule. He was so vitally concerned with physicians running the Plan that any other project would have surely been refused. But seeing the necessity for a well organized Professional Relations Program here and realizing its importance nationally, John felt that if other Plans were to adopt the program they would run more smoothly. Then, as now, Blue Shield was lost without the Doctor.

John became part-time Assistant Director of the Blue Shield Commission. He traveled all over the country explaining the Professional Relations Program. Difficulties were mounting faster than the Plans could handle them. Most all of the difficulties came from the lack of co-ordination between Doctor and Plan. Plans had some Professional Relations and didn't know it. Certain men in each Plan spent time talking to doctors, but the difficulty came from their lack of teamwork. Each Plan had field men talking to doctors and listening to complaints, but most of them failed to recognize constructive ideas when the doctor presented them. Castellucci changed most of this. Plans were shown how Michigan was handling the situation, and some basic philosophy of Blue Shield was reviewed. This was the Doctor's Plan. They had to know how it operated. They had to help operate it.

John talked loud enough and long enough. Many Plans all over the country set up a Professional Relations Department patterned after the Michigan program. They were programs that were responsible directly to the Plan Director and, in turn, the Board of Trustees. Again, Michigan had set the pattern. It would have been futile to a Professional Relations Program to get lost in the obscurity of other office procedures. Doctors had to know that the Professional Relations Representatives that talked to them would get their information, suggested modifications, and gripes to the apex of the organization. It went directly from the doctor to the place where it would do the good.

Castellucci returned to his office in Chicago and egan writing a manual for Professional Relations iat could be used all over the country. Mean-hile, here at home Professional Relations did not t dormant. In 1945, L. Gordon Goodrich, just :turned from the Navy, was appointed Assistant)irector of Michigan Medical Service. Part of his uty was to direct the program. Great strides with rofessional Relations were made while John was spreading the gospel." Personnel was added. he state was proportioned into areas in which)ecific contact people were to work. Doctors ere becoming interested again in their pre-pay-ient program. But more emphatically, the Plan as beginning to get the suggestions and advice of ie physicians in a steady flow. We used the allu-on before about the artillery commander not nowing where his shells were hitting. The doctors Michigan began telling Blue Shield about its de-ciencies. The doctors were telling Blue Shield)w far they were missing the target in many in-ances. This was good. This was what the Plan eeded. Sights were re-adjusted.

Make no mistake at this point. The primary ob-ctive of the Professional Relations Program is to xplain to the doctor the workings of the machine e, the doctor himself, created. On a very real lane, the contact person attempts to show why rtain procedures are necessary for sound opera-on. Sure, Doctor Service Reports are sometimes mbersome to complete. Granted there are some-mes delays in Blue Shield payments. Certainly iere are times when the machine just doesn't ork smoothly. Yet the machine *can* run smooth-. The motor can hit on all pistons if the other ears are meshing properly. You, individually, are iose other gears. The Professional Relations De-artment is merely the mechanism which greases ie gears and tries to make the motor operate venly.

This, basically, was the concept Castellucci put to his Professional Relations Manual which was ublished in 1950. It has become the standard xt of Physician Relations throughout the country. octors had to know the inner workings of Blue hield. This was essential. When each doctor in n area could see how his Plan operated, then and nly then would Blue Shield be doing the job the)ctors originally intended for it to do. When ie doctor knew his Blue Shield Plan, the public ould know it as well.

Castellucci's work with the Commission was at n end. He returned to Michigan Medical Service n a full-time basis in July of 1951 to put into ractice some of the ideas he had formulated con-rning field service for Blue Shield. He came ack to Michigan on a full-time schedule con-nced other Plans in the country would begin rganizing field forces. He was convinced the lans, too, would be keeping a keen eye on the lichigan program and its development.

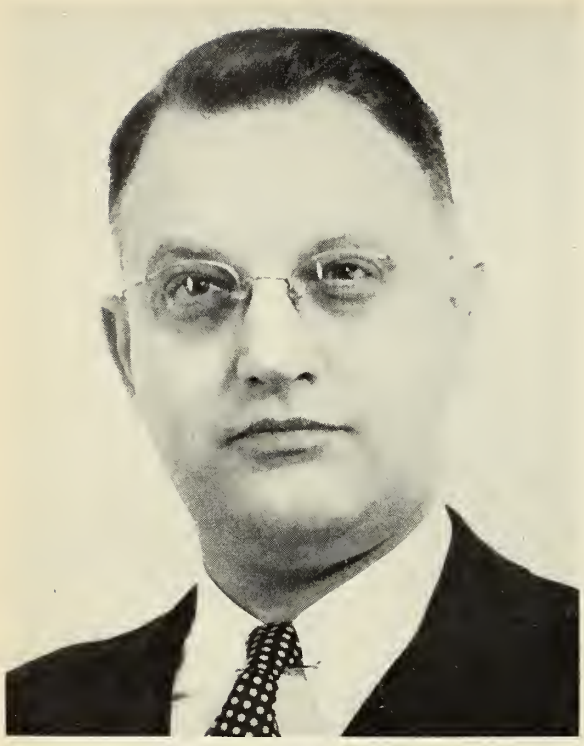
John came back to Michigan and the Profes-sional Relations Department was his again on a full-time basis. His sleeves were rolled up. There was a job to be done.

Many things needed to be explained to doctors about their organization. The keystone of Blue Shield needed to be reiterated over and over again. The Plan had evolved from a means of covering and protecting the public from the costs of every phase of medical treatment. This had changed and doctors needed to know why Blue Shield and Blue Cross had become a means of protection—because the public wanted it so—that protected a family against the financially disastrous hospital and medical bill. The basic philosophy of the two had become the same. They were identical from a primary approach. Doctors had to know it. And when a doctor got a patient that demanded hospi-tal care because he felt it was "coming to him" as a Blue Cross-Blue Shield subscriber, it was the doctor that was responsible for the explanation. It is a dominant factor in human nature to "get what's coming to us," and this attitude in itself could spell disaster for both pre-payment plans. One affects the other directly. Doctors had to be aware of it. Professional Relations people had to tell them about it. When the doctor understood only a few fundamental facts, then both Blue Shield and Blue Cross would become stronger and more vital to the profession, the hospital, and the public.

This was the problem as John saw it all over the country. Getting to the doctors of Michigan and having the opportunity of re-emphasizing these basics was essential. It was a big job and one that only a few could not accomplish.

More personnel was added to the department supplementing those field men that were already on the staff. Today there are eleven men and two women that are field representatives for the Plan.

In September of 1951, John's staff was strength-ened by Louis H. Freye, four-time member of the Michigan State House of Representatives. Keen of mind, likeable from the beginning, and thor-oughly interested in the Blue Shield program, Freye was appointed Representative-at-Large to cover the entire state. His interest in the Doctor-Plan relationship is one that can be traced through his entire career. "I've spent many years of my life with the Boy Scout program in this state (he holds the Eagle Award and the Silver Beaver Award) only because I can see the value in build-ing a strong country through a strong youth. The same can be applied to Professional Relations work. A strong Blue Shield can result from an in-formed Doctor. The work seems analogous." His work throughout the state in just the short time he has been associated with the Plan bears out his interest and the importance he feels lies within the program.



LOUIS H. FREYE, Representative-at-Large

"Louie" was born in Muskegon and has resided there all his life. He studied pre-law and received his certificate of education from Muskegon Junior College. He was a member of the Michigan State House of Representatives for four terms, resigning during his fourth term to take up his work with Blue Shield. His work with the Boy Scouts both here in Michigan and nationally has been outstanding. His awards include the Eagle Scout Award, the Scoutmasters Award, the Scoutmasters Key, and the coveted Silver Beaver Award. Louie was appointed chairman of the Michigan Veterans Facility Committee while a member of the House. He was the first non-veteran to serve on the committee and has been the only non-veteran ever to be appointed chairman of the group. He is married and has two sons.



WILLIAM H. BYRNE, Assistant Manager, Professional Relations Department

Bill was born in Detroit and has lived in that city all of his life. He attended Assumption College in Windsor, Ontario, and graduated from that institution in 1936 with an A.B. degree in history. After leaving college, Bill worked for an automobile insurance company in Detroit doing claims adjustments. After five years at this work, he came to Michigan Medical Service when the organization first began. His duties were comparable to an Office Manager. He was responsible for internal office procedures. Bill left for the Army in 1943 and was a classification specialist and vocational counsellor for two and a half years. He returned to Blue Shield as a field representative in the Port Huron area. His present position was made available to him in July of 1951. He is married and has no children.

Most doctors in Michigan know that when they have a Blue Shield question their Plan is as close to them as the nearest phone. This is good. And when a question is asked of a Blue Shield field man he can usually answer it, or if not he finds the answer. Questions of payments, benefits, the Doctor's Service Report, x-ray benefits, and many others are the routine problems which face most physicians. Yet to the Professional Relations man there is one very important idea he wants to tell each Doctor. An idea that is vital yet vague to so many in the profession: Doctors in the State of Michigan have two professionally sponsored organizations. The Michigan State Medical Society is an ethical, scientific, educational organization. Blue Shield is the administration of a corporation rendering a public service. Each doctor in the State should know Blue Shield as well as he knows the Society. Both are his.

At the last meeting of the MSMS House of Delegates a Liaison Committee was appointed to work with the Blue Shield Professional Relations Department. The Committee was geographically selected so that the field men in each area (see following maps) would have a Doctor to go to with problems and questions the representative cannot handle alone. Specifically, the Liaison Committee's functions are:

1. Serve as a source of reliable information about the Plan for the physicians in the area.
2. Refer to the Plan all complaints, criticisms, or problems arising among the physicians.
3. Interpret subscriber reaction concerning coverage to the Plan.
4. Work closely with the field man in the area to promote wider public acceptance of the Plan.

Blue Shield openly welcomes any means that will maintain a close relationship with its source, the doctor. The contact people know this. If there is one idea emblazoned in each of their minds, it is to establish thorough understanding between doctor and Plan. The field man does not want to sell you, the doctor, a thing. In reality, he has nothing to sell! He's not a salesman. His sole reason for existence as a Blue Shield employe is to create a mutual understanding between your Plan and every physician in the state.

Doctors are extremely busy men and Professional Relations Representatives are aware of it. He still tries to see the doctor in his office, but has also found equally effective places where the doctor is able to talk with him. He sees the doctor in cloak rooms of hospitals. He sees you at County Society meetings. He talks to your secretary or nurse explaining Blue Shield forms. He sees you at Medical Conventions. And he has seen some of you in classrooms before you graduated. These have all proven to be valuable avenues of information. It's you, the doctor, no matter where he sees you, that the Representative is anxious to talk to. It's you that govern the Plan. It's you that must know how it works. It's yours.



MSMS Liaison Committee meeting with the Michigan Medical Service Professional Relations Representatives

To relate some of the questions field men are asked in one typical day would be futile. None of the inquiries is irrelevant. None of the questions doctors ask is unreasonable. All of the questions and problems doctors have concerning Blue Shield have an answer and solution. The field men are there to answer the questions. Together you can solve the problems.

Facts speak for themselves. The nebular idea you, the doctors of Michigan, had twelve years ago is no longer merely a dream. The idea has evolved into a reality . . . a social institution . . . a necessity for millions of Michigan residents. The words of Senator Vandenberg ring truer each day. You have created a "public trust." You have created an acepted method of pre-paying medical services. The management and proper handling of this method is the responsibility of the doctors themselves. It is only through a close relationship between doctor and Plan that the method can function properly and with the utmost effectiveness. The responsibility is yours!

For many doctors in the state, Blue Shield is no longer the light in the darkness of the thirties when the social planner feverishly ranted the need for governmental control of the profession. And, on the other hand, many physicians have forgotten how desperately the public needed some means of medical cost protection. Many have forgotten that it was their own organization, their very own program of Blue Shield, that offered the light in the black period. Forgetting is easy. But the doctor must be aware of the necessity he created. He must realize that *his* Blue Shield has become a public trust. He must realize that the people of America need Blue Shield today even more desperately than they did years ago. The people are aware of it. Thousands each day enroll for the program. Today, the necessity is theirs. If the voluntary, professionally sponsored pre-payment programs collapse, the socializer will again have an opportunity to force his issues. This must not happen; Americans don't want it to happen! Through your interest and understanding of Blue Shield you can avert the collapse. Professional Relations Representatives bring the workings of the Plan to *you*. Understanding the Plan individually, you strengthen the Plan collectively. You have built a vehicle, a necessity. It is doing a job. It still has much to do. The strength of that vehicle is in *your* hands.



THESE ARE THE PEOPLE

To discuss Blue Shield, the Professional Relations Representatives and their function is one thing, but to acquaint you with the Professional Relations Representative in your area is another matter. On the pages which follow, the Professional Relations Representative and the Liaison Committee member for each area in the state are pictorially presented.

But before you flip to the next page, consider some of the people who operate Blue Shield from an internal basis. These are the people you may never meet. It's altogether possible that you have received a letter or a check, or perhaps even talked with some of these people over the phone and have often wondered, "Well, I wonder what that guy looks like!" Here's the opportunity to see for yourself.



THESE ARE THE PEOPLE THAT BEGIN THE PROCESSING OF YOUR SERVICE REPORT. Over 2,000 Doctor's Service Reports are received in the Blue Shield Mail Room each day. That averages about 48,000 a month!







THEY TRY TO READ YOUR WRITING . . . One of the first steps in processing your Report for payment is to code your name with a number. But one must be able to read the writing first!





THE PATIENT MUST BE IDENTIFIED, TOO! This group of young ladies attempt to verify the member's eligibility for the services you have rendered him. Actually, Blue Shield has over 13,000 Smiths enrolled . . . some fat, some short, some thin, and some tall.

When you receive a letter asking for more information concerning a patient, that inquiry originated here.



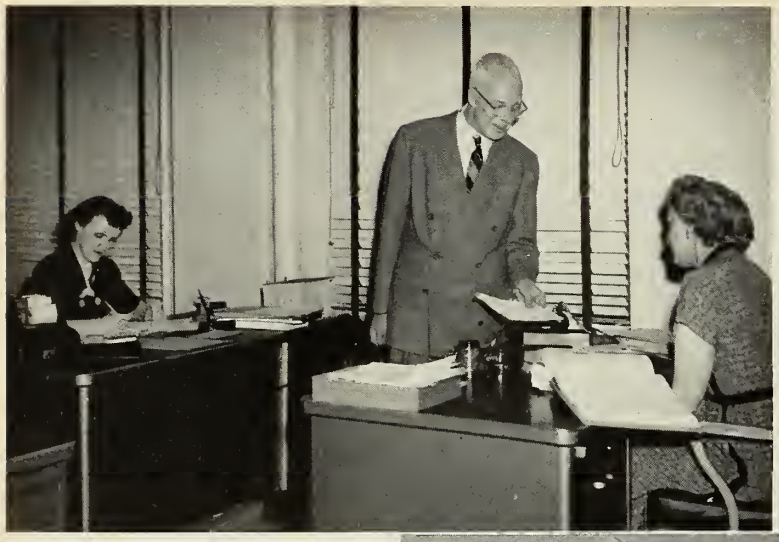


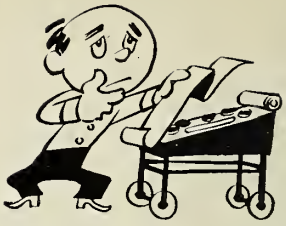
C. D. Moll, M.D., Medical Director, and Edward J. Reilly, Chief Examiner, with a staff of twenty-five give your Service Report the individual attention it deserves. If your report is a routine procedure the examiners record the amount Blue Shield will pay you for the service. When a report is of a more complicated nature it is referred to the Medical Advisory Board.



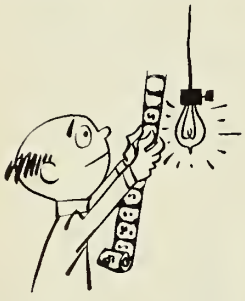


Robert Henshaw, Assistant Treasurer, is responsible for your check being completed. With the aid of a battery of International Business Machines, over 1,000 checks an hour are written to Doctors.





STATISTICS ARE OF VITAL IMPORTANCE. And it's Henry Hosmer's job (Chief Accountant) to keep accurate ones. Recording of utilization, payments, and other disbursements are of vital importance to the stability of the Plan.





THEY PHOTOGRAPH YOUR SERVICE REPORT. Because the records must be stored for an indefinite period of time, of course space is at a premium. With a microfilm apparatus, the space involved for storing these records is reduced tremendously.





TELEPHONE INFORMATION CENTER. These young ladies answer over 2,000 phone inquiries concerning Blue Shield each month. The question that is most frequently asked by subscribers is "How much did Blue Shield pay my doctor?"

Through inquiries by both subscribers and physicians, the Professional Relations Department is able to gauge the work that needs to be done.



NEAL McCUE
Representative
MMS—Professional Relations



HELEN SCHICK
Representative
MMS—Professional Relations



ELIZABETH NEUMANN
Representative
MMS—Professional Relations



VERNE COLLETT
Representative
MMS—Professional Relations



WILLIAM BROMME, M.D.
Chairman
MSMS—Liaison Committee

ELIZABETH NEUMANN was born and raised in Detrait. She attended the University af Detroit. After leaving the University she was employed as an airline hastess an the Chicaga and Sauthern Airlines. Betty has been with Blue Shield as a Prafessianal Relatians Representative far the past three years. Her area is Metrapalitan Dawntawn Detrait.

HELEN SCHICK came ta Blue Shield after a lang and successful career with Blue Cross. She is a native af Detrait and spent twa and a half years in Liberal Arts Studies at Wayne University. Helen began her wark with Blue Crass as a Cammunity Relatians Representative. Helen has been warking with physician relatians for abaut twa years. The area east af Waadward Avenue is her territary.

VERNE COLLETT came ta Blue Shield from New Yark City. He has been with the Prafessianal Relatians Department far the past eight manths. Verne spent five years with the paratraapers during World War II. He warked with the Judson Advertising Agency's television department writing, casting and producing nation-wide pragrams. He is married and the father af twa bays.

NEAL McCUE was barn in Gaadells, Michigan and has been in Detrait far a little aver a year. He graduated fram Albion Callege with a B.A. degree in 1948 with majars in bialagy and chemistry. He cantinued his past-graduate wark in chemistry at Albion. Neal spent twa years with the Army Medical Carps in Germany. When he returned he was accepted ta the University af Michigan Medical School but left his studies after ane year. He has been in the Prafessianal Relations Department far the past nine months. Neal has been married for a year and a half.

ALL OF THE ABOVE REPRESENTATIVES HAVE THEIR OFFICE IN THE WASHINGTON BLVD. BLDG., 234 STATE STREET, DETROIT, Phone: WO. 5-2700



AREA 1

Wayne County

POPULATION	2,435,235
DOCTORS IN AREA	2,996
BLUE SHIELD PAYMENTS TO DOCTORS (1951)	$8,304,253
BLUE CROSS HOSPITALS	54



BRADLEY M. HARRIS, M.D.
Member
MSMS—Liaisan Cammittee



WILLIAM W. BOYLES
Representative
MMS—Prafessianal Relatians

WILLIAM W. BOYLES is a native af Waukegan, Illinais. Called Bill by all thase wha knaw him, he has been in Detrait far the past twelve years. Cheerful, with a smile far every accasian, and a wanderful sense af humar, Bill finished his schaoling with a majar in sacialagy fram Narthwestern University in 1939.

He was emplayed by the Abbatt Labaratories in Narth Chicaga after graduation. Haw packaging pills has anything ta da with sacialogy even Bill has difficulty explaining.

Bill saw service an three major midwestern newspapers as a reparter. His wark with the Milwaukee Jaurnal was autstanding. Early in 1941 he began his wark with Michigan Medical Service and the Prafessianal Relatians Pragram.

He was drafted shartly after he began his wark with Blue Shield and was assigned ta the 101st Airbarne Unit. He held the rank af First Lieutenant and received his Captaincy before being discharged.

His twa sans and daughter take up mast af his time. "The Kids will saan be old enough ta go fishing with my wife and I. Then the five af us will really show these fishermen haw ta catch the big fellaws!"

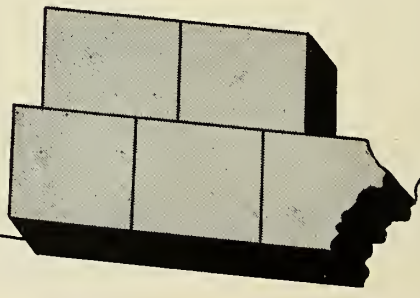
Office: 1200 Washingtan Baulevard Building, 234 State Street, Detrait, Phane: WO. 5-2700.

Hame: 13332 Winchester, Huntingtan Waods, Phane: LI. 3-9601.

AREA 2

COUNTIES: Hillsdale, Jacksan, Lenawee, Manrae, Washtenaw.

POPULATION	414,742
DOCTORS IN THE AREA	557
BLUE SHIELD PAYMENTS TO DOCTORS (1951)	$985,439
BLUE CROSS HOSPITALS	14





G. W. SLAGLE, M.D.
Member
MSMS—Liaisan Cammittee



WESLEY A. BARTON
Representative
MMS—Prafessianal Relatians

WESLEY "Wes" BARTON was born in Chicaga. He attended Palmer Callege in Missauri and graduated with a B.A. degree in Persannel Administratian from the University af Calarada.

Wes has held the pasition of Persannel Directar af the Chicaga Office af the Encyclapedia Brittanica. After leaving this jab he warked as a Public Relatians Directar far a Chicaga cancern and did sales work far the same campany.

He joined the Chicaga Blue Cross Plan as the Assistant Directar in 1946, and held that pasitian until he came ta Blue Shield in Michigan as a Prafessianal Relatians Representative.

His military career was spent with the Air Carps in which he held the rank af Captain. He was an instructar and personnel afficer at ane of the majar air bases.

Baating takes up mast of his leisure time. During the winter manths when it is impassible far him ta be aut in his baat, Wes studies current charts, depth charts, and plans his summer vayages.

Office: 202 Michigan Avenue, Bentan Harbar, Phane: 8105.

Hame: Bax BB, Calama, Phane: 344.

AREA 3

COUNTIES: Allegan, Barry, Berrien, Branch, Calhaun, Cass, Kalamazoo, St. Jaseph, Van Buren.

POPULATION	569,340
DOCTORS IN AREA	548
BLUE SHIELD PAYMENTS TO DOCTORS (1951)	$757,138
BLUE CROSS HOSPITALS	25





L. S. CARPENTER, M.D.
Member
MSMS—Liaison Committee



GLENN WILLARD
Representative
MMS—Professional Relations

With a deep, slow, typical western accent, GLENN WILLARD came to Michigan Medical Service from Nebraska in 1951. Actually, Glenn was born and raised in Kansas where he pioneered the Blue Cross work in the state. It was 1941 when the Blue Cross-Blue Shield movement came to Kansas and Glenn was right there to give it a push.

"In those early days none of us had any special jobs. We did everything and anything in the office or out of it to make the Plans run smoother," Glenn remarks of those beginning years. He was one of the first to venture Community Enrollment for Blue Cross and Blue Shield.

His work with the Nebraska Blue Cross-Blue Shield Plan was primarily of an organizational nature. He spent three years with the plans before coming to Michigan.

Glenn is the father of four children. The oldest son is a weather forecaster and hydrologist in the West. The next oldest son is a Doctor of Medicine finishing his residency in St. Lukes Hospital, New York City.

Incidentally, Glenn is the nephew of the famous boxer, Jess Willard. Glenn tried to defend his uncle's honor a number of times and has a broken nose to prove it!

Office: 752 Keeler Building, 60 Division Street, Grand Rapids, Phone: 9-4331.

Home: 1541 Giddings, S.E., Grand Rapids, Phone: 3-1506.

AREA 4

COUNTIES: Kent, Lake, Manistee, Mason, Mecosta, Muskegon, Newaygo, Oceana, Ottawa, Wexford, Benzie, Grand Traverse, Leelanau, half of Ionia, half of Montcalm, half of Osceola. (NOTE: The area indicated by the dotted line is covered periodically. Because this is a sparsely populated area, a full-time field man is not assigned to the section, but it is serviced by the Area 4 representative).

POPULATION	731,630
DOCTORS IN AREA	755
BLUE SHIELD PAYMENTS TO DOCTORS (1951)	$1,369,234
BLUE CROSS HOSPITALS	25



R. S. BREAKEY, M.D.
Member
MSMS—Liaison Committee



JOHN WELLMAN, M.D.
Member
MSMS—Liaison Committee



ROBERT MORSE
Representative
MMS—Professional Relations

Referred to as the "dean af Professional Relations" BOB MORSE has had a lang career in field wark with Michigan Medical Service.

Bab joined Blue Shield in 1943 as one af the first field men ta wark autside of Wayne Caunty. He has had his territary continuously ever since.

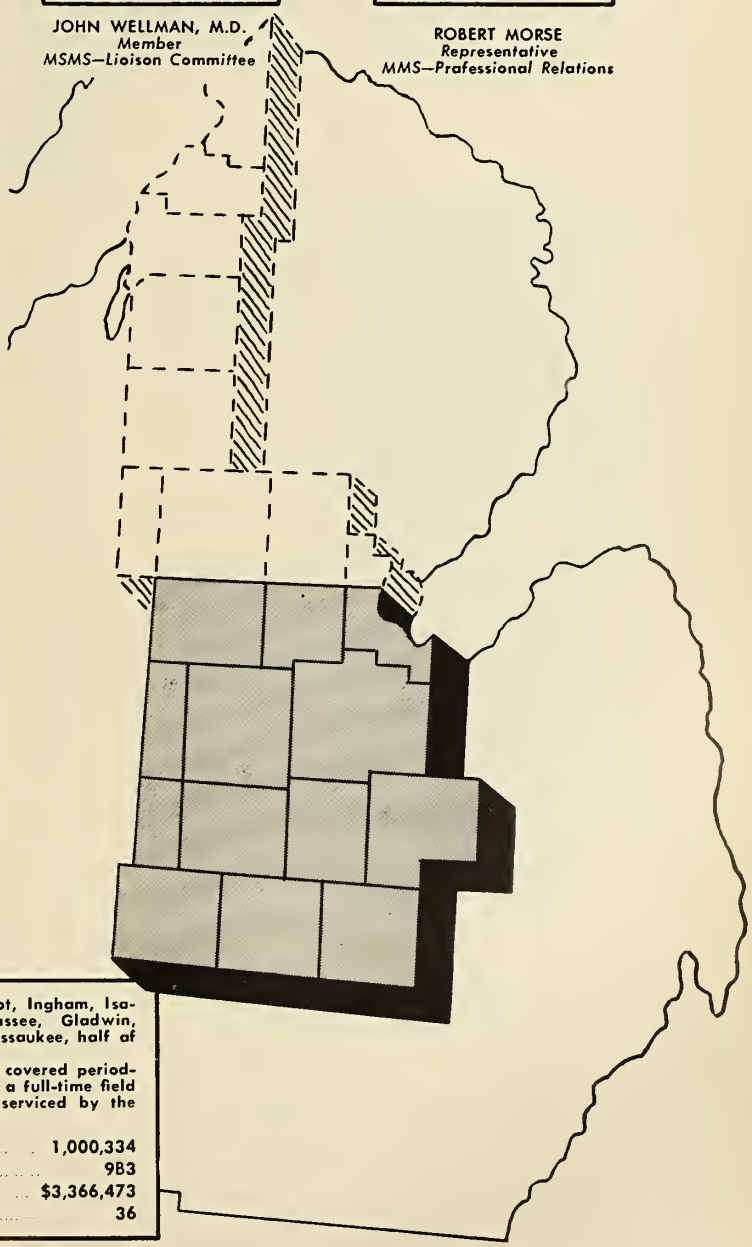
His tenacity in tracking dawn an unpaid bill is almast uncanny and certainly appreciated by the dactars in his area. Those wha knaw Bab knaw that if they ask him a Blue Shield question he gets them the answer . . . and quickly! Dactors in his area know him as "ald reliable" and "Mr. Blue Shield himself".

Befare beginning Blue Shield wark Bob was employed as Agency Director in the State Insurance Department. He was elevated ta Deputy Insurance Commissioner in 1936, and nat lang after, began work with the D. F. Braderick Campany as Agency Manager far their fire business.

Knawn as an autharity af fresh water fishing, Bab baasts af knawing where the big anes can be caught even when they're nat biting any place else. Alang with his fishing he enjays stamp callecting. A more javial and lavable persanality would be impassible ta find. He is married and his two children are the light af his life.

Office: 458 Hallister Building, Lansing, Phane: 2-1364.

Hame: 216 W. St. Jaseph, Lansing, Phone: 2-9439.



AREA 5

COUNTIES: Bay, Clintan, Eatan, Genesee, Gratiot, Ingham, Isabella, Livingstan, Midland, Saginaw, Shiawassee, Gladwin, Antrim, Charlevoix, Clare, Emmett, Kalkaska, Missaukee, half af Ionia, half of Montcalm, half af Osceola.
(NOTE: The area indicated by the dotted line is covered periodically. Because this is a sparsely populated area, a full-time field man is not assigned ta the section, but it is serviced by the Area 5 representative).

POPULATION	1,000,334
DOCTORS IN AREA	983
BLUE SHIELD PAYMENTS TO DOCTORS (1951)	$3,366,473
BLUE CROSS HOSPITALS	36



ANTON PATTI
Representative
MMS—Professional Relations



D. B. WILEY, M.D.
Member
MSMS—*Liaison Committee*

ANTON "Tony" PATTI is the newest addition to the Professional Relations Department. He began his work with Blue Shield in March of this year and is only now beginning to became acquainted with his area.

Tony is a likable guy from the beginning. Quiet, reserved, yet aggressive when the occasion presents itself, he is the kind of individual who has the polish and graciousness it takes to make a good field man.

He begins his work with Blue Shield after a lifetime of music. He played with the Detroit Symphony Orchestra for six consecutive seasons occupying a choir in the viola section. For the two years immediately preceding his work with Professional Relations, he led the Sheraton-Cadillac Hotel orchestra.

Tony spent five years with the Army. He was a First Lieutenant in the Infantry with the Fifth Corps Headquarters in Europe.

His education includes a year and a half in the Detroit Institute of Technology.

He is married, has three children and enjoys golf, fishing and music.

Office: 1200 Washington Boulevard Building, 234 State Street, Detroit, Phone: WO. 5-2700.

Home: 226 Prospect, Ramea, Phone: 3202.

AREA 6

COUNTIES: Huron, Lapeer, Macomb, Oakland, St. Clair, Sanilac, Tuscola, Alcona, Alpena, Arenac, Cheboygan, Crawford, Iosco, Montmorency, Ogemaw, Oscoda, Otsego, Presque Isle, Rascommon.
(NOTE: The area indicated by the dotted line is covered periodically. Because this is a sparsely populated area, a full-time field man is not assigned to the section, but it is serviced by the Area 6 representative).

POPULATION	918,027
DOCTORS IN AREA	638
BLUE SHIELD PAYMENTS TO DOCTORS (1951)	$1,861,650
BLUE CROSS HOSPITALS	20



RUDY BOLICH has done almost everything imaginable. When Costellucci interviewed him for his present Professional Relations job he asked him about his previous working experience. After many minutes of talking and explaining the various jobs he has had, John finally said, "You've done a lot of things, and the only thing I can think of that you haven't been is an old man!" And this is just about the only occupation Rudy has to look forward to.

He entered the Ferris Institute in 1931 in the curriculum prescribed for premedical students. He left the Institute a year later and began studying Cosmatology at the Jarvis Academy in Minneapolis. Two years later, he entered the Woodward Business College in Ironwood.

Throughout his life Rudy has been interested in Music. He is an accomplished musician, has had his own orchestras and has played with some of the finest popular bands of the country.

After a four year stint with the Army Medical Corps., the Army Band and Orchestra, Rudy returned to Michigan as the assistant administrator of Gladwin Hospital in Ironwood. His work with Blue Shield began in 1949.

He is married and has two children—a daughter and son. His present interests are photography, radio, and electronics. Incidentally, Rudy covers the largest Professional Relations territory in the state.

Office: 11 Union National Bank Building, 101 W. Washington Street, Marquette, Phone: 2948.

Home: 244 E. Ridge Street, Ironwood, Phone: 2194.



W. H. HURON, M.D.
Member
MSMS—Liaison Committee



RUDOLPH BOLICH
Representative
MMS—Professional Relations

AREA 7

Upper Peninsula

POPULATION	302,258
DOCTORS IN AREA	227
BLUE SHIELD PAYMENTS TO DOCTORS (1951)	$372,397
BLUE CROSS HOSPITALS	18

Michigan Medical Service

Officers and Directors

1951-1952



R. L. Novy, M.D.
President



W. Haughey, M.D.
Vice President



R. H. Baker, M.D.
Secretary



Waldo I. Stoddard
Treasurer



K. Babcock, M.D.



E. D. Barnett, M.D.



E. C. Baumgarten
M.D.



Harry Becker



William Bromme,
M.D.



E. I. Carr, M.D.



B. D. Dann



J. S. DeTar, M.D.



L. F. Foster, M.D.

Michigan Medical Service

Directors

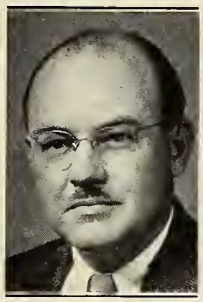
1951-1952



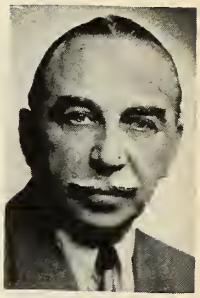
Carleton Fox, D.D.S.



C. K. Hasley, M.D.



W. H. Huron, M.D.



W. A. Hyland, M.D.



A. C. Kerlikowske, M.D.



Ralph N. Long



W. C. Perdew. D.D.



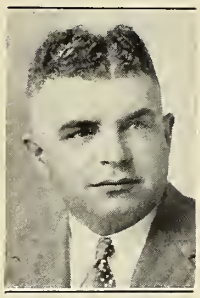
G. C. Penberthy, M.D.



E. A. Oakes, M.D.



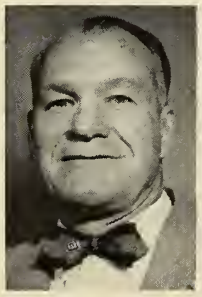
John Reid



Philip Riley, M.D.



E. F. Sladek, M.D.



Arch Walls, M.D.



Ronald Yaw

Michigan State Medical Society

Past Presidents 1866-1951

1866—*C. M. Stockwell, Port Huron
1867—*J. H. Jerome, Saginaw
1868—*Wm. H. DeCamp, Grand Rapids
1869—*Richard Inglis, Detroit
1870—*I. H. Bartholomew, Lansing
1871—*H. O. Hitchcock, Kalamazoo
1872—*Alonzo B. Palmer, Ann Arbor
1873—*E. W. Jenk, Detroit
1874—*R. C. Kedzie, Lansing
1875—*Wm. Brodie, Detroit
1876—*Abram Sager, Ann Arbor
1877—*Foster Pratt, Kalamazoo
1878—*Ed. Cox, Battle Creek
1879—*George K. Johnson, Grand Rapids
1880—*J. R. Thomas, Bay City
1881—*J. H. Jerome, Saginaw
1882—*Geo. W. Topping, DeWitt
1883—*A. F. Whelan, Hillsdale
1884—*Donald Maclean, Detroit
1885—*E. P. Christian, Wyandotte
1886—*Charles Shepard, Grand Rapids
1887—*T. A. McGraw, Detroit
1888—*S. S. French, Battle Creek
1889—*G. E. Frothingham, Detroit
1890—*L. W. Bliss, Saginaw
1891—*George E. Ranney, Lansing
1892—*Charles J. Lundy
(Died before taking office)
*Gilbert V. Chamberlain, Flint, Acting President
1893—*Eugene Boise, Grand Rapids
1894—*Henry O. Walker, Detroit
1895—*Victor C. Vaughan, Ann Arbor
1896—*Hugh McColl, Lapeer
1897—*Joseph B. Griswold, Grand Rapids
1898—*Ernest L. Shurly, Detroit
1899—*A. W. Alvord, Battle Creek
1900—*P. D. Patterson, Charlotte
1901—*Leartus Connor, Detroit
1902—*A. E. Bulson, Jackson
1903—*Wm. F. Breakey, Ann Arbor
1904—*B. D. Harison, Sault Ste. Marie
1905—*David Inglis, Detroit
1906—*Charles B. Stockwell, Port Huron
1907—*Hermon Ostrander, Kalamazoo
1908—*A. F. Lawbaugh, Calumet
1909—*J. H. Carstens, Detroit
1910—*C. B. Burr, Flint
1911—*D. Emmett Welsh, Grand Rapids
1912—*Wm. H. Sawyer, Hillsdale
1913—*Guy L. Kiefer, Detroit
1914—*Reuben Peterson, Ann Arbor
1915—*A. W. Hornbogen, Marquette
1916—*Andrew P. Biddle, Detroit
1917—*Andrew P. Biddle, Detroit
1918— Arthur M. Hume, Owosso
1919—*Charles H. Baker, Bay City
1920—*Angus McLean, Detroit
1921—*Wm. J. Kay, Lapeer
1922—*W. T. Dodge, Big Rapids
1923—*Guy L. Connor, Detroit
1924—*C. C. Clancy, Port Huron
1925—*Cyrenus G. Darling, Ann Arbor
1926—*J. B. Jackson, Kalamazoo
1927—*Herbert E. Randall, Flint
1928— Louis J. Hirschman, Detroit
1929— J. D. Brook, Grandville
1930—*Ray C. Stone, Battle Creek
1931—*Carl F. Moll, Flint
1932— J. Milton Robb, Detroit
1933—*George LeFevre, Muskegon
1934—*R. R. Smith, Grand Rapids
1935— Grover C. Penberthy, Detroit
1936— Henry E. Perry, Newberry
1937— Henry Cook, Flint
1938—Henry A. Luce, Detroit
1939— Burton R. Corbus, Grand Rapids
1940— Paul R. Urmston, Bay City
1941— Henry R. Carstens, Detroit
1942— H. H. Cummings, Ann Arbor
1943— C. R. Keyport, Grayling
1944—*A. S. Brunk, Detroit
1945—*V. M. Moore, Grand Rapids
(Died before taking office)
1945— R. S. Morrish, Flint
1946— Wm. A. Hyland, Grand Rapids
1947—*P. L. Ledwidge, Detroit
1948— E. F. Sladek, Traverse City
1949—Wilfrid Haughey, Battle Creek
(President-for-a-Day, Sept. 21, 1949)
1949—W. E. Barstow, St. Louis
1950—C. E. Umphrey, Detroit
1951—Otto O. Beck, Birmingham

*Deceased.

Michigan State Medical Society

The 87th Annual Session



William Bromme, M.D.
Detroit
Council Chairman



Otto O. Beck, M.D.
Birmingham
President



R. H. Baker, M.D.
Pontiac
Speaker



L. Fernald Foster, M.D.
Bay City
Secretary

OFFICIAL CALL

The Michigan State Medical Society will convene in Annual Session in Detroit, Michigan, on September 22, 23, 24, 25, 26, 1952. The provisions of the Constitution and By-Laws and the Official Program will govern the deliberations.

Otto O. Beck, M.D.
President

William Bromme, M.D.
Council Chairman

R. H. Baker, M.D.
Speaker

J. E. Livesay, M.D.
Vice Speaker

Attest:
L. Fernald Foster, M.D.
Secretary



J. E. Livesay, M.D.
Flint
Vice Speaker

TWO-DAY SESSION OF HOUSE OF DELEGATES

SEPTEMBER 22-23, 1952

The 1952 House of Delegates of the Michigan State Medical Society will hold a two-day session beginning Monday, September 22 at 10:00 a.m. The business of the House of Delegates will be transacted in the Grand Ballroom of the Sheraton-Cadillac Hotel, Detroit.

The House will also meet on Monday at 2:00 p.m. and at 8:00 p.m. and on Tuesday, September 23, at 10:00 a.m. and at 8:00 p.m.

The intervals between meetings of the House of Delegates have been spaced to permit the Reference Committees ample time to transact all business referred to them.

Seating of Delegates

"Any Delegate-Elect not present to be seated at the hour of call of the first meeting may be replaced by the accredited Alternate next on the list as certified by the Secretary of the component County Society involved."—MSMS By-Laws, Chapter 8, Section 6.

TENTATIVE OUTLINE OF 1952 ASSEMBLY AND SECTION SPEAKERS
87TH ANNUAL SESSION, MICHIGAN STATE MEDICAL SOCIETY

Detroit, September, 1952

Time	Wednesday September 24, 1952	Thursday September 25, 1952	Friday September 26, 1952
A.M. 8:30-9:00	Registration Exhibits open	Registration Exhibits open	Registration Exhibits open
9:00-9:30	*Surgery* Claude S. Beck, M.D. Cleveland, Ohio	*Gynecology* Emil Novak, M.D. Baltimore, Maryland	*Medicine* Dwight E. Harken, M.D. Boston, Mass.
9:30-10:00	*Medicine* Davio A. Rytand, M.D. San Francisco, Calif.	*Otolaryngology* Ben H. Senturia, M.D. St. Louis, Mo.	*Syphilology* Evan W. Thomas, M.D. Albany, N. Y.
10:00-11:00	Intermission to View Exhibits	Intermission to View Exhibits	Intermission to View Exhibits
11:00-11:30	*Pediatrics* Milton I. Levine, M.D. New York, New York	*Anesthesia* John J. Bonica, M.D. Tacoma, Washington	*General Practice* Philip Thorek, M.D. Chicago, Ill.
11:30-12:00 M	*Dermatology* Leonaro F. Weber, M.D. Chicago, Ill.	*Public Health & Preventive Medicine* Gaylord W. Anoerson, M.D. Minneapolis, Mianesota	*Nervous & Mental Diseases* Rolano P. Mackay, M.D. Chicago, Ill.
P.M. 12:00-1:00	Discussion Conference	Discussion Conference	Discussion Conference
2:00-2:30	*Urology* Ormono S. Culp, M.D. Rochester, Minn.	*Gastroenterology & Proctology* Samuel F. Marshall, M.D. Boston, Mass.	*Pediatrics* Daniel C. Darrow, M.D. New Haven, Conn.
2:30-3:00	*Obstetrics* Duncan E. Reid, M.D. Boston, Mass.	*General Practice* George Crile, Jr., M.D. Cleveland, Ohio	*Radiology* Earl R. Miller, M.D. San Francisco, Calif.
3:00-4:00	Intermission to View Exhibits	Intermission to View Exhibits	3:00 to 3:30 P.M. Final Intermission to View Exhibits
4:00-4:30	*Ophthalmology* Peter C. Kronfeld, M.D. Chicago, Ill.	*Obstetrics* Eowin J. DeCosta, M.D. Chicago, Ill.	*Surgery* 3:30-4:00 Clauoe E. Welch, M.D. Boston, Mass.
4:30-5:00	*Surgery* Speaker to be announced	*Surgery* Speaker to be announced	*Medicine* 4:00 to 4:30 P.M. Garfield G. Duncan, M.D. Philadelphia, Pa.
5:00-6:00	Five Section Meetings 5:00 to 6:00 P.M.	Five Section Meetings 5:00 to 6:00 P.M.	Four Section Meetings 4:30 to 5:30 P.M.
	Dermatology-Syphilology Leonaro F. Weber, M.D. Chicago, Ill.	*Anesthesia* John J. Bonica, M.D. Tacoma, Washington	*Radiology* Earl R. Miller, M.D. San Francisco, Calif.
	Pediatrics Milton I. Levine, M.D. New York, New York	*Otolaryngology* Ben H. Senturia, M.D. St. Louis, Mo.	*Medicine* Dwight E. Harken, M.D. Boston, Mass.
	Urology Ormond S. Culp, M.D. Rochester, Minn.	*Public Health & Preventive Medicine* Gaylord W. Anoerson, M.D. Minneapolis, Minn.	*General Practice* Philip Thorek, M.D. Chicago, Ill.
	Obstetrics-Gynecology Duncan E. Reio, M.D. Boston, Mass.	*Gastroenterology & Proctology* Samuel F. Marshall, M.D. Boston, Mass.	*Nervous & Mental Diseases* Roland P. Mackay, M.D. Chicago, Illinois
	Ophthalmology Peter C. Kronfeld, M.D. Chicago, Ill.	*Surgery* Speaker to be announced	
8:30	8:30 A.M to 10:30 P.M. Officers' Night Biddle Lecture Paul oe Kruif, Ph.D. Holland, Michigan	10:00 P.M. to 1:00 A.M. State Society Night MSMS Entertainment	5:30 P.M. END OF ASSEMBLY

Michigan State Medical Society

The 87th Annual Session

SHERATON-CADILLAC HOTEL, DETROIT, MICHIGAN

September 22, 23, 24, 25, 26, 1952

INFORMATION

● **DETROIT WILL BE HOST TO MSMS IN SEPTEMBER, 1952.**

● **MSMS HOUSE OF DELEGATES** convenes Monday, September 22 at 10:00 a.m., English Room, Sheraton-Cadillac Hotel. It will hold three meetings on Monday and two meetings on Tuesday, September 23.

● **THE PROGRAM OF THE ASSEMBLY** for the 87th Annual Session of the Michigan State Medical Society lists guest speakers from all parts of the United States. They are the usual stars in the medical world which always grace the annual conventions of the Michigan State Medical Society; they insure a valuable concentrated continuation course in all phases of medicine and surgery for the busy practitioners of Michigan, neighboring States and the Province of Ontario, on September 24-25-26, 1952.

● **REGISTRATION,** Tuesday afternoon through Friday afternoon, September 23-26, Fifth Floor, Sheraton-Cadillac Hotel. Advance registration—on Tuesday and early Wednesday morning—will save your time. Present your State Medical Society or Canadian Medical Association membership card to expedite registration.

NO REGISTRATION FEE FOR STATE MEDICAL SOCIETY AND CMA MEMBERS.

Doctors of Medicine, who are not members of their state medical society or of the Canadian Medical Association, will be accorded the privileges of the MSMS Annual Session upon payment of a $25.00 registration fee.

REGISTER AS SOON AS YOU ARRIVE. ADMISSION BY BADGE ONLY.

● **ALL SUBJECTS** at the MSMS Annual Session are applicable to clinical medicine. They stress diagnosis and treatment, usable in everyday practice.

● **POSTGRADUATE CREDITS** given to every MSMS member who attends MSMS Annual Session.

● **SIX ASSEMBLIES AND ONE PUBLIC MEETING** —fourteen Section Meetings—three Discussion Conferences on September 24-25-26.

● **A DISCUSSION CONFERENCE**—featuring the eight Guest Essayists of each day—will be held daily from 12:00 noon to 1:00 p.m. in the Grand Ballroom of the Sheraton-Cadillac Hotel. Audience participation desired.

● **SECTION MEETINGS** will follow the daily Assemblies—5:00 to 6:00 p.m. on Wednesday-Thursday, and 4:30 to 5:30 p.m. on Friday.

● **PAPERS WILL BEGIN AND END ON TIME.** This scientific meeting will feature by-the-clock promptness and regularity.

● **NINETY-NINE TECHNICAL EXHIBITS** will contain much of interest and value. Intermissions to view the exhibits have been arranged.

● **ARCH WALLS, M.D., DETROIT,** is General Chairman of the Detroit Committee on Arrangements for the 1952 MSMS Annual Session.

● **CABARET-STYLE DANCE AND ENTERTAINMENT,** with the compliments of the Michigan State Medical Society, will be held in the Grand Ballroom, Sheraton-Cadillac Hotel, Thursday evening, September 25. All who register, and their ladies, will receive a card of admission and are cordially invited to attend.

● **THE WOMAN'S AUXILIARY** to the Michigan State Medical Society will present an attractive social and business program at the Statler Hotel, Detroit. The wife of every MSMS member is cordially invited to attend.

● **MEMBERS OF MICHIGAN MEDICAL SERVICE** will meet in annual Session, Tuesday, September 24, Grand Ballroom, Sheraton-Cadillac Hotel, at 2:00 p.m., following the annual MMS luncheon at 1:00 p.m. in the English Room.

SCIENTIFIC ASSEMBLY

Wednesday-Thursday-Friday, Sept. 24-25-26, 1952

SAVE AN ORDER FOR THE EXHIBITOR AT THE MICHIGAN STATE MEDICAL SOCIETY ANNUAL SESSION

MICHIGAN STATE MEDICAL SOCIETY

The 87th Annual Session

Sheraton-Cadillac Hotel, Detroit, September 22-23, 1952

House of Delegates

ORDER OF BUSINESS*

MONDAY, SEPTEMBER 22

English Room, Sheraton-Cadillac Hotel, Detroit

10:00 a.m.—First Meeting

1. Call to order by Speaker
2. Report of Committee on Credentials
3. Roll call
4. Appointment of Reference Committees
 - (a) On Officers' Reports
 - (b) On Reports of The Council
 - (c) On Reports of Standing Committees
 - (d) On Reports of Special Committees
 - (e) On Constitution and By-Laws
 - (f) On Resolutions
 - (g) On Special Memberships
 - (h) On Rules and Order of Business
 - (i) On Legislation and Public Relations
 - (j) On Hygiene and Public Health
 - (k) On Medical Service and Prepayment Insurance
 - (l) On Miscellaneous Business
 - (m) On Executive Session
 - (n) On Emergency Medical Service
5. Speaker's Address—R. H. Baker, M.D., Pontiac
6. President's Address—Otto O. Beck, M.D., Birmingham
7. President-Elect's Address—R. J. Hubbell, M.D., Kalamazoo
8. Annual and Supplemental Reports of The Council—William Bromme, M.D., Detroit, Chairman
9. Report of Delegates to American Medical Association—W. D. Barrett, M.D., Detroit, Chairman
10. Brief of Annual Report of Woman's Auxiliary President—Mrs. R. S. Breakey, Lansing
11. Selection of Michigan's Foremost Family Physician
12. Resolutions**

MONDAY, SEPTEMBER 22

English Room, Sheraton-Cadillac Hotel, Detroit

2:00 p.m.—Second Meeting

13. Supplementary Report of Committee on Credentials
14. Roll Call
15. Reports of MSMS Standing Committees
 - A. Committee on Postgraduate Medical Education
 - B. Preventive Medicine Committee
 - (1) Rheumatic Fever Control Committee (and Subcommittees)
 - (2) Cancer Control Committee (and Subcommittees)
 - (3) Maternal Health Committee
 - (4) Venereal Disease Control Committee
 - (5) Tuberculosis Control Committee
 - (6) Industrial Health Committee
 - (7) Mental Hygiene Committee
 - (8) Child Welfare Committee
 - (a) Subcommittee on Hearing Defects
 - (b) Subcommittee of Ophthalmologists
 - (9) Iodized Salt Committee
 - (10) Geriatrics Committee
 - (a) Subcommittee on Diabetes Control
 - (b) Subcommittee to Study Problem of Caring for Aged
 - (11) Committee on Infectious Diarrhea
 - C. Committee on Distribution of Medical Care
 - D. Committee on Public Relations (and Subcommittees)
 - E. Committee on Ethics
 - F. Legislative Committee
16. Reports of Special Committees
 - A. Beaumont Memorial Restoration Committee
 - B. Scientific Radio Committee
 - C. Advisory Committee to Woman's Auxiliary
 - D. Liaison Committee with Michigan State Medical Assistants Society
 - E. Advisory Committee to National Foundation for Infantile Paralysis

Reports of the Committees of the Council, including Committee on Scientific Work, are included in the Annual Report of the Council

MONDAY, SEPTEMBER 22

Grand Ballroom, Sheraton-Cadillac Hotel, Detroit

8:00 p.m.—Third Meeting

17. Supplementary Report of Committee on Credentials
18. Roll Call
19. Unfinished Business
20. New Business
21. Reports of Reference Committees
 - (a) On Officers' Reports
 - (b) On Reports of The Council
 - (c) On Reports of Standing Committees
 - (d) On Reports of Special Committees
 - (e) On Constitution and By-Laws
 - (f) On Resolutions
 - (g) On Special Memberships
 - (h) On Rules and Order of Business
 - (i) On Legislation and Public Relations
 - (j) On Hygiene and Public Health
 - (k) On Medical Service and Prepayment Insurance
 - (l) On Miscellaneous Business
 - (m) On Executive Session
 - (n) On Emergency Medical Service

*See the Constitution, Articles IV, VII and XII, and the By-laws, Chapter 8 on "House of Delegates."

**All Resolutions, special reports, and new business shall be presented in writing in triplicate (By-laws, Chapter 8, Section 10-m).

TUESDAY, SEPTEMBER 23

Grand Ballroom, Sheraton-Cadillac Hotel, Detroit

10:00 a.m.—Fourth Meeting

22. **Supplementary Report of Committee on Credentials**
23. **Roll Call**
24. **Unfinished Business**
25. **New Business**
26. **Supplementary Reports of Reference Committees**

TUESDAY, SEPTEMBER 23

Grand Ballroom, Sheraton-Cadillac Hotel, Detroit

8:00 p.m.—Fifth Meeting

27. **Supplementary Report of Committee on Credentials**
28. **Roll Call**
29. **Special Order of Business**
30. **Unfinished Business**
31. **Supplemental Report of The Council**
32. **Supplementary Reports of Reference Committees**
33. **Elections**
 (a) Councilors:
 7th District—H. B. Zemmer, M.D., Lapeer—Incumbent
 8th District—L. C. Harvie, M.D., Saginaw—Incumbent
 9th District—G. B. Saltonstall, M.D., Charlevoix—Incumbent
 10th District—F. H. Drummond, M.D., Kawkawlin—Incumbent
 (b) Delegates to American Medical Association:
 W. D. Barrett, M.D., Detroit—Incumbent
 W. H. Huron, M.D., Iron Mountain—Incumbent
 R. L. Novy, M.D., Detroit—Incumbent
 (c) Alternate Delegates to the American Medical Association:
 R. H. Denham, M.D., Grand Rapids—Incumbent
 C. I. Owen, M.D., Detroit—Incumbent
 (d) President-Elect
 (e) Speaker of House of Delegates
 (f) Vice Speaker of House of Delegates
34. **Adjournment.**

Doctor:

Are you and

your family

registered to

vote in November?

This is a Must!

Annual Session Appointments

- General Chairman of the 1952 MSMS Annual Session is Arch Walls, M.D., Detroit.
- *House of Delegates Press Relations Committee:*
 R. A. Johnson, M.D., Detroit, *Chairman*
 R. H. Baker, M.D., Pontiac
 H. F. Dibble, M.D., Detroit
 L. Fernald Foster, M.D., Bay City
 J. E. Livesay, M.D., Flint
- *Scientific Assembly Press Relations Committee:*
 R. A. Johnson, M.D., Detroit, Chairman
 E. C. Long, M.D., Detroit
 W. S. Reveno, M.D., Detroit
 A. E. Schiller, M.D., Detroit
 C. L. Weston, M.D., Owosso

HOTEL RESERVATIONS

MICHIGAN STATE MEDICAL SOCIETY

87th Annual Session

Detroit, September 22 to 26, 1952

The reservation blank below is for your convenience in making your hotel reservations in Detroit. Please send your application to Robert M. Buckley, Sheraton-Cadillac Hotel, Detroit, Michigan. Mailing your application now will be of material assistance in securing hotel accommodations.

As very few singles are available, registrants are requested to co-operate with the Committee on Hotels by sharing a room with another registrant, when convenient.

.....

Committee on Hotels,
Michigan State Medical Society
c/o Sheraton-Cadillac Hotel,
Detroit, Michigan

Attention: Robert M. Buckley

Please make hotel reservation (s) as indicated below:

.....Single Room(s)

.....Double Room(s) for.....persons

.....Twin-Bedded Room(s) for.....persons

Arriving September.....hour A.M. P.M.

Leaving September.....hour A.M. P.M.

Hotel of First Choice:.....

Second Choice:.....

Names and addresses of all applicants including person making reservation:

Name	Address	City	State
.....			
.....			
.....			
.....			
.....			

Date Signature.....

Address City.....

MSMS HOUSE OF DELEGATES—1952

Delegates and Alternates

(Names of Alternates appear in Italics)

ALLEGAN

Lewis F. Brown, M.D., 133 E. Allegan Street, Otsego
Elwin B. Johnson, M.D., 144 Brady, Allegan

ALPENA-ALCONA-PRESQUE ISLE

Elbert S. Parmenter, M.D., 140 E. Washington, Alpena
James E. Spens, M.D., Professional Building, Alpena

BARRY

Alexander B. Gwinn, M.D., City Bank Building, Hastings
Herbert S. Wedel, M.D., 304 S. Washington Street, Hastings

BAY-ARENAC-IOSCO

Orlen J. Johnson, M.D., 207 N. Walnut, Bay City
Walter S. Stinson, M.D., 101 W. John, Bay City
Robert E. Fisher, M.D., 5th and Jackson Streets, Bay City
Neal R. Moore, M.D., 704 N. Jackson, Bay City

BERRIEN

Donald W. Thorup, M.D., 610 Fidelity Building, Benton Harbor
Franklyn A. Rice, M.D., 318 N. Fourth, Niles
Henry J. Klos, M.D., Mercy Hospital, Benton Harbor
Frederick H. Lindenfeld, M.D., 8 N. St. Joseph Avenue, Niles

BRANCH

Harold J. Meier, M.D., 87 W. Pearl, Coldwater
Nathaniel J. Walton, M.D., 61 E. Chicago, Quincy

CALHOUN

Stanley T. Lowe, M.D., 1009 Security Bank Building, Battle Creek
Harvey C. Hansen, M.D., 417 Post Building, Battle Creek
James W. Hubly, M.D., 1407 Security Bank Bldg., Battle Creek
Leland R. Keagle, M.D., 196 North Avenue, Battle Creek

CASS

Sherman L. Loupee, M.D., Dowagiac
Uriah M. Adams, M.D., Marcellus

CHIPPEWA-MACKINAC

Benjamin T. Montgomery, M.D., 309 Ashmun, Sault Ste. Marie
Donnell C. Howe, M.D., 300 Court Street, Sault Ste. Marie

CLINTON

Franklin W. Smith, M.D., Ovid
William B. McWilliams, M.D., Maple Rapids

DELTA-SCHOOLCRAFT

William A. LeMire, M.D., 1106 First Avenue S., Escanaba
Albert H. Miller, M.D., 904 Wisconsin, Gladstone

DICKINSON-IRON

Lionel E. Irvine, M.D., 422 Third Street, Iron River
William Fiedling, M.D., First National Bank Building, Norway

EATON

To be announced

GENESEE

Clifford W. Colwell, M.D., 706 Citizens Bank Building, Flint
Leon M. Bogart, M.D., 1008 Genesee Bank Building, Flint
Jackson E. Livesay, M.D., 619 Mott Foundation Building, Flint
Frank D. Johnson, M.D., 312 Paterson Building, Flint
Harold H. Hiscock, M.D., 1315 Mott Foundation Building, Flint
Edwin P. Vary, M.D., 608 First National Building, Flint
Franklin W. Baske, M.D., 923 Maxine Street, Flint
Fleming A. Barbour, M.D., 1439 Mott Foundation Building, Flint

GOGEBIC

Wayne A. Gingrich, M.D., 109 E. Aurora Street, Ironwood
Florian J. Santini, M.D., 109 E. Aurora Street, Ironwood

GRAND TRAVERSE-LEELANAU-BENZIE

Donald G. Pike, M.D., 876 E. Front Street, Traverse City
Charles E. Lemen, M.D., 216½ E. Front Street, Traverse City

GRATIOT-ISABELLA-CLARE

Myron G. Becker, M.D., Edmore
Earle S. Oldham, M.D., Breckenridge

HILLSDALE

Arthur W. Strom, M.D., 32 S. Broad Street, Hillsdale
Luther W. Day, M.D., 111 Evans Street, Jonesville

HOUGHTON-BARAGA-KEWEENAW

John T. P. Wickliffe, M.D., 1167 Calumet Avenue, Calumet
Paul S. Sloan, M.D., 214 Clark, Houghton

HURON

Charles W. Oakes, Jr., M.D., Harbor Beach
Charles I. Herrington, M.D., Bad Axe

INGHAM

Franklin L. Troost, M.D., 4341 W. Delhi Road, Holt
Harold W. Wiley, M.D., 137 N. Larch Street, Lansing
Kenneth H. Johnson, M.D., 1116 Olds Tower, Lansing
Oliver B. McGillicuddy, M.D., 1816 Olds Tower, Lansing
John M. Wellman, M.D., 301 Seymour, Lansing
Edmund J. Robson, M.D., 215 N. Walnut, Lansing
Leo W. Walker, M.D., St. Lawrence Hospital, Lansing
Lawrence A. Drolett, M.D., 903 Prudden Building, Lansing

IONIA-MONTCALM

William L. Bird, M.D., Greenville
Milton E. Slagh, M.D., Saranac

JACKSON

John D. Van Schoick, M.D., Hanover
John W. Rice, M.D., 603 Jackson City Bank, Jackson
Nathan D. Munro, 740 W. Michigan, Jackson
James J. O'Meara, M.D., 1508 Reynolds Building, Jackson

ALAMAZOO

Frederick C. Ryan, M.D., 507 S. Burdick, Kalamazoo
Irmel W. Brown, M.D., 306 Kalamazoo National Bank Building, Kalamazoo
William A. Scott, M.D., 208 Bronson Medical Center, Kalamazoo
Kenneth L. Crawford, M.D., 612 Douglas Avenue, Kalamazoo
Warren B. Crane, M.D., 420 S. Rose, Kalamazoo
Paul F. Cooper, M.D., 252 E. Lovell Street, Kalamazoo

ENT

Andrew A. Van Solkema, M.D., 953 E. Fulton Street, Grand Rapids
Luther C. Carpenter, Jr., M.D., 604 Metz Building, Grand Rapids
Guy W. DeBoer, M.D., 220 Medical Arts Building, Grand Rapids
William R. Torgerson, M.D., 321 Metz Building, Grand Rapids
Torrance Reed, M.D., 304 Ashton Building, Grand Rapids
Stanley L. Moleski, M.D., 528 Medical Arts Building, Grand Rapids
Lee O. J. Grant, M.D., 420 Medical Arts Building, Grand Rapids
Raymond S. Van Bree, M.D., 204 Loraine Building, Grand Rapids
Charles E. Farber, M.D., 68 Ransom, NE, Grand Rapids

APEER

Daniel J. O'Brien, M.D., Nepassing Street, Lapeer
James R. Doty, M.D., Clay Street, Lapeer

ENAWEE

John D. Hamilton, M.D., 122 Toledo Street, Adrian

IVINGSTON

Harold C. Hill, M.D., 116 N. Michigan, Howell
Thomas A. Barton, M.D., 112 E. Grand River, Howell

UCE

Earl H. Campbell, M.D., Newberry
Thomas W. Thompson, M.D., Newberry State Hospital, Newberry

ACOMB

Sydney Scher, M.D., 610 Monitor-Leader Building, Mt. Clemens
Russell W. Ullrich, M.D., 91 Cass Avenue, Mt. Clemens

ANISTEE

Ellery A. Oakes, M.D., 401 River Street, Manistee
Robert E. Rowe, M.D., 326 18th Street, Manistee

ARQUETTE-ALGER

Lloyd W. Howe, M.D., Savings Bank Building, Marquette
Robert F. Berry, M.D., Bacon Building, Marquette

ASON

Ephraim B. Boldyreff, M.D., Custer
Arthur F. Boon, M.D., 808 W. Court Street, Ludington

ECOSTA-OSCEOLA-LAKE

Paul Ivkovich, M.D., Reed City
Gordon H. Teo, M.D., 126 Maple Street, Big Rapids

EDICAL SOCIETY OF NORTH CENTRAL OUNTIES

Stanley A. Stealy, M.D., P.O. Box 485, Grayling
Louis F. Hayes, M.D., Grayling

MENOMINEE

John R. Heidenreich, M.D., Daggett
Herman R. Brukardt, M.D., Electric Square Building, Menominee

MIDLAND

Harold L. Gordon, M.D., Dow Chemical Company, Midland
Harold H. Gay, M.D., Dow Chemical Company, Midland

MONROE

Thomas A. McDonald, M.D., 7 E. Front, Monroe
John P. Flanders, M.D., 31 Washington, Monroe

MUSKEGON

Robert D. Risk, M.D., 1160 Ransom Street, Muskegon
Norbert W. Scholle, M.D., 1001 Peck Street, Muskegon Heights
Devere R. Boyd, M.D., 1735 Peck Street, Muskegon
Louis L. LeFevre, M.D., 450 W. Western Avenue, Muskegon

NEWAYGO

John P. Klein, M.D., 16 W. Sheridan, Fremont
Brooker L. Masters, M.D., 38 State Street, Fremont

NORTHERN MICHIGAN MEDICAL SOCIETY

John R. Rodger, M.D., Bellaire
Jerrian Van Dellen, M.D., East Jordan

OAKLAND

Palmer E. Sutton, M.D., 629 Washington Square Building, Royal Oak
Harold A. Furlong, M.D., 932 Riker Building, Pontiac
Oliver R. MacKenzie, M.D., 128 Common Street, Walled Lake
James D. Green, M.D., 217 Briggs Building, 222 E. Maple, Birmingham

OCEANA

To be announced

ONTONAGON

William F. Strong, M.D., Ontonagon
Carl R. Lahti, M.D., 700 River Street, Ontonagon

OTTAWA

Dirk C. Bloemendaal, M.D., 47 E. Main, Zeeland
Kenneth N. Wells, M.D., Spring Lake

SAGINAW

Joseph P. Markey, M.D., 808 N. Michigan, Saginaw
David P. Gage, M.D., 514 First Savings & Loan Building, Saginaw
Martin F. Bruton, M.D., 315 S. Jefferson, Saginaw
Vital E. Cortopassi, M.D., 324 S. Washington Avenue, Saginaw
Allen K. Cameron, M.D., 409 First Savings & Loan Building, Saginaw
Charles W. Cory, M.D., 611 First Savings & Loan Building, Saginaw

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Michigan State Medical Society

HOUSE OF DELEGATES, 1952

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ANNUAL REPORT OF LEGISLATIVE COMMITTEE 1951-1952

The 1952 Legislature (second term of sixty-seventh session) considered 842 proposals. A total of 126 of these measures were of interest to the medical profession. Despite the heavy pressure of activity which marked the concentrated four-month session, no bills became law which might tend to lower the high standards of Medicine in Michigan.

Two measures of vital importance to the Michigan State Medical Society and to the practice of medicine were enacted; these contained amendments to the Basic Science Act and the Medical Practice Act as desired by the 1951 MSMS House of Delegates.

All other important legislation, which benefitted the health of the residents of Michigan, was supported by MSMS.

Bills Passed by the Legislature

S.B. 251—

Amendments to Basic Science Act.—All changes in the Basic Science Act as recommended by the 1951 MSMS House of Delegates were included in this bill adopted by both Houses of the Michigan Legislature.

Changes: The Basic Science Board is now permitted to approve those applicants who have successfully passed the basic science examinations in practically any other "basic science" state. The Act was amended to omit the examination in "public health and hygiene." Interns and residents are now exempt from the Basic Science Examination. Subjects passed successfully need not be taken again where the applicant fails in one or more subjects. The membership of the Basic Science Board will be subject to change (service limited to 2 consecutive six year terms). The records of the board—in respect to the reason for approval of applicants—will be open to public inspection. Public Act 198.

S.B. 301—

Amendments to Medical Practice Act.—This bill, containing changes as recommended by the 1951 MSMS House of Delegates, was passed by the Legislature with only two minor amendments which were not opposed by the Michigan State Medical Society.

The principal changes involve the deletion of obsolete language regarding the appointment of members of the Board of Registration in Medicine, the number of Board members necessary to transact business, and the dates for such business; the Board will now consist of ten doctors of medicine, nine of whom are to be from the "regular" school of medicine and one to be a graduate of a homeopathic school. The other adjustments in the bill reduced the passing grade from 75 to 70 per cent; doubled the present fees, to give additional funds to the Board for administrative purposes; allowed the Board to grant and revoke temporary annual licenses to residents in hospitals which may be renewed; extended the statutory definition of unprofessional and dishonest conduct, to include doctors guilty of "claims . . . to cure . . . by secret methods"; the Board to suspend licenses when a doctor has been adjudged mentally incompetent. An amendment requiring applicants to show evidence of being either a citizen of the United States or of having valid second naturalization papers was added by committees in the House and Senate. The bill was given immediate effect and became law on April 25, 1952. Public Act 172.

S.B. 317—

Franchise Tax.—This bill as originally written included Blue Cross-Blue Shield plans and would have imposed a privilege fee or tax of five mills on each dollar of their assets with a ceiling of $50,000. Blue Cross-Blue Shield was removed from this measure before it was passed. (See S.B. 328, below). Public Act 180.

S.B. 240—

Permissive Licensure of Practical Nurses.—For the first time, practical nurses are given an opportunity to be licensed if they meet certain qualifications. The Michigan Board of Nursing will now include three licensed practical nurses who will serve only on matters affecting licensed practical nurses. Public Act 135.

S.B. 55—

State Health Laboratory, Grand Rapids.—Under the provisions of this bill, agreements were authorized between the State Administrative Board and the City of Grand Rapids for the building of a state health laboratory in Grand Rapids. Public Act. 15.

H.B. 63, 65, 66, and 69—

Sex Deviates.—These bills, dealing with sex deviate problems, were the result of recommendations from the Governor's Study Commission. They were concerned with the criminal sexual psychopath, indeterminate sentences and sex deviation crimes. The principles of these measures were developed with the co-operation of the MSMS Mental Hygiene Committee. Public Acts 58, 73, 234, and 72. (See H.B. 64 and H.B. 67, below).

H.B. 297—

Births and Deaths Registrations.—This bill consolidates registration districts keeping records of births and deaths. Public Act. 65.

H.B. 278
S.B. 294—

Dairy Products Inspection.—These measures established systems for inspecting and licensing of dairy products. They divide the responsibility between the State Health Department and the State Department of Agriculture. Public Acts 258 and 238.

H.B. 172—

Community Hospitals.—As passed, this bill allows for construction and operation of a community hospital by one or more cities, villages or townships acting jointly. Public Act 170.

H.B. 166—

Minimum Standards, Children's Welfare Agencies and Boarding Homes.—Minimum standards of care, personnel, food, sanitation and fire protection which can be enforced by Circuit Courts are provided for in this bill. Public Act. 47.

S.B. 92—

Narcotics.—This bill abolishes distinction in penalties for selling or administering narcotics illegally to minors or adults. Public Act 132.

.B. 423
.B. 449—

Amendments to Crippled and Afflicted Children Acts.—These measures provide changes in collection requirements for monies to reimburse the state. The cases are to be reviewed every three years; investigations to be made by the Michigan Department of Social Welfare. Public Acts 245 and 244.

.B. 202—

Osteopathy.—A bill to permit license renewal by compliance with requirement for attendance at eight hours of educational courses as prescribed by the State Board of Osteopathic Examiners. Public Act 93.

'orkmen's Compensation.—

Sixteen Workmen's Compensation bills were entered in the House and Senate. Each bill was carefully reviewed by the MSMS through industrial and labor advisors. These bills were: S.B. 31, 112, 173, 188, 193, 293, and 314. H.B. 38, 51, 156, 160, 174, 226, 277, 314, and 325. Those which passed are: S.B. 193, (P.A. 155); H.B. 226, (P.A. 77); H.B. 314, (P.A. 107); and H.B. 325, (P.A. 263). The MSMS had no major objection to any of those which passed.

Bills Which Failed to Pass the Legislature

I.B. 358—

Repeal of Basic Science Act.—A perennial. Died in House State Affairs Committee.

I.B. 183—

Chiropractic Proposal.—Chiropractors' bill to legislate themselves into the practice of medicine. Failed to come out of House Public Health Committee.

H.B. 184—

Chiropractic Use of State Laboratory.—The chiropractors' companion bill to H.B. 183 which would have opened the State laboratories to all of the healing arts. This was killed in the House Public Health Committee.

H.B. 400—

Naturopathy.—Would have legalized naturopathy by establishing a board of registration, defining educational requirements, etc. A perennial. Died in House Public Health Committee.

S.B. 69—

Little Hoover Commission's "Umbrella" Bill re Health Agencies.—Proposed to transfer to the Michigan Department of Health the power and duties of the Crippled Children Commission, Tuberculosis Sanatorium Commission and TB Hospitals, Mental Health Department and mental hospitals, Social Welfare Department concerning maternity or lying in hospitals. Due to considerable objection, this all-encompassing proposal to create a gigantic state bureau with almost unlimited control over health matters in Michigan died in the Senate State Affairs Committee.

S.B. 265—

Hospital Cost Commission. — This bill sought to create a hospital cost commission to consist of the auditor-general, state health commissioner and comptroller of the State for the purpose of establishing annually the per diem costs for services performed by hospitals to patients who are the direct responsibility of the State. Since this proposal involved the expenditure of considerable funds, the bill was re-referred to the Senate Committee on Appropriations. The Session ended before the Committee concluded its study of the proposal.

S.B. 328—

Tax on Blue Cross-Blue Shield.—Introduced for the purpose of specifically taxing medical care and hospital service corporations (Blue Cross and Blue Shield Plans) by a tax of 1c per subscriber contract. The bill was killed on the floor of the Senate by a narrow margin.

S.B. 26—

State Medical Examiner System.—This bill to create a medical examiner system and to abolish the office of coroner died in the Senate Judiciary Committee. Despite the fact that it was not reported from the Committee, much more interest in this progressive proposal was indicated by the 1952 Legislature than in prior sessions.

H.B. 286—

Wayne County Medical Examiner Bill.—Would have established a county medical examiner system in Wayne County; it was amended to include all counties with 150,000 population or over. Would have abolished the coroner's office. This bill abolishing the county coroner's office, passed the House, with great difficulty, but failed in the Senate.

Senate Concurrent Resolution 39—

Violent and Unexplained Deaths, Investigation.—Senator Perry Greene offered a resolution providing for an interim committee of the Legislature to study the advisability of new legislation to improve the investigation of violent and unexplained deaths. This resolution died in Committee on Senate Business and Rules.

S.B. 64—

Optometric Measure.—This bill prohibited the prescribing or selling of eye-glasses except by registered optometrists and M.D.s and prevented practice of optometry by lay groups and organizations. This proposal was strongly opposed by dispensing opticians and the medical profession. The bill died in the Senate State Affairs Committee.

H.B. 175—

Optometry Advertising.—Would have prohibited the advertising of eye-glasses by optometrists and defined other unlawful conduct. Passed the House but failed to come out of the State Affairs Committee in the Senate.

H.B. 49—

Flour Enrichment.—This bill would have provided for the enrichment of white flour. It successfully passed the House but due to strong objections failed to come out of the Senate Committee.

Senate Joint Resolution "A"—

Reapportionment of Legislature.—This provided for proposal on the ballot of a reapportionment of the Michigan Senate and House of Representatives; the change would provide 34 Senators and 110 Representatives on a geographical and population basis. The bill passed the Senate and failed in House due to requirement of ⅔ majority necessary to pass.

H.B. 453—

Autopsies.—A bill to clarify the legal requirements of autopsies, postmortems or dissections. Failed to come out of House State Affairs Committee.

S.B. 291—

Mental Health Commission.—This bill would have revised the Mental Health Commission to consist of a psychiatrist, physician, attorney-at-law and two members to represent the public. Required a phychiatrist as Director and provided Deputy Director as business manager. Died in Senate Health and Welfare Committee.

S.B. 313—

Advisory Hospital Council Membership.—This proposal would have removed the requirement providing for appointment of a full time health officer from a list submitted by the Michigan Health Officers Association. If this measure had passed, the Governor could have appointed any health officer to this Council regardless of the Michigan Health Officers Association list. Senator Frank Heath, of Bay City, sponsored this bill.

H.B. 64 and 67—

Sex Deviate.—Part of the original group dealing with sexually motivated crimes and the mentally ill. Both bills passed the House but failed to pass the Senate.

S.B. 109—

Physically Handicapped—Labor Department.—Would have created a state advisory council within the Department of Labor for the purpose of advising all agencies of state government dealing with problems of the physically handicapped (including crippled and afflicted children). Failed to come out of Senate State Affairs Committee.

H.B. 360—

75 Per Cent Passing Grade for M.D.s.—This bill would have required at least a 75 per cent passing grade for specified subjects in medical licensure examinations. A perennial. Died in House Public Health Committee.

S.B. 85—

Forensic Medicine.—Would have provided for a post-mortem examination following death by poison, violence or criminal act; also provided for taking of blood samples to determine the degree of alcohol in blood when intoxication may have been the cause of death. Failed to come out of Senate Judiciary Committee.

S.B. 65—

Migratory Labor.—Would have required migratory agriculture workers to carry or furnish a certificate of non-affliction of tuberculosis. Reported out by the Senate Judiciary Committee but re-referred to the Senate Health and Welfare Committee where it died.

Resolution re

Reapportionment.—A House resolution (HJR-C) to establish a joint committee for the study of the reapportionment problem in the State of Michigan failed to come out of committee. HJR-G a House companion resolution to SJR "A" was reported from Committee but was laid on the table due to failure to obtain ⅔ majority vote.

H.B. 80—

Eleemosynary Status; Defense for Negligence.—A bill to abolish any defense for negligence based on charitable, eleemosynary or non-profit character of organization. Not passed by House.

H.B. 101—

Temporary Detainment of Mentally Ill.—To provide temporary detainment of mentally diseased persons in state hospital for custody and treatment. Passed the House but remained in Senate Health and Welfare Committee.

H.B. 197—

Drugs.—A bill to make it unlawful to compound or sell substitutes or alternative drugs or medicines specified in prescriptions. This measure failed to come out of House Public Health Committee.

H.B. 220—

Aid to Indigent Patients.—A bill to give aid to patients in public and private medical institutions who are now excluded from receiving aid because of limitations on federal funds—(bill excluded tuberculosis or psychosis patients). Did not get out of House Social Aid and Welfare Committee.

Appropriations

1. The total state budget provided $6,000,000 for the care of state-at-large tuberculosis patients; $1,243,393 for the TB Sanatorium at Howell; $256,227 for Pinecrest Sanatorium at Ostemo; $439,393 for Northern Michigan Sanatorium at Gaylord; and $292,563 for the Copper Country Sanatorium at Hancock. The Legislature also approved the "borrowing" of $2,500,000 from the hospital bond issue money for construction of a new 250-bed tuberculosis treatment wing at Herman Kiefer Hospital, Detroit.

2. The Legislature voted $225,000 to rehabilitate the Basic Science building at Michigan State College and $1,000,000 to continue construction of a Medical Science building at Wayne University. Appropriations for the University of Michigan included $325,000 for rehabilitation of the Natural Science building, $16,000 for plans for rehabilitation of the present out-patient clinic, and $726,800 to complete a new out-patient clinic.

3. Funds appropriated for the operation of state-supported mental institutions included $2,219,884 for Caro State Hospital, $1,423,966 for Ionia State Hospital, $4,027,706 for Kalamazoo State Hospital, $2,158,379 for Newberry State Hospital, $3,826,405 for Pontiac State Hospital, and $4,303,873 for Ypsilanti State Hospital.

Thanks

The Legislative Committee extends sincere appreciation to all Doctors of Medicine who aided the MSMS Legislative program of 1952—true thanks for splendid co-operation and constant help. This back home support with our Senators and Representatives insured success. This was a vitally important session because the MSMS House of Delegates had requested the passage of measures pertaining to changes in the Medical Practice Act and the Basic Science Act. That these bills were passed as directed in the 1951 House of Delegates recommendations is proof that the efforts of individual doctors with Legislators results in improved medical services for the people of this state. The Michigan medical profession thanks its friends in the Legislature for their activities which forwarded good health in Michigan.

Respectfully submitted,

L. A. Drolett, M.D., *Chairman*
G. V. Conover, M.D.
J. H. Fyvie, M.D.
J. R. Pedden, M.D.
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AUTHORS	No. of Patients	Chronic, Resistant to Other Therapy	TYPES OF ULCERS				RELIEF OF SYMPTOMS (Chiefly Pain)				Surgery or Complications[1]	Side Effects Requiring Discontinuance of Drug[2]	EVIDENCE OF HEALING			
			Duodenal	Jejunal	Stomal	Gastric	Good	Fair	Poor	No Report			Complete	Moderate	None	No Report
Grimson, Lyons, Reeves	100	100	93	7			80	11	4		5		47		19	29
Friedman	15	15	14			1	5		4	6[3]			2			13
Bechgaard, Nielsen, Bang, Gruetund, Tobiassen	26	26	21			5	16	4	6				8	6	12	
McHardy, Browne, Edwards, Marek, Ward	162		162				136	12	11		3	1	14	9	7	129
Segal, Friedman, Watson	34	34	34[4]				14	13			7	2	5		8	14
Brown, Collins	117	99	117				97	7	8		5	8	55	9	8	40
Asher	77		65		7	5	52	9	16			16		9	21	47
Rodriguez de la Vega, Reyes Diaz	5	4	5				4		1					3	2	
Winkelstein	116	116	102	8		6	102		14				53		18	45
Hall, Hornisher, Weeks	18	18	18				11		1	6[5]			18			
Maier, Meili	38	38	24			14[6]	27	7	4[7]				10	2	5	21
Meyer, Jarman	25	18	25				21		4							25
Poth, Fromm	37	37	37				33	3	1				33	3	1	
Plummer, Burke, Williams	41	41	41				36		5				38		3	
McDonough, O'Neil	104	100	104				63	10	31			11	4		11	89
Broders	60	60	58		1	1	35	19	6				10	1	49[8]	
Legerton, Texter, Ruffin	11		11				11									11
Holoubek, Holoubek, Langford	76	69	76				35	27	10		4	10	26		10	36
Ogborn	42		39	2		1	42[9]									42
Shaiken	48	48	48				33	10	3		2		33	10	3	
Johnston	145	145	145				143		2			2	143		2	
Rossett, Knox, Stephenson	146		141			5	146					4[10]	53			93
TOTALS	*1443*	*968*	*1380*	*17*	*8*	*38*	*1142*	*132*	*131*	*12*	*26*	*54*	*552*	*52*	*179*	*634*
PERCENTAGES		*67.8*	*95.6*	*1.2*	*0.6*	*2.6*	*81.3*	*9.4*	*9.3*			*3.7*	*70.5*	*6.6*	*22.9*	

1. Not included in tabulations.
2. Included in "Relief of Symptoms" as "Poor" and in "Evidence of Healing" as "None."
3. Four had no symptoms when Banthine therapy was begun.
4. Of which seven were penetrative lesions and five partially obstructive.
5. No symptoms were present in four.
6. Two with symptoms only; no demonstrable ulcer.
7. Three were psychopathic patients and one had a ventricular ulcer of the lesser curvature.
8. Roentgen findings after treatment period of two weeks; forty-seven had duodenal deformity.
9. All returned to work within a week.
10. In these four, after relief of symptoms, Banthine was discontinued because of urinary retention.

During the past two years, more than 200 references to Banthine therapy in peptic ulcer and other parasympathotonic conditions have appeared in medical literature. Of these reports, 22 have presented specific facts and figures on the results of treatment in a total of 1,443 peptic ulcer patients, 67.8 per cent of whom were reported as chronic or resistant to other therapy. These results are tabulated above and show:

"Good" relief of symptoms was obtained in 81.3 per cent of the 1,405 patients on whom reports were available.

"Complete" evidence of healing was obtained in 70.5 per cent of the 883 patients on whom reports were available.

In all but 9.7 per cent, relief of pain was "good" or "fair." In all but 22.9 per cent, evidence of healing was "complete" or "moderate."

During treatment, 26 patients required surgery or developed complications other than ulcer which required discontinuance of the drug before results could be evaluated.

Of the remaining 1,417 patients, only 3.7 per cent experienced side effects sufficiently annoying to require discontinuance of the drug.

ACCEPTED COUNCIL ON PHARMACY AND CHEMISTRY AMERICAN MEDICAL ASSOCIATION

*Volume containing complete references, with abstracts of 39 additional reports, will be furnished on request by

G. D. Searle & Co., P. O. Box 5110, Chicago 80, Illinois.

Michigan's Department of Health

Albert E. Heustis, M.D., Commissioner

The amendment to the registration law which went into effect May 1 consolidated the unincorporated portions of the townships of each county and designated the county clerks as registrars of these new primary registration districts. As a result of the amendment, duties of township clerks that have to do with registration of births, deaths and stillbirths and the issuance of burial-transit permits were transferred to county clerks. The status of city and village registrars was not affected.

The legislation leaves 602 registrars, 1,177 less than formerly, for unincorporated areas of the county, for cities and villages and for state hospitals, charitable and penal institutions. This change from a large number of small registration districts to a smaller number of larger districts is a logical result of improvement in transportation and hospital facilities.

* * *

A progress report on the special venereal disease and tuberculosis survey being carried on in Detroit shows that from May 1, when the survey started, to May 7, a total of 3,147 persons had had blood tests and 3,555 had been given chest x-rays. One of the areas in which the work is being concentrated had a 1950 tuberculosis death rate of 96.8 in comparison with the rate of 19.9 for the state.

* * *

A recent reprint from the Congressional Record of the speech of a Congressman on fluoridation of public water supplies has brought inquiries to the Department from many parts of the United States. The Congressman quoted statistics to prove that deaths in Grand Rapids from heart disease, nephritis and intra-cranial lesions had increased 50 per cent since the city's water supply had been fluoridated. The period he cited was from 1944 to 1948.

A simple but serious mistake in reading base-line data apparently accounts for the Congressman's conclusions. He compared the 1944 figures for Grand Rapids with the 1948 figures for all of Kent County.

Check of the vital statistics figures to which the Congressman refers shows that deaths from heart disease in Grand Rapids in 1944 totaled 585 as compared with 726 for 1948. This is an increase of about 25 per cent but, as Dr. Prothro, Grand Rapids Health Director, points out, the population increase was 25 per cent for the same period. Nephritis and intra-cranial lesions showed normal fluctuations.

Judging from the comments coming to the Section of Public Health Dentistry of the Department, fluoridation of water supplies to prevent tooth decay among children is going through the same cycle followed by vaccination against smallpox and, in fact, all immunization procedures, and pasteurization of milk. In the present situation, a small group of vocal opponents offers claims ranging from statements that the fluoridation of water socialistic to assertions that it is "a master plan to wrec the United States." Medical and dental authorities re their case on evidence over the years that people drink ing naturally fluoridated water have little tooth decay and on experimental programs such as that in Gran Rapids where fluoridation of the public water supply be gun in 1945 has resulted in a reduction in tooth deca of approximately 60 per cent in children five throug eight years of age and of 25 per cent in boys and girl nine through sixteen.

Their contention that fluorine in the recommende concentration is harmless is based on exhaustive labora tory studies and also on studies of individuals livin throughout life in communities whose water supplie contain fluorides.

* * *

W. B. Prothro, M.D., is director of the Grand Rapid City Health Department, appointed on April 14 to succeed C. C. Slemons, M.D., who retired after forty-three years of outstanding service to public health in Michigan. Dr. Prothro resigned as director of the Kalamazoo City-County Health Department to accept the Grand Rapids position. Norma Anderson, M.D., has been appointed acting director of the Kalamazoo City-County Health Department to serve until a full-time director is chosen.

* * *

For the second summer, the Department is conducting a state-wide, self-supporting program of topical fluoride applications that will combine treating the teeth of children with training of junior dental and dental hygiene students from the University of Michigan.

Beginning in June and continuing through August, twenty-seven students will work in sixty-eight communities throughout the state. This is an increase of ten students over the number participating in a similar project last summer. Portable dental equipment will be supplied by the Department and the Public Health Service.

Children in these sixty-eight communities will be offered sodium fluoride treatments of their teeth at a minimal charge. Any child not able to pay will be treated free. Fees will be sufficient to pay living expenses of the students and to provide expendable supplies. Local dentists will supervise the work in each community and local health departments, schools and parent groups will co-operate in making arrangements and carrying them through. Last summer, 5,700 children were given treatments and the expanded program this summer is expected to reach over 12,000 children.

* * *

The number of births in Michigan in 1951 broke all records. Provisional figures show 171,568 live births recorded as compared with 160,275 for 1947, the previous high year.

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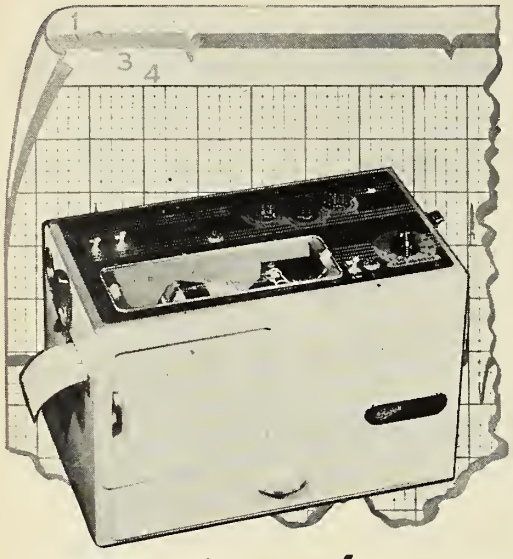


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Correspondence

Lansing, Michigan

To: All Michigan Physicians

Act No. 65, P.A. 1952, Imd. Eff., consolidates the unincorporated portion of the townships of each county as a primary registration district and designates the county clerk of each county as registrar of the consolidated area. Effective May 1, 1952, those parts of the duties of the township clerks that have to do with the registration of births, stillbirths, and deaths, will be transferred to the county clerk. It will, therefore, be necessary for you in the future to file birth certificates for those births that occur in the unincorporated parts of the townships with the county clerk instead of the township registrar.

Act No. 65 does not affect the status of village or city registrars so that the record of live births occurring in hospitals or in homes within the limits of an incorporated city or village will be filed with the registrar in whose jurisdiction the event occurred just as was the custom in the past.

ALBERT E. HEUSTIS, M.D., *Commissioner*
Michigan Department of Health

April 23, 1952

New York, N. Y.

Dr. Wilfrid Haughey
Battle Creek, Michigan

Dear Dr. Haughey:

Thank you so very much indeed for devoting the April cover of your publication to the Cancer Crusade. The cover is extremely striking and we are most appreciative of your generosity in giving us this coveted space.

Sincerely yours,
SANDRA MUNSELL, *Supervisor*
Magazine Advertising Services
American Cancer Society, Inc.

May 9, 1952

L. Fernald Foster, M.D., Secretary
Michigan State Medical Society
Lansing 15, Michigan

Dear Dr. Foster:

The Hillsdale County Medical Society wishes to take this opportunity to express to the Michigan State Medical Society its appreciation for the recognition of its work in tumor detection by the presentation of a beautiful scroll at the Spring Session in Detroit on March 13. The scroll now hangs in the Society's meeting room at the Hillsdale Community Health Centre, and makes us feel very proud of our small part in helping the State Society in its great work of fighting cancer by early detection.

Very truly yours,
ARTHUR J. STEIN, M.D.
Secretary, Hillsdale County Medical Society
Hillsdale, Michigan

April 11, 1952

New York, N. Y.

Dr. Wilfred Haughey, Editor
THE JOURNAL, Battle Creek, Michigan

Dear Dr. Haughey:

A patron of the Society for the Prevention of Asphyxial Death Inc., interested in making the causes and prevention of asphyxia better known among physicians of Michigan State, has kindly offered to donate a copy of the Art of Resuscitation, by Paluel J. Flagg, M.D., to the first 100 physicians who become members of the Society following the release of this information in THE JOURNAL of the Michigan State Medical Society.

The book lists for $6.00. Volumes donated will be autographed by Dr. Flagg.

Physicians who wish to receive this autographed volume for their library are asked to apply for membership in the Society for the Prevention of Asphyxial Death Inc. enclosing membership dues of $5.00. Communications should be addressed to, Secretary, SPAD Inc., 2 East 63 Street, New York 21, New York.

Dr. Chevalier Jackson in the preface of this book says, "To learn from this book means to save human lives."

May we ask your co-operation in publicizing the offer of our patron to the end that Dr. Jackson's belief may become more completely realized in the State of Michigan?

Very sincerely yours,

J. RICHARDSON, *Secretary,* SPAD

Wilfrid Haughey, M.D., Editor
THE JOURNAL MSMS
Battle Creek, Michigan

Dear Dr. Haughey:

We have recently received a copy of the February, 1952, issue of THE JOURNAL of the Michigan State Medical Society. You can imagine how pleased all of us here at the National Society were to see the excellent display on your front cover plugging our 1952 Easter Seal Campaign. We also appreciate your using the editorial we supplied you with which appears on page 164, and also like the publicity given to our 1952 convention appearing on page 249. This certainly can be regarded as a National Society issue and we want you to know how much we appreciate your splendid co-operation.

Again, thank you for your wonderful contribution on behalf of crippled children.

Cordially yours,

ALVIN BERNSTEIN, *Consultant Information Service, National Society for Crippled Children and Adults, Inc.*
Chicago 3, Illinois

April 7, 1952

Mr. William J. Burns, Executive Director
Michigan State Medical Society
Lansing 15, Michigan

Dear Bill:

You are of course familiar with the resolutions that have been passed by the House of Delegates in past years dealing with the deductibility, for federal income tax purposes, of the expenses incurred by physicians for postgraduate work.

From time to time we have attempted to induce the Commissioner of Internal Revenue to reconsider and reverse the old opinion disallowing the deductibility of such expenditures but have not met with any success.

During the early part of this year, we retained special counsel in Washington to prosecute this question for us to a satisfactory conclusion. It was discovered that there was pending before the U. S. Tax Court a case in which a lawyer had been denied the right to deduct certain expenditures made by him in attending a series of lectures given by the New York University Institute on Federal Taxation. This case involves the same issue in which physicians are interested and our tax counsel requested and obtained permission from the Court to file a brief for the American Medical Association as amicus curiae.

No conclusion has been reached by the Court as of this date.

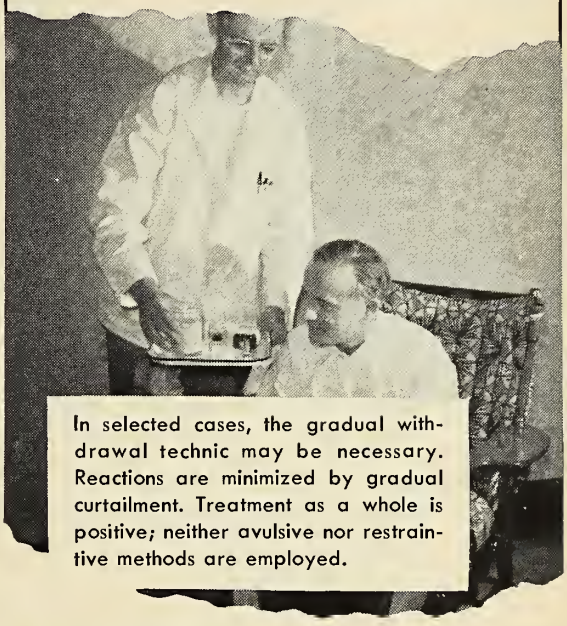
Sincerely yours,

J. W. HOLLOWAY, JR.
AMA Bureau of Legal Medicine and Legislation
Chicago 10, Illinois

April 14, 1952

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At The Keeley Institute we have the facilities and the specialized experience for outlining and carrying through a comprehensive, coordinated plan of therapy.

From the initial physical and laboratory investigations until the final evaluation prior to discharge, every step in the management of the patient is under the supervised control of full-time physicians.

As the referring physician, you are kept advised of the patient's progress. On dismissal the patient is referred back to you together with a complete report of pertinent findings.

[*This is the third of a series describing the successive steps in the treatment of the "Problem Drinker."*]

Complete information, including rates, will be furnished to physicians on request.

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In Memoriam



R. M. KEMPTON, M.D.

ROCKWELL M. KEMPTON, M.D., of Saginaw, died April 5 at the age of sixty-three.

For the past thirty-two years he had served the community of Saginaw twenty-seven years as a pediatrician. He was graduated from the University of Michigan Medical School in 1918 and served his internship and residency in the University of Michigan Hospital. He pursued additional postgraduate work at Boston Floating Hospital.

The first five years Dr. Kempton was in Saginaw he devoted himself to the general practice of medicine. In 1925, after postgraduate work, he limited his work to pediatrics. Dr. Kempton established pediatric departments at Saginaw General Hospital and St. Mary's Hospital and for the past 25 years served as chairman of the departments.

In commenting on outstanding contributions made by Dr. Kempton, *The Bulletin* of the Saginaw County Medical Society reported:

"In the early thirties, before it was commonly done in the large medical centers, newborn care was recognized in Saginaw as a pediatric, not an obstetrical problem. With this premise Dr. Kempton took over the supervision of the newborn nurseries in the hospitals in the city. This was a pioneer activity which has since been accepted nationally. We must give to him the credit of developing an accredited residency program at the Saginaw General Hospital for teaching residents in pediatrics."

Dr. Kempton also helped establish the Saginaw Valley Children's Center. This Center, organized in 1942, was the third established in Michigan. Dr. Kempton was a member of its original board of directors.

He was an active member of the Saginaw County Medical Society and served as its president in 1932. In 1949, he was head of the Saginaw County Public Health Association. He was also a director of the Saginaw Community Chest. He was also greatly interested in the history of Saginaw Valley, Indian lore and archeology.

Dr. Kempton was a Diplomate of the American Board of Pediatrics and a member of the American Academy of Pediatrics, American College of Physicians, the University of Michigan Pediatric Society and the Detroit Pediatric Society.

Dr. Kempton also contributed his time and talent to the Michigan State Medical Society. He was chairman of the MSMS Child Welfare Committee from 1947 to 1949. He also served as a lecturer in pediatrics at clinical sessions of the state society.

In addition, Dr. Kempton was the author of numerous medical papers and articles.

Two memorials to Dr. Kempton have been established at Saginaw General Hospital and St. Mary's Hospital.

Say you saw it in the Journal of the Michigan State Medical Society

The Saginaw General Hospital memorial is a continuing scholarship for nurses in postgraduate and postgraduate pediatric training. The second memorial at St. Mary's Hospital is the Rockwell M. Kempton Pediatric Library.

As a fitting tribute to a beloved member, the members of the Saginaw County Medical Society eulogized Dr. Kempton in sincere words fitting the high accord in which he was held within his community:

"Rockwell M. Kempton will long be remembered for love of his fellow men, his kindly counsel, and gentle understanding when people from all walks of life came to him with their problems. His greatest fear was of hurting someone. When decisions were to be made, he would first review his thinking before stating his position to be sure that the decision would be a constructive one —one which would make no person suffer. He was devoted, always, to his family, friends, colleagues, and patients and will ever be remembered by all of them as a thoughtful, kindly physician."

WILBERT B. CLARK, M.D., a Life Member of the Michigan State Medical Society, died March 30 at the home of a son in Kenmore, New York, at the age of eighty-four.

Dr. Clark received his medical degree from the Michigan College of Medicine and Surgery, Detroit, in 1894. He began his practice of medicine at St. Louis and remained there until 1903 when he moved to Saginaw. Dr. Clark had actively practiced medicine for fifty-two years before his retirement in 1946. In addition to his practice in Saginaw he served as Saginaw County health officer and as City Physician, and for eight years as Coroner.

Dr. Clark is survived by his wife, Elizabeth; and two sons, Kenneth and Leland.

GEORGE O. McDONALD, M.D., of Detroit, died April 8 at Thamesford, Ontario, at the age of sixty.

Until his retirement six months ago, Dr. McDonald had engaged in the general practice of medicine in Detroit since 1926. He was a former member of the staff of Mt. Carmel Mercy Hospital.

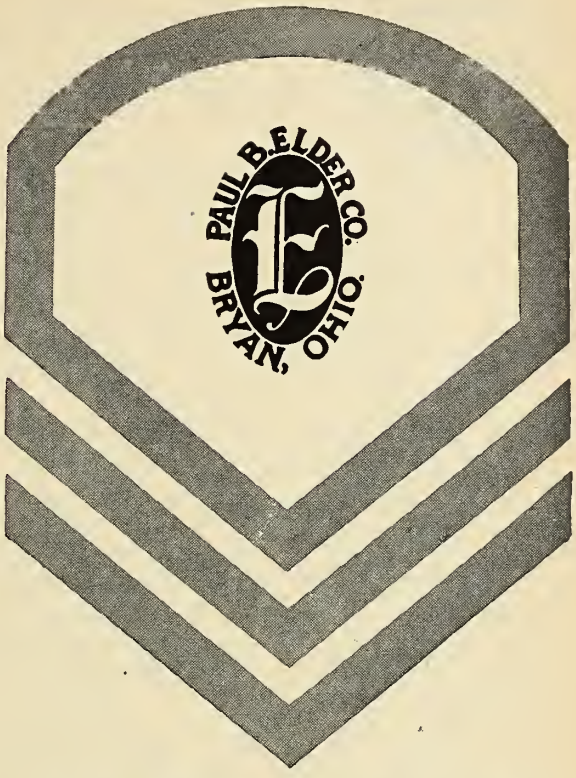
Dr. McDonald was graduated from the University of Toronto Faculty of Medicine in 1920. He was a member of the Wayne County Medical Society and of the Michigan State Medical Society and a fellow of the American Medical Association.

CHARLES C. ENGLEHART, M.D., of Houghton, died March 26 at the age of fifty-two.

For the past year and a half, Dr. Englehart had served the community of Hougton as an ophthalmologist-otologist. Previous to coming to Houghton, Dr. Englehart had practiced in Harrisburg, Pennsylvania, following his graduation from Temple University School of Medicine in 1931.

Dr. Englehart served his internship at the Harrisburg Poly-Clinic. His postgraduate studies were conducted at

(Continued on Page 788)



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. NEWS MEDICAL

MICHIGAN AUTHORS

William C. Baum, M.D., of Ann Arbor, is the author of an article, "Physiology of the Male Reproductive Tract," published in *The Student American Medical Association Journal,* April, 1952.

John R. Rodger, M.D., of Bellaire, is the author of of an article, "Rural Practice Can Be Fun," published in *The Student American Medical Association Journal,* April, 1952.

Lida A. Mattman, Ph.D., of Detroit, is one of the authors of the article, "Rhinoscleroma Successfully Treated with Streptomycin," published in *The Journal of the American Medical Association,* February 23, 1952, and abstracted in the *Digest of Ophthalmology and Otolaryngology,* April, 1952.

J. H. Maxwell, M.D., of Ann Arbor, is the author of an article, "Extra Temporal Repair of the Facial Nerve—Case Reports," in the *Annals of Otolaryngology, Rhinology and Laryngology,* December, 1951.

J. H. Maxwell, M.D., and **R. W. Waggoner, M.D.**, are the authors of an article, "Hypertrophy of the Masseter Muscles," in the *Annals of Otolaryngology, Rhinology and Laryngology,* November, 1951.

Henry Archambault, M.D., and **Rene Archambault, M.D.**, of Detroit, are the authors of an article, "Leiomyoma of the Common Bile Duct," published in the *Archives of Surgery,* April, 1952.

Grover C. Penberthy, M.D., and **Clifford N. Benson, M.D.**, are the authors of an editorial, "Injuries to the Abdomen in Industry," reprinted from the *American Journal of Surgery,* 1947, and published in *Surgery, Gynecology and Obstetrics,* May, 1952.

Leland F. Carter, M.D., of Detroit, is the author of an article, "Progressive Essential Atrophy of the Iris," published in the *American Journal of Ophthalmology,* April, 1952.

Samuel J. **Nichamin, M.D.**, of Detroit, is the author of an article, "Pleurodynia in Children—Clinical Observations in Fifty-Four Cases," published in *The Journal of the American Medical Association,* March 22, 1952.

Herbert I. Kallet, M.D., and **Lavelle Patrick Davlin, M.D.**, of Detroit, are the authors of an article, "Anal Irritation Following the Use of Antibiotics," published in *The American Practitioner Digest of Treatment,* May, 1952.

To the M.D. who contributed $5.00 cash for the Beaumont Memorial Restoration on the occasion of the Michigan Clinical Institute in Detroit last March:

Through a loss in shipment of records from Detroit to Lansing, the card indicating your $5.00 cash contribution has been lost or mislaid. Would you please report your name and address to the Beaumont Memorial Restoration Committee, 606 Townsend Street, Lansing, Michigan? The Committee wishes you to receive full credit for your contribution.

Otto O. Beck, M.D.,
MSMS President.

Recent appointments to the Michigan State Board of Registration in Medicine for terms expiring September 30, 1955, were: W. C. Behen, M.D., Lansing, J. T. Bertucci, M.D., Ishpeming, Paul G. Hanna, M.D., St. Joseph, J. E. McIntyre, M.D., Lansing (reappointed), O. D. Stryker, M.D., Mt. Clemens.

* * *

Members of the Wayne County Medical Society are being polled by the WCMS Council on the following questions:

1. Are you in favor of a geographical telephone listing?

2. Do you believe the Wayne County Medical Society should operate a telephone exchange service?

The Wayne County Medical Society has a "Medical Service Bureau" which answers an average of 184 emergency calls per month, but the Society feels the service is inadequate: (1) because there are too few doctors who actually accept emergency calls when requested; (2) it is too difficult to locate physicians, especially between 11:00 a.m. and 1:00 p.m.

Through the establishment of a telephone message exchange, WCMS believes that it will be able to provide quicker and more adequate service because it will be easier to locate a physician, since complete information on his regular schedule would be available and the doctor would contact Society headquarters when contemplated changes in his daily routine are planned; further, the Society would have a closer contact with all of those who subscribe to the exchange.

"Since it is planned to correlate the exchange with the emergency service, it would undoubtedly result in more physicians participating in the emergency program of the Society," states the *Detroit Medical News* of April 21, 1952.

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	Single	Double	Triple	Quadruple
60 days in Hospital	5.00 per day	10.00 per day	15.00 per day	20.00 per day
30 days of Nurse at Home	5.00 per day	10.00 per day	15.00 per day	20.00 per day
Laboratory Fees in Hospital	5.00	10.00	15.00	20.00
Operating Room in Hospital	10.00	20.00	30.00	40.00
Anesthetic in Hospital	10.00	20.00	30.00	40.00
X-Ray in Hospital	10.00	20.00	30.00	40.00
Medicines in Hospital	10.00	20.00	30.00	40.00
Ambulance to or from Hospital	10.00	20.00	30.00	40.00
DISABILITY COSTS (Quarterly)				
Adult	2.50	5.00	7.50	10.00
Child to age 19	1.50	3.00	4.50	6.00

$5,000 accidental death Quarterly $8.00
$25 weekly indemnity, accident and sickness

$10,000 accidental death Quarterly $16.00
$50 weekly indemnity, accident and sickness

$15,000 accidental death Quarterly $24.00
$75 weekly indemnity, accident and sickness

$20,000 accidental death Quarterly $32.00
$100 weekly indemnity, accident and sickness

COST HAS NEVER EXCEEDED AMOUNTS SHOWN

$4,000,000.00 INVESTED ASSETS

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David I. Sugar, M.D., Associate Editor of the *Detroit Medical News,* blasts the outmoded governmental and labor union idea that retirement must begin at sixty-five. His editorial in the *Detroit Medical News* of April 21, entitled "64 years and 364 days" indicates that this period "is a variable and shifting milestone. While in some it postdates an era, in many it is but another day in a busy useful life."

Congratulations, Dr. Sugar, on a forthright, sensible and modern statement of fact. Your editorial reflects the considered thinking of the MSMS Geriatrics Committee on this subject.

* * *

The Bulletin of the Saginaw County Medical Society (April 15, 1952) contains the following item in connection with a regular meeting of Saginaw County Medical Society held March 25, 1952: "A new policy of several insurance companies whereby payment is made for house and office calls was discussed. It was stated that a great deal of paper work is involved in this matter and that it is becoming a considerable burden to handle. The matter was referred to the Economics Committee with the request to report at the next meeting."

* * *

"**Indifference** is the most deadly and damning sin of our time. In my judgment, the curse of our times is that we have so many 'good' people who believe the right things and never do anything about them."—KENNETH MCFARLAND, Ph.D., of Topeka, Kansas, at AAGP Annual Assembly Banquet, Atlantic City, March 27, 1952.

Flood victims are being aided by Eli Lilly and Company, with replacement of all Lilly products in pharmacies and hospitals ravaged by the flood in the Missouri and Mississippi River Valleys. Lilly representatives in a dozen states, from Montana to Missouri, have been directed to make the replacement of flood-damaged Lilly pharmaceuticals and biologicals their first order of business. Eli Lilly and Company has been replacing stocks damaged by uninsurable hazards as far back as the 1906 San Francisco disaster.

* * *

From the Grocery Manufacturers of America comes this most startling thought . . . Citizens of the United States now pay more money for taxes than for all the food they eat . . . In 1950 taxes cost $57 billion . . . food, $52 billion.

* * *

Something to Vote About: The voters in leading countries exercise their right of franchise (according to the *Saturday Evening Post)* as follows:

Belgium	90 per cent
Italy	89 per cent
Great Britain	82 per cent
France	75 per cent
Japan	70 per cent
United States	51 per cent

"Why are Americans so apathetic?" quote the Editors of the *Bulletins* of the Genesee County and the Muskegon County Medical Societies, April 15, 1952.

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"Why do so many of us sit back and 'Let George it' "? Perhaps it is basically an unawareness of ues,

"Japan had a new-found individual freedom when per cent of its voters cast their ballots. France and lgium had just dropped the Nazi yoke. England rned to Churchill after years of Socialist rule. Italy ose against Communist infiltration. People in those itions really had something to vote about.

"Americans have something to vote about, too. Daily e issues are growing more clearly defined. The world eeds a strong, sure America—and only Americans can ep our nation strong.

"Our role is clear. Whatever path we want America take, *we* citizens at the grass roots must make the oice. We must study the issues. We must decide. We ust vote. And as good citizens, we must do everything our power to see that others register and vote, too—ecause today we Americans, of all the peoples of the orld, have something vital to vote about!"

* * *

Another "pat on the back" re the Michigan Clinical nstitute of 1952:

F. Hilton Smith, M.D., Salinas, California: "This is o thank you and your conferees for an excellent clinical rogram and for proving to be such pleasant hosts. The mphasis of your group on the practical side of things vas particularly appealing, and has left me with an am-ition to emulate it in our local society.

"I enjoyed the luncheon and the regional meeting on trauma of the American College of Surgeons, but especially appreciated the opportunity of seeing new faces and new viewpoints in the common problems that confront us in our practices wherever they may be."

Thanks, Dr. Smith, and come back to Michigan soon.

* * *

John R. Rodger, M.D., of Bellaire, Michigan, is the author of an original article "Rural Practice Can Be Fun" published in the *Journal of the Student AMA*, April, 1952 number. Dr. Rodger relates to rural communities the following three questions so important to every medical student and intern: "Can I practice good medicine there?" "Can I make a decent living there?" "Will I enjoy making my home there?"

The Rodger article is worth while reading—not only for students but for practitioners of medicine.

* * *

Hill-Burton hospital construction in Michigan, as of March 31, 1952:

Completed and in operation: Eighteen projects at a total cost of $14,383,781, including federal contribution of $5,176,257 and supplying 943 additional beds.

Under construction: Seventeen projects at a total cost of $18,766,002, including federal contribution of $7,245,068 and designed to supply 1,122 additional beds.

Approved, but not yet under construction: Three projects at total cost of $959,155, including $531,183 federal contribution and designed to supply 62 additional beds.



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Kenneth B. Babcock, M.D., Detroit, was elected President of Michigan Hospital Service (Blue Cross) at a meeting of the Board of Trustees, April 24. Dr. Babcock succeeds E. Dwight Barnett, M.D., who recently resigned to become Director of Columbia University Institute of Administrative Medicine.

New medical members elected to the Executive Committee were Robin C. Buerki, M.D., and E. C. Baumgarten, M.D., both of Detroit.

* * *

S. L. Loupee, M.D., Dowagiac, long-time member of the Michigan Legislature, who resigned at the end of the 1950 session, was recently elected Mayor of Dowagiac.

Congratulations, Dr. Loupee!

* * *

More than 115,000 opportunities for professional work with handicapped children and adults await young people seeking careers, according to a new publication, "Careers in Service to the Handicapped" sponsored by the National Society for Crippled Children and Adults, Chicago, Ill. Lawrence J. Linck, Executive Director of the Society, states that current vacancies exist for an additional 4,000 occupational therapists, more than 16,000 physical therapists, and 12,000 to 15,000 speech therapists; 80,000 specially trained teachers are needed immediately to educate the nation's physically handicapped children.

For copy of the booklet "Careers in Service to the Handicapped" write Mr. Linck at 11 S. LaSalle St., Chicago 3, Illinois.

Cook County Graduate School of Medicine

ANNOUNCES CONTINUOUS COURSES

SURGERY—Intensive Course in Surgical Technic, two weeks, starting June 16, August 4, August 18.
Surgical Technic, Surgical Anatomy and Clinical Surgery, four weeks, starting September 8, October 20.
Surgical Anatomy and Clinical Surgery, two weeks, starting June 16, September 22.
Surgery of Colon and Rectum, one week, starting September 15, October 13.
Gallbladder Surgery, ten hours, starting June 16, October 20.
Basic Principles in General Surgery, two weeks, starting September 8.
General Surgery, one week, starting October 6.
General Surgery, two weeks, starting October 6.
Breast and Thyroid Surgery, one week, starting June 23.
Esophogeal Surgery, one week, starting June 23.
Thoracic Surgery, one week, starting October 20.
Fractures and Traumatic Surgery, two weeks, starting June 16.
GYNECOLOGY—Intensive Course, two weeks, starting June 16.
Vaginal Approach to Pelvic Surgery, one week, starting September 22, November 3.
OBSTETRICS—Intensive Course, two weeks, starting September 29, November 3.
PEDIATRICS—Informal Clinical Course every two weeks.
MEDICINE—Electrocardiography and Heart Disease, two weeks, starting July 14.
Hematology, one week, starting June 16.
Gastroscopy and Gastroenterology, one week, Advanced Course. June 23.
UROLOGY—Intensive Course, two weeks, starting September 8.
Cystoscopy, ten days, starting every two weeks.
DERMATOLOGY—Intensive Course, two weeks, starting October 13.
Informal Clinical Course, every two weeks.

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In a recent article, "Pregnancy and TB," Jay Arthur Myers, M.D., of Minnesota reports: "It has become so general a practice in hospitals and offices of physicians to examine expectant mothers for tuberculosis that in this state of approximately three million people only one infant died from tuberculosis in 1950."

Michigan, with a little more than twice Minnesota's population, had nine tuberclosis deaths in infants under one year of age in 1950. There were also seven deaths in one-year-olds among a total of 35 in children under five.

Reprints of Dr. Myers' article may be obtained from:

MICHIGAN TUBERCULOSIS ASSOCIATION

The Michigan Crippled Children Commission sponsored an "Institute on the Crippled Child" in Grand Rapids, April 17-18-19. Co-sponsor was the Michigan Department of Public Instruction. Medical participants included James W. Rae, Jr., M.D., Ann Arbor, and Carleton Dean, M.D., Lansing.

* * *

The beginning dates of medical associations and of woman's auxiliaries was the subject of a recent survey by the West Virginia State Medical Association which reported that the beginning date of the Association year and of the Auxiliary year is the same in thirty-six of the forty-one states reporting, and different in but five states.

* * *

Tri-State Hospital Association "Key" of 1952 was presented to Mother Mary Carmelita Manning, R.S.M., Director of Hospitals for the Sisters of Mercy in Detroit. The award, made during the Tri-State Hospital Assembly in Chicago on April 29 and conferred by the Michigan Hospital Association, represents the highest award by that organization to an individual for meritorious service in hospital and health fields.

Mother Carmelita is well known to the medical profession of Detroit and of the entire State of Michigan. She was long the Mother Superior at Mt. Carmel Mercy Hospital, Detroit.

* * *

Grover C. Penberthy, M.D., Detroit, was guest speaker at the Iowa State Medical Society's 1952 Annual Session in Des Moines. Dr. Penberthy's address on April 30 was entitled "Some Surgical Problems of the Newborn and Infants."

* * *

The "Formula For Freedom" program will be presented in the Upper Peninsula on Friday noon, June 27, during the annual meeting of the Upper Peninsula Medical Society in Iron Mountain.

* * *

Democracy—that form of government which leaves every citizen free to do his best for the public welfare.—Louis Pasteur.



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"Upper Peninsula Day" will be celebrated at the 1952 MSMS Annual Session, Sheraton-Cadillac Hotel, Detroit, on Wednesday, September 24.

W. S. Jones, M.D., Menominee, is chairman of "Upper Peninsula Day," and his goal is to interest a high percentage of the membership of the Upper Peninsula's ten county medical societies to visit Detroit for the 87th Annual Session of the Michigan State Medical Society.

Detailed plans for "Upper Peninsula Day" will be published in subsequent issues of JMSMS.

MFMHE: Manistee County Medical Society members have developed a unique method of financial support for the Michigan Foundation for Medical and Health Education, Inc. Each year the members contribute $10 each to the Foundation. This $10, is collected annually at the same time the regular County Society dues are paid.

* * *

Waiting List for Operations.—The *Chicago Daily News* reports that in Britain, where medicine has been socialized for nearly four years, there are 124,587 persons waiting to be admitted to hospitals for operations. "There s a scarcity of both beds and nurses plus a bigger demand for operations which now are 'free'," the story said.

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James J. Lightbody, M.D., Detroit, was toastmaster a the dinner during the Governor's Conference to Stud Problems of the Aging held at Michigan State Colleg East Lansing, on May 12-13.

* * *

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* * *

Addressing the National Association of Chain Drug stores in Florida recently, Dr. R. B. Robins, Camden Arkansas, former vice president of the American Medical Association and new president of American Academy of General Practice, lashed out at "big government" in Washington for regimenting the lives of the American people.

"The people's health," he said in his first speech as president of the American Academy of General Practice, "has in recent years become a verbal political football for public officials, legislators, bureaucrats, economists, and a wide variety of pseudo-experts with an uncertain knowledge of the subject.

"Unfortunately, far too many of the people who have been telling America how to solve its medical care problems are not qualified to do so. They not only have never diagnosed a case or filled a prescription, they have had no close practical connection with the many complex factors involved in medical care."

Dr. Robins, who is the elected Democratic National Committeeman from Arkansas, urged the chain druggists to take a more active civic role in problems relating to health.

* * *

New Secretary of Medical Education Foundation. The executive committee of the Board of Trustees announced recently a split-up of the secretarial duties of two American Medical Association groups—the American Medical Education Foundation and the Student AMA.

Activities of both groups have expanded at such an accelerated rate that one secretary can no longer serve both groups.

Russell F. Staudacher will devote full time to the job of executive secretary of the Student AMA and executive editor of its journal.

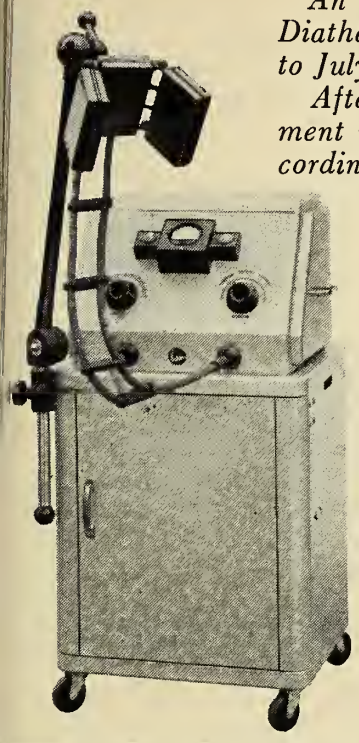
Hiram W. Jones, of Elmhurst, Illinois, who has been with the Research Council for Economic Security, Chicago, was appointed executive secretary of the American Medical Education Foundation. He formerly served as director of finance for the Chicago region of the National Conference of Christians and Jews and at one time was director of fund raising for Community Relations Consultants, Inc., specializing in hospital fund raising.

Say you saw it in the Journal of the Michigan State Medical Society

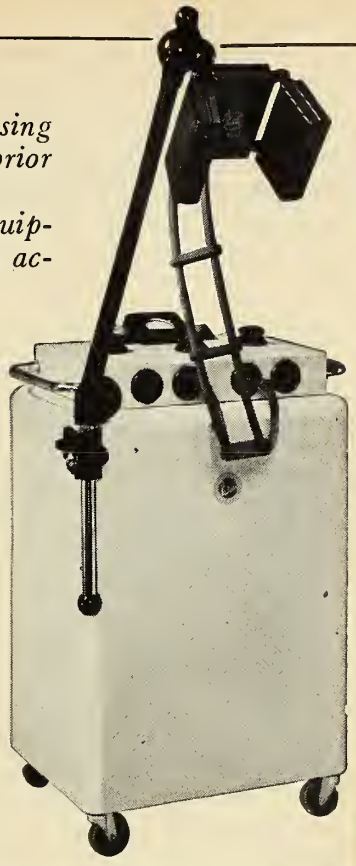
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Mr. Staudacher came to the A.M.A. in May, 1951, from Lansing, where he served as associate public relations counsel for the Michigan State Medical Society. During his tenure with both the Student A.M.A. and the foundation, great strides have been made.

Today, the Student A.M.A. has approximately 10,000 members in forty-four active chapters with twelve more provisional chapters being taken in next December.

During the first three months of 1952, the American Medical Education Foundation received more individual contributions than during the entire year of 1951. These contributions were received before the actual drive for funds—April 1 to June 30—got under way. The goal during that period is $2,000,000.

* * *

The Atomic Energy Commission has begun negotiations with Dow Chemical Company and Detroit Edison Company on their proposal to continue for one year, on a jointly financed basis, the Dow-Detroit Edison study of greater industrial participation in the development of nuclear reactors for the production of fissionable materials and power. The work proposed by Dow-Detroit Edison is in line with the AEC reactor development program.

The Dow-Detroit Edison group is one of the four pairs of industrial and power firms participating in preliminary studies as a part of the industrial participation plan first recommended by Dr. Charles A. Thomas of Monsanto Chemical Company. Other groups are Monsanto and Union Electric of St. Louis; Commonwealth Edison and Public Service of Northern Illinois, Chicago and Pacific Gas and Electric and the Bechtel Corporation of San Francisco.

* * *

Polio cases are running slightly ahead of last year according to reports from the Public Health Service. For the first three weeks of the "disease year" which began April 1, cases of poliomyelitis totalled 192 as against 152 for the same period last year. Public Health Service said states reporting largest numbers of cases were Texas 71, Louisiana 17, Florida 13, California 27 and New York 10. For the year ending March 29, total cases in the United States were 28,692 compared with 33,393 a year before. Both totals are reported as provisional.

* * *

The Army Surgeon General has requested commercial manufacture of a new self-gripping cotton bandage developed by Agriculture Department. Shrunk in a caustic soda solution and then washed in a dilute acid, the new bandage has a greater kinkiness, which gives it a non-slipping quality. Army has found them useful in holding burn dressings in place.

* * *

The Veterans Administration reports that 2,272 disabled veterans have received loans totaling nearly $20.5 million for "wheelchair" homes. If they meet other VA requirements, veterans suffering loss or loss of use of lower limbs, requiring certain convenience devices in their homes, are eligible for loans of up to half the cost of the homes. . . . VA is issuing Prosthetic Service Cards to veterans using orthopedic braces, entitling the veteran to emergency repairs without prior VA approval.

* * *

The Third Symposium on Physical Medicine and Rehabilitation was presented by the American Congress of Physical Medicine and the American Society of Physical Medicine Rehabilitation, Michigan Group, in cooperation with the Veterans Administration Hospital, Saginaw, Michigan, on May 22, 1952, in the auditorium of the Veterans Administration Hospital, Saginaw. A practical program of discussion and demonstration of modern techniques of Physical Medicine and Rehabilitation in medicine and surgery was given.

The following program serves to outline present procedures utilized in commonly encountered pathological states:

1. "Physical Medicine and Rehabilitation—Modern Concept and Practice"—Dr. James Rae, Jr., Professor of Physical Medicine and Rehabilitation, University of Michigan School of Medicine and Director, Department of Physical Medicine and Rehabilitation, University Hospital, Ann Arbor, Michigan.
2. "Management of Circulatory Disturbances of the Central Nervous Systems Associated with Peripheral Paralysis"—Dr. M. K. Newman, Director of Physical Medicine and Rehabilitation, Grace Hospital and Detroit Memorial Hospital, Detroit, Michigan.
3. "Consideration of Problems Associated with Amputee Training and Prosthetic Devices"—Dr. Lewis



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Cohen, Acting Chief of Physical Medicine and Rehabilitation, Veterans Administration Regional Office, Detroit, Michigan.

4. "Management of Rheumatic and Arthritic States" —Dr. Joseph Markle, Director of Physical Medicine and Rehabilitation, Veterans Administration Hospital, Dearborn, Michigan.
5. "Utilization of Occupational Therapy Procedures in Rehabilitation"—Miss H. B. Jewett, R.O.T., Director of the School of Occupational Therapy, Wayne University, Detroit, Michigan.

A discussion and question period followed the presentation of the papers.

* * *

The Industrial Medical Association on April 23, 1952, presented the Knudsen Award to Max R. Burnell of Michigan and General Motors. This is the fourteenth annual presentation, and is given for the year's outstanding contribution to industrial medicine. Dr. Burnell was cited for the part he played in General Motors' contribution of more than $1,500,000 to the University of Michigan for establishment of the Institute of Industrial Health. The Institute, dedicated to research, education and service in industrial medicine, recently began operation.

* * *

A Midwestern Cardiovascular Center specializing in the care of children with operable congenital malformations of the heart opened at the Children's Memorial Hospital, Chicago, on Wednesday, April 30.

Funds totaling $30,000, available on an annual basis, have been allocated by the Children's Bureau of the Federal Security Agency to the University of Illinois Division of Services for Crippled Children for the establishment of the Center.

The potential area to be served by the Center includes the states of Ohio, Michigan, Kentucky, Indiana, Wisconsin, Minnesota, Illinois, Iowa, North Dakota, South Dakota, Kansas, Nebraska and Missouri.

* * *

As of **April 1, 1952,** 2,676 members of the Michigan State Medical Society had paid their dues to the County Society, and they had been forwarded to the office in Lansing. This is 546 more than last year, and, of these, 2,637 have included the AMA dues, a remarkable proportion, when the AMA dues are voluntary.

* * *

National Science Foundation fellowships for the academic year 1952-53 include more awards in the biological sciences than in any other one field. Of the 624 graduate fellowships granted, 158 predoctoral and postdoctoral awards went to biological science students with the remainder divided among students of chemistry, physics, engineering, mathematics, earth sciences, agriculture, astronomy and anthropology. Fellows receive stipends ranging from $1,400 to $3,000 plus certain dependent alllowances.

* * *

Mississippi's 1,500 physicians were honored on March 30 when the state observed "Doctor's Appreciation Day."

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The occasion was set aside in a gubernatorial proclamation by Gov. Hugh L. White, who enjoined statewide observance in appreciation of the physicians' personal dedication to service.

The tributes to individual physicians were personalized in churches, civic clubs, and special gatherings where doctors were presented red carnations as tokens of appreciation. A number of local programs were conducted.

The event gained a lot of favorable support from the press and radio within the state.

IN MEMORIAM

(Continued from Page 777)

the University of Vienna, Knapp Memorial Hospital New York Eye Hospital, New York Poly-Clinic and the University of Indiana.

At the time of his death, he was on the staff of St. Joseph Hospital Medical Center. Dr. Englehart was a member of the Houghton-Baraga-Keweenaw County Medical Society.

He is survived by a sister, Mrs. Hazel Allander of Hampstead, Maryland, and four brothers: Howard and Leon Englehart of Shreveport, Louisiana; Elwood Englehart of Charleston, North Carolina, and Earl Englehart, M.D., of Kingston, North Carolina.

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knowledgment of all books received will be made in this column, d this will be deemed by us as full compensation to those ıding them. A selection will be made for review, as expedient.

LLERGIC PRURITUS. ITS DERMATOLOGIC MANAGEMENT. By Stephan Epstein, M.D., Editor; Panel Discussion: Rudolf L. Baer, M.D.; Stephan Epstein, M.D.; Carl Laymon, M.D.; Francis W. Lynch, M.D.; Herbert Rattner, M.D.; Stephan Rothman, M.D., and James R. Webster, M.D. An official publication of The American College of Allergists, Inc. Saint Paul: Bruce Publishing Co., 1952. Price $2.50.

This little book of seventy-six pages is a record of a Symposium on Itching Dermatoses" presented at a ıeeting of The American College of Allergists. It does ot go into the diagnosis and treatment of pruritic derıatoses from an allergic viewpoint but rather stresses eatment from the topical and systemic dermatologic iewpoint. Included is a good brief review of nonllergic dermatoses to be considered in differential iagnosis.

By noting the names of the panel members on this ymposium, one will know this contribution is worthhile. These physicians have presented time-tested derıatologic treatment methods which will help others to void making their patients worse by "overtreatment." his book will prove valuable to those not too familiar vith topical therapy. It is up to date.

H. E. A.

FUNDAMENTALS OF PSYCHIATRY. By A. Strecker, M.D., Sc.D., LL.D., Litt.D., F.A.C.P., Professor of Psychiatry and Chairman of the Department, Undergraduate and Graduate Schools of Medicine, University of Pennsylvania; Psychiatrist to the Pennsylvania, Philadelphia and Germantown Hospitals; Consultant and Chief-of-Service, Institute of the Pennsylvania Hospital; Consultant to the Surgeons General, U. S. Army and U. S. Navy, and formerly Consultant for the Secretary of War to the U.S.A.A.F.; Senior Consultant in Psychiatry, Veterans Administration; Consultant in Mental Hygiene, U.S.P.H.S.; Chairman, Committee on Psychiatry, National Research Council; Chairman, Committee on Psychiatry, American National Red Cross. Fifth Edition. 21 illus. Philadelphia: J. B. Lippincott Co., Price $4.50.

A fifth edition needs no introduction. It does seem necessary to point out that the author addressed this edition to general practitioners and workers in medicine and surgery. It is his hope that the basic principles of psychiatry will be stimulated in order to better treat the great number of psychoneurotics and psychosomatic disabilities that are seen in every doctor's office. He has listed all the various types of psychiatric and psychoneurotic reaction types. With each description of the illness he presents the psychopathology. For this reason a new chapter on psychotherapy has been included. This chapter gives an idea of the available treatment technics. He has rewritten his chapter on psychosomatic medicine. The author is one of the outstanding men in American psychiatry. He is able to speak authoritatively.

G.K.S.



SURGICAL FORUM. Proceedings of the Forum Sessions, Thirty-seventh Clinical Congress of The American College of Surgeons, San Francisco, California, November, 1951. Surgical Forum Committee: Owen H. Wangensteen, M.D., F.A.C.S., Minneapolis, Chairman; Warren H. Cole, M.D., F.A.C.S., Chicago; Robert E. Gross, M.D., F.A.C.S., Boston; Michael L. Mason, M.D., F.A.C.S., Chicago; Carl A. Moyer, M.D., F.A.C.S., Dallas, and I. S. Ravdin, M.D., F.A.C.S., Philadelphia. Philadelphia: W. B. Saunders Co., 1952. Price $10.00.

Perhaps you have wondered what is going on in the surgical research departments and clinics of the great Universities throughout this land? This book will answer your questions. Students of surgery will find it a remarkable convenience.

As Dr. Owen H. Wangensteen, Chairman of the Surgical Forum Committee of the American College of Surgeons, says in the foreword, "The progress of surgery in America from year to year will be documented and reflected in these volumes, which bid fair to become the vade mecum of the forward looking surgeon and the Arabian Nights' reader of that which is new and exciting in surgery." That about sums up what the reader may expect to find in this book. It is highly recommended to all surgeons and students of surgery.

J.W.H.

HAROFE HAIVRI—The Hebrew Medical Journal, Semi-Annual Publication, Moses Einhorn, M.D., Editor. Volume 1—1951. The Twenty-fourth Year. New York: The Hebrew Medical Journal.

DIAGNOSTIC BACTERIOLOGY. A Textbook for the Isolation and Identification of Pathogenic Bacteria. By Isabelle Gilbert Schaub, A.B., Technical Director, Clinical Bacteriology Laboratories, The Johns Hopkins Hospital; Instructor in Bacteriology, The Johns Hopkins University School of Medicine and the Nurses Training Schools, The Johns Hopkins Hospital and Sinai Hospital, and M. Kathleen Foley, M.A., Instructor in Bacteriology, Department of Biological Sciences, College of Notre Dame of Maryland; Formerly Bacteriologist in Charge of the Diagnostic Bacteriological Laboratory of the Medical Clinic, The Johns Hopkins Hospital. Fourth edition. St. Louis: The C. V. Mosby Co., 1952. Price $4.50.

The reviewer was impressed with the terse and practical character of this book when he purchased the first edition 12 years ago and he has noted its improvement with succeeding editions. A small volume originally, it fortunately has remained this convenient size through the various revisions. It is more current than many new texts and even such recent procedures as the dilution-sensitivity tests for the newer antibiotics are fully outlined. While it may be of limited usefulness to clinicians, it is strongly recommended as a shelf refcrence in all laboratories and as a teaching aid for students in medical technology and bacteriology.

A.A.H.

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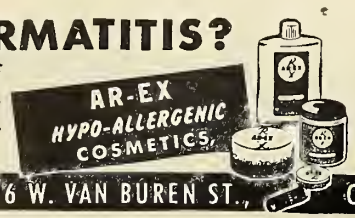
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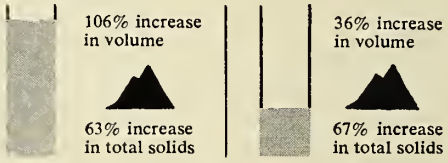
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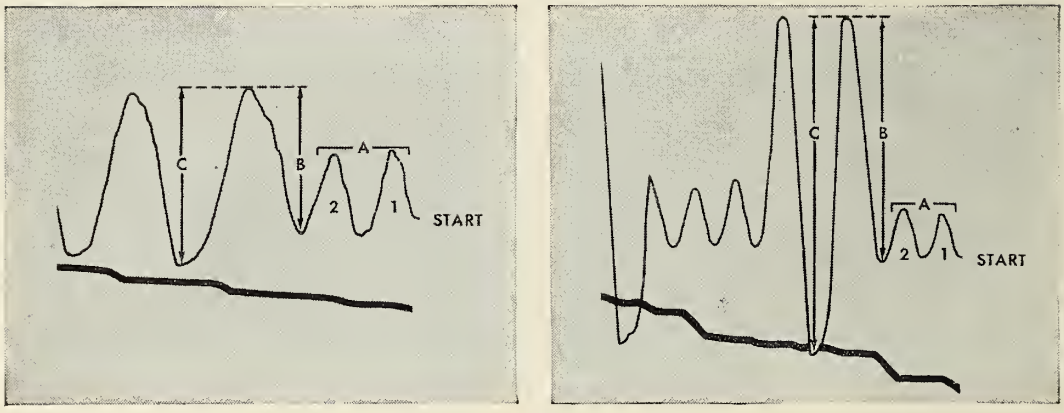
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VOLUME 51 JULY, 1952 NUMBER 7

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A. I. Dodson



S. Rothman



B. B. Stamell

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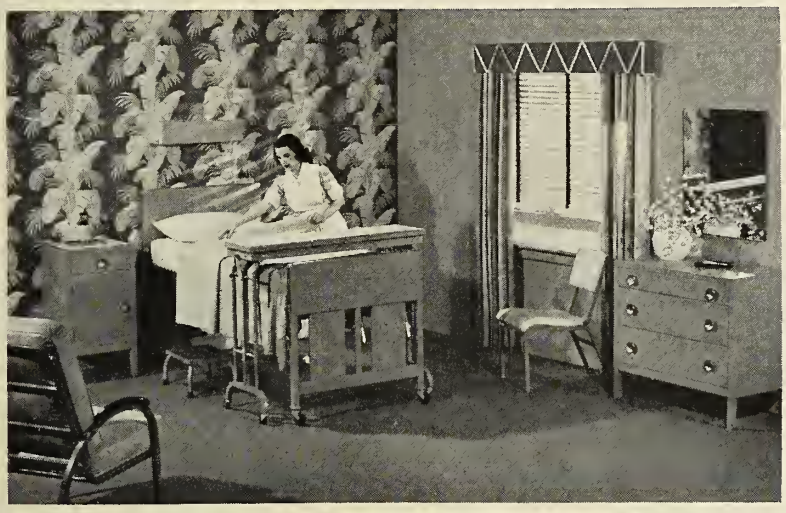
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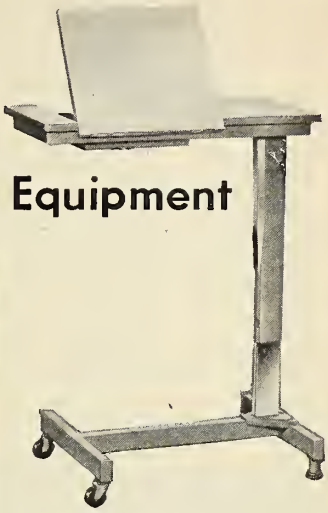
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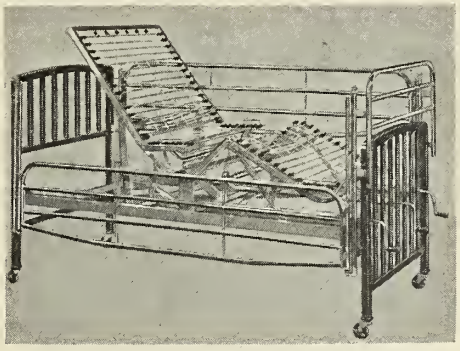




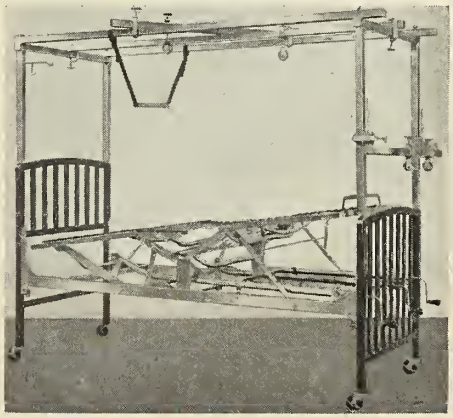
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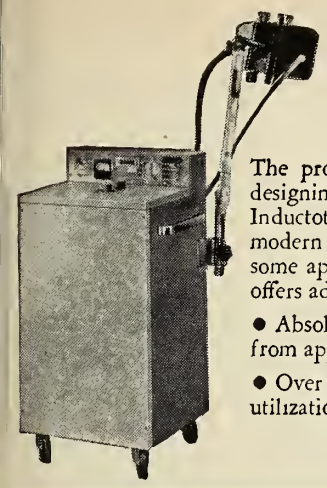
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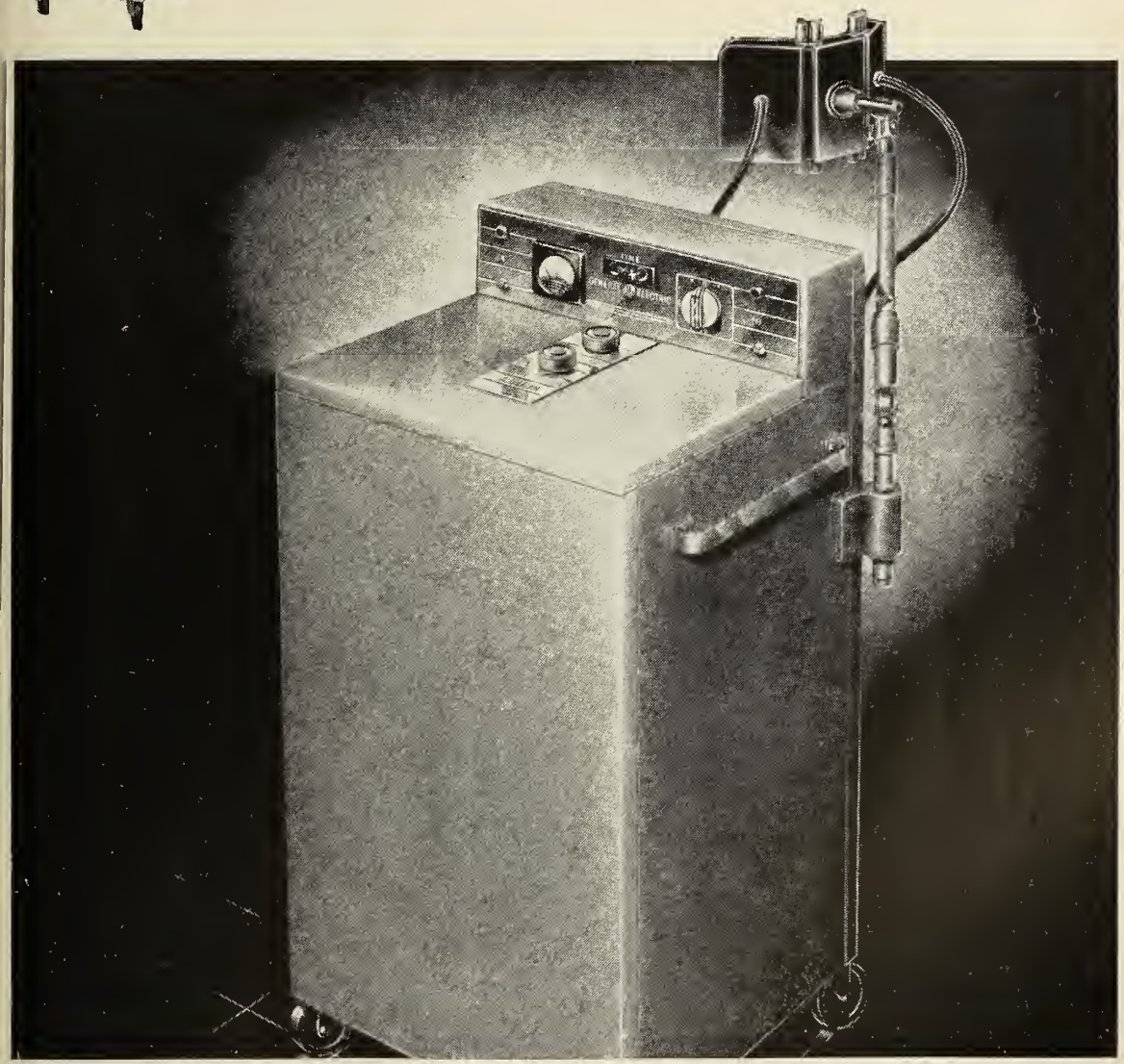
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You and Your Business

MICHIGAN STATE MEDICAL SOCIETY ANNUAL SESSION
DETROIT—September 24-25-26, 1952

DIRECT ENROLLMENT PLAN BLUE CROSS-BLUE SHIELD

July 1-25, 1952

Thousands of persons not eligible for Blue Cross-Blue Shield through a group will be able to obtain hospital and surgical coverage on an individual basis during a state-wide enrollment period set for July 1 through July 25.

This non-group, direct enrollment program, which provides many of the benefits of group coverage, was initiated on a state-wide basis for the first time last September.

Over 75,000 persons enrolled in the three-week period, and because of thousands of requests which have come in since, a similar direct enrollment period was set for July 1 through 25, 1952.

Any person under sixty-five years of age, whether working or retired, may join during that time. However, married persons must enroll spouse and dependents. The spouse can be over 65.

Two contracts are available under the direct enrollment program. One provides a room allowance of up to $8 per day and the other a room allowance of up to $10 per day. They are optional except in Wayne, Oakland, Macomb, Genesee, St. Clair and Lapeer counties, where only the $10 contract is offered.

Otherwise benefits in the two contracts are identical. They provide for coverage without dollar limit of all essential hospital services such as use of the operating room, laboratory, anesthesia, physical therapy and drugs and dressings.

On the family contract, maternity benefits of up to $9 per day plus a $50 fee to the doctor under the surgical certificate are provided nine months after the effective date of the contract.

The direct enrollment contract entitles every member on the contract to thirty days of hospital care and another thirty days, six months after the first thirty days has been used up.

No physical examination or health statement is required. Because there is a specific and limited enrollment period, Blue Cross is able to cover even pre-existing and chronic conditions six months after the effective date of the contract. Acute conditions are covered immediately.

Enrollment will be by mail or by applying in person at any Blue Cross-Blue Shield office. Applications and folders outlining details and cost of coverage can be obtained by mailing an inquiry card, mailing in the coupon which will appear in newspaper advertisements, or by calling a Blue Cross office (Main Office: 234 State Street, Detroit).

The Blue Cross-Blue Shield direct enrollment campaign has the full endorsement and co-operation of the Michigan State Medical Society and the Michigan Hospital Association.

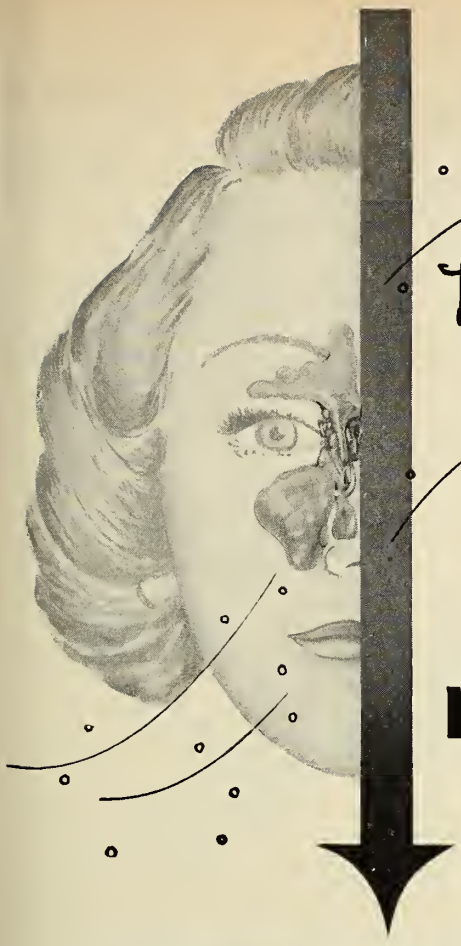
HIGHLIGHTS OF EXECUTIVE COMMITTEE OF THE COUNCIL

Meeting of May 24, 1952

Sixty-one items were presented to the Executive Committee of The Council on May 24. Chief items of importance were:

- Financial Reports were presented, studied and approved.
- Bills Payable were presented and payment was authorized.
- Health and accident insurance plan for MSMS members: this proposal was presented by the MSMS Insurance Studies Committee, W. Jones, M.D., Menominee, Chairman. The details as devised by the insurance brokers were thoroughly discussed and the Committee was requested to file a written report for presentation to The Council at its July, 1952, Session.
- American Medical Education Foundation. Follow-up organizational work in Michigan, recommended by Councilor G. B. Saltonstall, M.D., Charlevoix (MSMS representative AMEF), was presented and accepted. Action to carry out the recommendation was ordered.
- H. F. Mattson, M.D., Hillsdale; G. W. Slagle, M.D., Battle Creek; and J. D. Littig, M.D., Kalamazoo, were appointed as MSMS representatives to serve on the Planning Committee for the Southwestern Nurses Regional Conference, scheduled for Hillsdale in the autumn of 1952.
- Committee Reports—the following were given consideration: (a) Committee to Meet with Basic Science Board Officers, meeting of April 23; Mental Hygiene Committee, meeting of May 1; Rheumatic Fever Control Committee, meeting of May 7; Committee on Survey of Hospital Facilities at State Prison of Southern Michigan, meeting of May 7; Cancer Control Committee, meeting of May 8; Committee to Study Veterans Administration Hospital Policy, meeting of May 13; Beaumont Memorial Re-

(Continued on Page 802)



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A few drops of Neo-Synephrine 0.25% in each nostril will promptly check mucosal engorgement and hypersecretion, promoting greater breathing comfort over a period of several hours.

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Neo-Synephrine does not lose its effectiveness on repeated application and may, therefore, be relied upon to give relief throughout the hay fever season.

Neo-Synephrine is practically free from sting and compensatory congestion; does not appreciably inhibit ciliary activity. Neo-Synephrine has been found relatively free from systemic side effects such as nervous excitation, cardiac reaction or insomnia even when tested on hypertensive, cardiac and hyperthyroid patients.[1]

Supplied in 0.25% solution (plain), bottles of 1 oz., 4 oz. and 16 oz.; 0.25% solution (aromatic), bottles of 1 oz. and 16 oz.; 0.5% solution, bottles of 1 oz.; 1% solution, bottles of 1 oz., 4 oz. and 16 oz.; 0.125 (⅛)% solution, bottles of ½ oz.; 0.5% water soluble jelly, in ⅝ oz. tubes.

1. Van Alyea, O. E., and Dannelly, Allen: Arch. Otolaryng., 49:234, Feb., 1949.

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HIGHLIGHTS OF THE COUNCIL

(Continued from Page 800)

toration Committee, meeting of May 13; Permanent Conference Committee, meeting of May 14; Committee to Study Proposed AMA Reorganization—report referred to Michigan Delegates to AMA House of Delegates; Joint Committee on MSMS and Michigan Health Council re Periodic Health Appraisal, meeting of May 19.

- President Otto O. Beck, M.D., reported on contributions to date to the Beaumont Memorial Restoration Fund.
- Dispensing barbituric acid preparations without proper labeling and marking on the containers, and not indicating the name of the patient as provided in the Dangerous Drug Act: a letter on this subject from the Director of Drugs and Drug Stores, Michigan Board of Pharmacy, was presented and referred for publication in JMSMS and in the next Secretary's Letter to all members.
- Request of American Hospital Association for an MSMS representative to speak at its annual convention in Philadelphia, September 18, on "Medical Staff Participation in Reducing Patient Costs": Kenneth B. Babcock, M.D., Detroit, was appointed as MSMS representative for this presentation.
- Monthly report of Rheumatic Fever Coordinator Leon DeVel, M.D., was presented and accepted.
- The progress report of the Public Relations Counsel included listing of the MSMS television shows; the Formula For Freedom Nights throughout the State; appointment of Warren F. Tryloff as Field Secretary to the Michigan Health Council; reprinting of Medical Associates brochure (10,000 copies) with request for 27 copies from the Office of the President of the United States; and a report on four different plans to reapportion the Michigan Legislature.
- Matters presented by Michigan Health Commissioner A. E. Heustis, M.D., included request for help in finding a physician for Beaver Island; changes in the laws governing registration of births and deaths; decrease in the size of the Michigan Health Department personnel; progress in Medical Civil Defense; special Venereal Disease and Tuberculosis Survey in Detroit; joint efforts of MSMS Child Welfare Committee and the State Health Department in the control of certain communicable diseases; and a request that MSMS review the public health programs of the State "so that sound and worthwhile recommendations might be available in the case of future activity in governmental reorganization of the health field."
- An invitation to all members of the MSMS Council and to all MSMS members to attend the Upper Peninsula Medical Society meeting in Iron Mountain on June 27-28 was extended by AMA Delegate W. H. Huron, M.D., of Iron Mountain.
- Thanks were extended to W. S. Jones, M.D. Menominee, who acted as host at this meeting

ESSAYISTS FOR ANNUAL SESSION

The Michigan State Medical Society Annual Session will be a great gathering of medical folk at the Sheraton-Cadillac Hotel, Detroit, September 24, 25 and 26. No registration fee to MSMS members. Get your hotel reservations *now* by writing Committee on Housing, c/o Sheraton-Cadillac Hotel, Detroit, Attention: Robert M Buckley, Secretary.

Some of the guest essayists who already have accepted invitations to speak at the MSMS Annual Session are: Claude S. Beck, M.D., Cleveland; John J. Bonica, M.D., Tacoma, Wash. George Crile, Jr., M.D., Cleveland; Ormond S. Culp, M.D., Rochester, Minn.; Daniel C. Darrow, M.D., New Haven, Conn.; Edwin J. DeCosta, M.D., Chicago; Garfield G. Duncan, M.D., Philadelphia; Dwight E. Harken, M.D., Boston; Peter C. Kronfeld, M.D., Chicago; Milton I. Levine, M.D., New York; Roland P. MacKay, M.D., Chicago; Samuel F. Marshall, M.D., Boston; Earl R. Miller, M.D., San Francisco; Emil Novak, M.D., Baltimore; Duncan E. Reid, M.D., Boston; David A. Rytand, M.D., San Francisco; Ben H. Senturia, M.D., St. Louis, Mo.; Evan W. Thomas, M.D., Albany, N. Y.; Philip Thorek, M.D., Chicago; Leonard F. Weber, M.D., Chicago; and Claude E. Welch, M.D., Boston.

IT WOULDN'T WORK

The well-advertised Social Security Hospitalization scheme is fundamentally unsound, economically.

The Social Security Agency states that the cost of this hospital program could be paid out of the Social Security surplus. While there is an unexpended balance in Social Security collections, we must remember that most of the contributors are still young and have not reached the retirement age, and therefore continue to pay dues; however, if Social Security were ended as of today, all of the surplus and more would be required to liquidate the contracts that the government has entered into with the present contributors. That's one reason why Altmeyer has asked that the dues for Social Security be increased.

Under the proposal, the impression is gained that hospitalization would be guaranteed to all beneficiaries under Social Security. Actually the government's contract is not to guarantee one bed in a hospital, but only to assume the payment up to sixty days in a semi-private room—if the patient is fortunate enough to get admitted.

The hospitals would be the real beneficiaries under this plan, as admitted by the Federal

(Continued on Page 804)

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IT WOULDN'T WORK

(Continued from Page 802)

Security Agency. Hospitals are already crowded, and if this extra burden were to be added to them, the situation would be considerably aggravated in certain areas. In other words, patients would not be able to gain hospitalization in some sections of the country (as in most parts of England at the present moment).

Inasmuch as the hospital benefits would be available to all contributors under the Social Security Law (with no means test), one can readily see how the number of potential applications for hospital benefits would annually increase.

The Social Security Agency would give the impression that this program could be instituted and administered without increase in taxation. Such an idea is entirely unwarranted.

This so-called "insurance" would be mandatory: the worker would pay whether he wants the service or not. Yet FSA cannot guarantee that he would be able to get into a hospital if, after sixty-five, he needs hospitalization.

It's all a New Deal bureaucratic mirage!

FORMULA FOR FREEDOM NIGHTS

Twenty-two (22) Formula For Freedom Nights sponsored by the Michigan State Medical Society and held during the winter and spring seasons were climaxed June 27 at the meeting of the Upper Peninsula Medical Society, Iron Mountain.

At the June 27 U.P. luncheon meeting, the Formula For Freedom presentation was made to the members of all county medical societies in the Upper Peninsula. The speakers were L. Fernald Foster, M.D., Bay City; D. Hale Brake, Lansing, Treasurer, State of Michigan; and Hugh W. Brenneman, Lansing, MSMS Public Relations Counsel.

OREGON MEDICAL SOCIETY VINDICATED

The sale of medical service is not trade or commerce.

Doctor-sponsored prepaid medical plans won a major victory in the United States Supreme Court decision handed down on April 28 in favor of the Oregon State Medical Society. This organization had been charged by the Federal Government with conspiring to monopolize the business of providing prepaid medical care in the State of Oregon and conspiring to restrain competition between medical plans within the state in violation of the Sherman Anti-Trust Act. In affirming the trial court's decision, the U. S. Supreme Court held:

"The sale of medical services by doctor-sponsored organizations in the State of Oregon is not trade or commerce within the meaning of the Sherman Anti-Trust Laws. Nor is it commerce within the meaning of the constitutional grant of power to Congress 'to regulate commerce among the several states.' "

MEDICAL MEETINGS AND CLINIC DAYS

A list of known medical meetings and clin days, sponsored by county medical societies ar other physicians' groups in Michigan, follows:

1952

July 24-25	Annual Coller-Penberthy Medical Su gical Conference.....Traverse Ci
July 24-26	Conference on Housing of the Aging Ann Arb
August 21	Third Annual Clinic, Central Michig Committee, ACS Michigan Committ on Trauma, plus Michigan Nation Guard Medical Personnel, and Me ical Society of North Central Counti Graylin
Sept. 24-26	MICHIGAN STATE MEDICAL SC CIETY ANNUAL SESSION.....Detro
Oct. 8	Clara Elizabeth Fund—Genesee Coun Medical Society—Lectures of 1952...Flin
Oct. 9	Fourth Michigan Cancer Conference Kellogg Center, East Lansin
Nov. 17-18	Wayne County and Michigan Academi of General Practice..... Kellogg Center, East Lansin
Autumn	MSMS Postgraduate Extramural Cours State-wid

1953

April 9	Genesee County Medical Society 8t Annual Cancer Day.....Flin
May 13	Annual Clinic Day and Reunion c Wayne University College of Medicin Hotel Fort Shelby, Detroi

Additions to this list of meetings are invited b the Editor of JMSMS, in order to make thi monthly announcement complete and accurate.

Oscar C. Pogge, director of Bureau of Old Age an Survivors Insurance, reports that 4,600,000 persons no are on OASI rolls; the total will be 7,195,000 by 196 and by the year 2000 it will be 19,872,000.



"...particularly beneficial in the treatment of hay fever."[1]

Because CHLOR-*TRIMETON*® maleate, chlorprophenpyridamine maleate, has the greatest potency milligram for milligram of any available antihistamine, and because "Chlor-Trimeton has a relatively low incidence of side reactions,"[2] it is a drug of choice for hay fever patients.

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1. Silbert, N. E.: New England J. Med. 242:931, 1950.
2. Eisenstadt, W. S.: Journal Lancet 70:26. 1950.

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Heart Beats

RESEARCH ACTIVITIES SUPPORTED BY THE MICHIGAN HEART ASSOCIATION

FRANKLIN D. JOHNSTON, M.D.
Chairman, Research Committee Michigan Heart Association
Ann Arbor, Michigan

Many physicians in this state may not appreciate the diversity and extent of the investigations in the field of cardio-vascular disease being carried out in Michigan with funds provided by the Michigan Heart Association or how these studies may help them to take better care of patients suffering from disorders of the heart and vascular system. Over $65,000.00 will be spent by eighteen different groups of research workers during the period from July 1, 1951, to July 1, 1952, and nearly $85,000.00 has been allocated to support continuing or new projects during the next year. These are large amounts of money, even in these days, and some comments regarding what has already been accomplished and work in progress or in prospect is clearly in order.

It should be pointed out that most of the money available to the Michigan Heart Association for research or other purposes comes from the public through the United Health and Welfare Fund of Michigan and the United Foundation in Detroit and the Research Committee, as well as other groups in the Association, are keenly aware that these funds must be used in the best possible way. Many of the research activities are concerned with studies on patients, and it is often difficult to say whether certain costs may properly be considered part of the research program or whether they should be included as items under routine patient care. The Research Committee has taken a very definite stand on this matter and in general does not look favorably on requests for money to pay for hospitalization of patients, professional fees of any kind, or any of the other costs commonly borne by the patient. Only under exceptional circumstances have funds been granted for studies which are closely related to the care of patients.

Funds for the purchase of ACTH or cortisone to treat patients with acute rheumatic fever have been given to three groups of workers, one in Detroit, one in Grand Rapids and one in Ann Arbor. Although approval of these grants m be considered as a violation of the general pc expressed above, it was felt that the importa of the matter under investigation far outweig other considerations. Preliminary results wh have already been reported by Doctors Wooley Hecht from the Children's Hospital in Det indicate these endocrine preparations have definite place in the treatment of acute rheum infection.

Most of the money allocated for resea activities has been or will be spent to supp young physicians devoting all or part of th time to research work, to pay the salaries of te nicians, and to purchase equipment and supp of many kinds. The Research Committee d not think it likely that any great discoveries be made or any revolutionary new treatments heart disease will be devised in the near future, they do believe that important facts will be covered and new techniques for diagnosis a treatment will be perfected. These contributi although small, may in the long run help measurably in the management of cardiac patie A cardinal principle in the granting of funds been to give money to individuals or groups individuals who have already demonstrated abi to carry out research work of high grade and allow them to go ahead with the studies t interest them.

Space is not available to even mention all the research projects sponsored wholly or in p by the Michigan Heart Association, so only a f of the representative ones will be presented he Studies of several kinds are being carried out the departments of Medicine and Chemistry Wayne University in Detroit under the supervisi of Dr. Gordon B. Myers. These include work the metabolic aspects of cardiac and renal diseas hemodynamic aspects of cardiac and pulmona

(Continued on Page 808)

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RESEARCH ACTIVITIES

(Continued from Page 806)

diseases and studies on atherosclerosis. Studies on patients and experimental animals which involve extensive chemical work and development of new techniques and methods have already led to many papers for presentation at scientific meetings and many publications. The work of this excellent group of investigators will be materially aided by the completion of a new cardio-vascular research unit, now under construction in the annex of Receiving Hospital.

Important work relating to nutrition in patients with rheumatic fever and rheumatoid arthritis is being done in the Henry Ford Hospital under the direction of Dr. Joseph A. Johnston. Dr. Conrad R. Lam and associates in the same Hospital are continuing experimental studies which have already contributed a great deal to the surgical treatment of several different kinds of congenital and acquired cardio-vascular diseases. Dr. F. D. Dodrill of the Harper Hospital in Detroit is working intensively to develop artificial heart-lung mechanisms which have already given promising results on experimental animals and may, in the future, aid greatly in surgical treatment of cardiac defects. Studies on experimental myocardial infarction in dogs being carried out in Harper Hospital by Doctors Johnson, Gerisch, Saltzste and Scheinberg are of great interest, since pr liminary work suggests that animals receivi cortisone after the ligation have an increase in t vascularity of the heart and smaller infarcts compared with control animals not receiving t drug. The implications of this study are of gre importance, and further studies are under way.

Special techniques have been developed for t recognition of a pressor substance by Doctor Sibl W. Hoobler and associates in Ann Arbor, and th are working to identify and isolate the materi from the blood of patients with essential hype tension. Studies, also being carried out in An Arbor by Doctor F. E. Shideman in the depar ment of Pharmacology, are concerned wit mechanisms for reabsorption of sodium by the ren tubules. This work may bring to light informatio which will provide effective means of increasin elimination of sodium by the kidney and aid i the reduction of edema.

Some of the activities mentioned above may b of immediate practical value, while others ma not. All of them, however, represent earnest effor to widen our field of knowledge and improv methods for the diagnosis and treatment of cardi vascular disease. The Michigan Heart Associatio is proud to help in this work.

MICHIGAN'S TAX "PUT" RISES AS "TAKE" FALLS

Amateur card players know that in a poker game operated by professionals all the money poured into the pot doesn't come back out.

Likewise, taxpayers know that the money they shower on the Federal Treasury doesn't all come back to their various states in the form of Federal assistance or grants-in-aid.

In a poker game or at a horserace track the "take" is reasonably stable.

But in Government the percentage returned to the donors fluctuates wildly.

Some needy states, poor in resources, pay little taxes but get large grants. Others contribute heavily but get relatively little assistance from the Federal Government.

Michigan consistently is in the latter group.

In 1951, it took a particularly bad beating.

Compared with 1950 figures, Michigan's hard-working citizens boosted their Federal tax payments by 51 per cent.

But in spite of their increased contribution, the State's Federal grants-in-aid were cut nearly six per cent!

The two years compare thus:

Federal Tax Collections	
1950	1951
$2,747,571,000	$4,156,022,000
Federal Grants	
86,962,000	81,817,000

In the fiscal year 1951, Michigan was third on the li of states carrying the greatest Federal tax burdens. Th first five were:

New York	$9,243,924,00
Illinois	4,329,996,00
Michigan	4,156,021,00
Pennsylvania	3,886,470,00
California	3,558,227,00

The money was paid into the United States Treasur mostly through individual income-tax payments and co poration taxes.

Other sources were excise taxes, employment levie customs collections and other minor taxes.

Of the champion contributors listed above, four wer among the five states that received the most in Federa grants-in-aid.

The top five were:

California	$202,823,23
New York	156,171,46
Texas	118,139,54
Pennsylvania	106,814,74
Illinois	92,414,74

Michigan was one of 17 states that got less financia assistance from Federal sources in 1951 than it did i 1950. The remaining 31 got more than they did i 1950.

The question facing Michigan's industrious citizen at a time when they are paying record-high taxes is Is it really better to give than to receive?



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Politics and Medicine

The city-operated General Hospital of Bay City has, since its inception, been a medical institution staffed by doctors of medicine of Bay City and environs.

On June 9, 1952, the members of the Bay City Commission, by a vote of five to four, authorized osteopaths, of whom there are eight in the city, to practice in the 154-bed General Hospital. This action forced out of the hospital the seventy medical doctors, who comprised the staff, since the principles of medical ethics of the American Medical Association specifically state, "All voluntarily associated activities with cultists are unethical. A consultation with a cultist is a futile gesture if the cultist is assumed to have the same high grade of knowledge, training and experience as is possessed by the doctor of medicine. Such consultation lowers the honor and dignity of the profession in the same degree in which it elevates the honor and dignity of those who are irregular in training and practice" (Chapter II, section 1). Moreover, the Bay County Medical Society members realized that Bay City General Hospital would lose its accreditation with the American College of Surgeons if osteopaths were permitted to practice therein.

Within a week, the number of patients at General Hospital dwindled to thirty-two as doctors of medicine began treating their patients in Mercy Hospital and other hospitals of the area. This was in spite of the oftrepeated boast of the osteopathic leaders that they would completely staff and fill General Hospital with patients, in case the City Commission turned the hospital over to them. At no time did the osteopaths have more than six cases—eight of these being tonsillectomy cases (nine were from outside of the City of Bay City

Faced with a daily deficit of over $2,000, City Commission reversed itself, again by a v of five to four, at its meeting of June 16. Im diately, the patients of medical men were mo into the hospital, as they desired to go to Gen Hospital.

The Bay City experience, although most unf tunate, gives further proof to the well-known f that politics can be fought only by politics. Ir vidual members of the medical profession m understand and become a directing force in poli or else they will be engulfed by politics.

DIETARY NOTES

Construing "Dietetics" as a triumph of mind o platter, we give you daffynitions of some of the comm dietary terms, intended to stimulate the mental, rat than the digestive processes:

Eggplant—pumpkin with apoplexy.

Beans—a vegetable that someone is always spilling

Onions—a vegetable that builds you up physically, l tears you down socially.

Peas—vegetable pills.

Beets—potatoes with high blood pressure.

Hash—a food that isn't made but just accumulates.

Vegetable soup—the same as hash, except that it looser.

Vegetarianism—a harmless practice, though it is a to fill a man with wind and self-righteousness.

Please be seated!—*Kiwanis News Letter.*

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TURKISH & DOMESTIC BLEND CIGARETTES
CHOICE QUALITY
More people get more pleasure from Camels than from any other cigarette!

Medicine and TV

Phase One of a successful television program has been completed by the doctors of medicine of the Michigan State Medical Society. And without a break in continuity, Phase Two of the production has been taken up by the Michigan Health Council.

After a year and a half of successful weekly television shows in a series called "It's Your Life," MSMS concluded the series on May 28, 1952. The weekly shows had been broadcast each Sunday since December 17, 1950, over WJBK-TV (Channel 2), Detroit.

The Michigan Health Council is producing a series called "Court of Health." This program is telecast in the time slot on WJBK-TV originally occupied by "It's Your Life." MSMS Public Relations Committee members are on the TV Committee of the Michigan Health Council. It is chairmanned by R. W. Teed, M.D., of Ann Arbor.

The Michigan State Medical Society, however, is still very active in the production of television shows. Each Wednesday at 12:00 Noon, doctors of medicine appear on a half-hour portion of the "Bud Lanker Show" which is televised on WXYZ-TV (Channel 7), Detroit.

Seventy-One TV Shows Sponsored by MSMS

Before "It's Your Life" went off the air, seventy-one shows had been produced by the Public Relations Department of the Michigan State Medical Society. These three score and eleven presentations were presented in an interesting and informative manner to possible weekly audiences numbering 1,000,000 televiewers.

A heavy response of letters served as a barometer to demonstrate the popularity of the show. The topics of each show covered every aspect of medical science. The doctor of medicine participants in the program were taken from the ranks of Michigan's own medical practitioners.

In the year and a half that "It's Your Life" was telecast, eighty-one different Michigan M.D.s appeared on the show in addition to twenty-seven lay persons who had a particular interest in the topic being considered for that week.

When the Michigan State Medical Society first entered the field of television, few other state societies had taken the plunge into the new medium. Since that time, however, other state medical societies and the American Medical Association have seen the possibilities of TV as an outlet for information of a health nature and are using it.

The early "It's Your Life" shows used Jack Pickering of the *Detroit Times* as moderator. Later John Holland of Detroit became the M.C. of the show.

Motion pictures screened on the program supplemented the information supplied by the participating doctors of medicine. In fact, it was on "It's Your Life" that the latest Michigan State Medical Society film "To Save Your Life" was given its television premiere.

Credit for the success of the television production goes to the doctors of medicine and other participants who were willing to give up their Sunday mornings to take part in the show. The Michigan State Medical Society extends to these doctors a sincere vote of thanks for their unselfish response to requests to appear on the show.

Television has become an important part in the lives of a majority in the United States. This new medium has tremendous possibilities for presentations by the medical profession. As time goes on these TV possibilities will be explored further by MSMS.

"It's Your Life" and its successor, the "Court of Health," are only the beginning.

DEVELOP PLASTIC SURGICAL INSTRUMENTS

Surgical instruments made from methyl methacrylate resin (lucite, trade mark) have proved superior in many ways to their metal counterparts, it was reported in the July 12 *Journal of the American Medical Association.*

Developed for use in neurosurgical operations, the transparent plastic instruments are easy to make, inexpensive, easily handled and light in weight, according to Dr. Frank T. Padberg, of the department of surgery, Northwestern University Medical School, Chicago. Dr. Padberg designed the instruments.

In addition, he reported, the instruments are transparent so that underlying matter can be seen, they reflect light poorly, they do not conduct the electrocoagulating current, they are sufficiently strong, and they are durable.

"IT'S YOUR LIFE" SHOWS

December 17, 1950, to May 25, 1952

WJBK-TV (Channel 2) Detroit

PARTICIPANTS	TOPIC	DATE
W. B. Cooksey, M.D., Detroit	Heart	December 17, 1950
George Thosteson, M.D., Detroit	Diabetes	December 24, 1950
F. J. Hodges, M.D., Ann Arbor	Cancer	December 31, 1950
Carleton Dean, M.D., Lansing	Amputees	January 7, 1951
Arch Walls, M.D., Detroit	Family Doctor	January 14, 1951
A. H. Whittaker, M.D., Detroit	Industrial Health	January 21, 1951
E. F. Lutz, M.D., Detroit		
LeMoyne Snyder, M.D., Lansing	Legal Medicine	January 28, 1951
W. S. Reveno, M.D., Detroit	Goiter Areas	February 4. 1951
H. B. Zemmer, M.D., Lapeer	Epilepsy	February 11, 1951
A. E. Schiller, M.D., Detroit	Skin Diseases	February 18, 1951
Mr. Emmet Richards, Alpena	Crippled Children Commission	February 25, 1951
Frank Van Schoick, M.D., Jackson		
L. Fernald Foster, M.D., Bay City	History of Medicine	March 4, 1951
J. J. Lightbody, M.D., Detroit	Arthritis	March 11, 1951
Earl Merritt, M.D., Detroit	Relationship Between Pharmacist	March 18, 1951
Dean C. H. Stocking, Ann Arbor	and Physician	
A. C. Furstenburg, M.D., Ann Arbor	Doctor's Training	March 25, 1951
Gordon H. Scott, Ph.D., Detroit		
R. W. Teed, M.D., Ann Arbor	What the Health Council	April 1, 1951
J. S. DeTar, M.D., Milan	Could Do For You	
Mrs. Marjorie Karker, Lansing		
Mr. E. H. Wiard, Lansing		
Mr. H. W. Brenneman, Lansing		
J. G. Bielawski, M.D., Detroit	Cardiac Housewife	April 8, 1951
Claire L. Straith, M.D., Detroit	Plastic Surgery	April 15, 1951
Ralph Pino, M.D., Detroit	Cataract	April 22, 1951
R. K. Whiteley, M.D., Detroit	Pregnancy	April 29, 1951
J. G. McIner, M.D., Detroit	Detroit Health Department	May 6, 1951
Raymond W. Waggoner, M.D., Ann Arbor	Emotional Factor in Diseases	May 13, 1951
A. E. Heustis, M.D., Lansing	Blood	May 20, 1951
Harland Anderson, Ph.D., Lansing		
Otto van der Velde, M.D., Holland		
Ralph Johnson, M.D., Detroit	Vacation Safety	May 27, 1951
Mr. Palmer Bunker, Lansing		
Mr. Bennett McCarthy, Detroit		
Mr. C. F. Van Bankensteyn, Lansing		
Robert Mason, M.D., Detroit	Pediatrics	June 3, 1951
B. E. Brush, M.D., Detroit	Iodized Salt	June 10. 1951
O. B. McGillicuddy, M.D., Lansing	Hearing Defects	June 17, 1951
W. H. Gordon, M.D., Detroit	Your Doctor in War	June 24, 1951
John Towey, M.D., Powers	Tuberculosis	July 1, 1951
G. T. McKean, M.D., Detroit		
Alice Palmer, M.D., Detroit	Sunburn	July 8, 1951
Edwin DeJongh, M.D., Detroit	Migraine headache	July 15, 1951
Archibald MacGregor, M.D., Brighton	First Aid	July 22, 1951
Frederick Swartz, M.D., Lansing	Old Age	July 29, 1951
Edgar Martmer, M.D., Detroit	Poliomyelitis	August 5, 1951
Max Newman, M.D., Detroit		
Harold Kullman, M.D., Dearborn	Veteran Rehabilitation	August 12, 1951
Joseph Markel, M.D., Dearborn		
L. Fernald Foster, M.D., Bay City	Michigan Medical Service	August 19, 1951
R. L. Novy, M.D., Detroit		
Mr. Jay Ketchum, Detroit		
Mr. William S. McNary, Detroit	Blue Cross-Blue Shield	August 26, 1951
Mr. William Klein, Flint		
Kenneth Babcock, M.D., Detroit		
Wilfred S. Nolting, M.D., Detroit	Life of a Healthy Child	September 2, 1951
No Production		September 9, 1951
Roy D. Tupper, M.D., Detroit	Rheumatic Fever	September 16, 1951
David Sandweiss, M.D., Detroit	Ulcers	September 23, 1951
H. Marvin Pollard, M.D., Ann Arbor		
F. D. Dodrill, M.D., Detroit	Blue Babies	September 30, 1951
William Blodgett, M.D., Detroit	Foot Health	October 7, 1951
J. G. Reid, M.D., Detroit		
C. E. Umphrey, M.D., Detroit	Hernia	October 14, 1951
Eugene A. Osius, M.D., Detroit		
Harold G. McLean, M.D., Detroit		

(Continued on next page)

(Continued from Preceding Page)

PARTICIPANTS	TOPIC	DATE
James Croushore, M.D., Detroit	The Throat and Its Importance	October 21, 1951
Charles G. Jennings, M.D., Detroit	Baby's First Year	October 28, 1951
Donald H. Kaump, M.D., Detroit	Blood Banks	November 11, 1951
E. D. Spalding, M.D., Detroit	Underweight and Overweight Problems	November 18, 1951
C. A. Payne, M.D., Grand Rapids	The "RH" Factor	November 25, 1951
A. D. Ruedemann, M.D., Detroit	Eyesight	December 2, 1951
Willard W. Dickerson, M.D., Caro	Epilepsy	December 9, 1951
Lyle G. Waggoner, M.D., Detroit	Bronchology	December 23, 1951
Mr. Hugh W. Brenneman, Lansing	Advantages of a Rural Health	January 6, 1952
Mr. Gene Wiard, Lansing	Conference	
H. B. Zemmer, M.D., Lapeer		
W. C. Baguley, Lansing		
Harold W. Longyear, M.D., Detroit	Childbirth Safety	January 20, 1952
Harold A. Ott, M.D., Detroit		
Harry A. Pearse, M.D., Detroit		
R. W. Teed, M.D., Ann Arbor	Public Health	January 27, 1952
Lawrence Drolett, M.D., Lansing		
Rep. Howard R. Estes, Birmingham		
Rep. Martha Griffiths, Detroit		
Franklin D. Johnston, M.D., Ann Arbor	New Hope for Hearts	February 3, 1952
Warren B. Cooksey, M.D., Detroit		
Conrad Lam, M.D., Detroit		
Robert F. Ziegler, M.D., Detroit		
Senator Felix H. H. Flynn, Cadillac	Your Life after 65	February 10, 1952
Ralph Johnson, M.D., Detroit		
Senator Elmer R. Porter, Blissfield	Mental Illness	February 17, 1952
Henry A. Luce, M.D., Detroit		
Raymond W. Waggoner, M.D., Ann Arbor		
Oliver Field, A.M.A., Chicago	Electronic Radioclast	February 24, 1952
C. I. Owen, M.D., Detroit	Medical Examiners System	March 2, 1952
Le Moyne Snyder, M.D., Lansing		
Rep. Richard L. Thomson, Highland Park		
Rep. William P. Littlewood, Wyandotte		
Harold Henderson, M.D., Detroit	Michigan Clinical Institute	March 9, 1952
G. C. Penberthy, M.D., Detroit		
Otto O. Beck, M.D., Birmingham	Beaumont Memorial	March 16, 1952
A. H. Whittaker, M.D., Detroit		
O. D. Stryker, M.D., Mount Clemens	Communicable Diseases	March 23, 1952
Rep. Robert Montgomery, Lansing		
J. K. Altland, M.D., Lansing	Public Health	March 30, 1952
John Martin, Auditor General, Lansing		
Mr. Martin Fleming, Detroit	Rheumatic Fever	April 6, 1952
Mr. John Lee, Detroit		
No Production		April 13, 1952
Mr. Warren R. Mullen, Ann Arbor	The Family Doctor	April 20, 1952
J. S. DeTar, M.D., Milan		
L. Fernald Foster, M.D., Bay City	Formula For Freedom	April 27, 1952
D. Hale Brake, Lansing		
Hugh W. Brenneman, Lansing		
Francis P. Walsh, M.D., Detroit	Cerebral Palsy	May 4, 1952
Harold B. Fenech, M.D., Detroit	General Surgery	May 11, 1952
J. E. Livesay, M.D., Flint	Radiology	May 18, 1952
Louis Jaffe, M.D., Detroit	Medical Aspects of Civil Defense	May 25, 1952
Max L. Lichter, M.D., Detroit		

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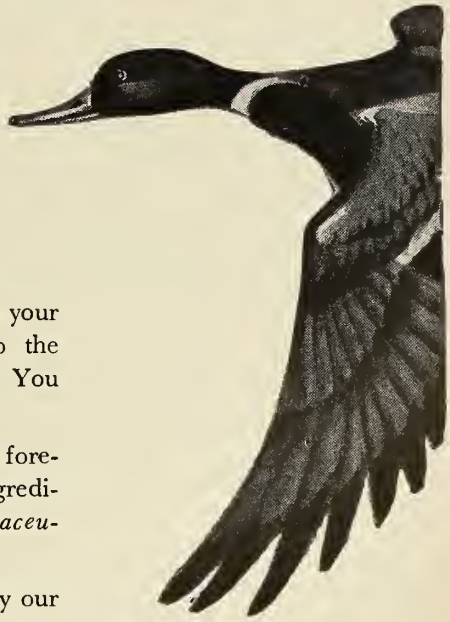
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Say you saw it in the Journal of the Michigan State Medical Society

Cancer Comment

IS PROFESSIONAL CANCER EDUCATION BEING OVERDONE?

A thirty-five-year-old woman was having persistent irregular vaginal bleeding. She consulted a gynecologist who prescribed hormones to control the bleeding and told her to return in two weeks when he would make a vaginal examination if the bleeding had ceased or would continue hormones until the bleeding stopped. As she continued to bleed, hormones continued to be given without a vaginal examination. This continued for several months without any lessening of hemorrhage or a vaginal examination.

Tiring of this form of treatment and becoming more concerned about her condition, the patient consulted another physician, who promptly made a pelvic examination and discovered a large pedunculated polyp protruding from the cervical os. Fortunately, it was found to be a benign growth. Had it been malignant, it does not require a very active imagination to realize the danger to this patient's life due to the neglect of the first physician to make a pelvic examination "until after the bleeding has been controlled."

* * *

An obese married woman, aged twenty-eight, sought medical attention in October for overweight. A pelvic examination was done and reported as "a tumor or pregnant." Friedman test was negative. Menses continued for five months, the abdomen continuing to enlarge. In the following March the same physician again examined the patient, who was told "he could not tell if she was pregnant."

Dissatisfied with the medical opinions already given, three months later the patient was examined in another hospital where again she was told she was pregnant. Bleeding continued. Another examination late in June, nine months after her first examination, resulted in decision she was not pregnant.

Patient was admitted to a hospital in July, and laparotomy revealed pelvic organs in such condition "it was not possible to remove them." X-ray treatments were given in August and September. The following January panhysterectomy and bilateral salpingo-oöphorectomy was done, with findings of primary right ovarian papillary carcinoma with metastases.

In this case, diagnosis was established *only after 14 months delay.*

* * *

From the *Westchester Medical Bulletin* (Westchester County, N. Y.) May, 1952, issue, the following case is cited: "I first noticed the lump in my breast over a year ago; it didn't bother me but I thought I should tell my doctor. He said we should 'watch it.' I saw him several months later, and it hadn't changed in any way so he said to 'watch it.' I was in an auto accident and was examined by another doctor. I asked him about it, and he said it would be all right to 'watch it.' Finally a friend of mine urged me to see another doctor. He explained it was probably not serious but would best be out. Now I know that it was cancerous and I have had what they call a 'radical'; I feel fine and my doctor is very hopeful that I have been cured!"

This is a verbatim report from a forty-year-old intelligent and "well adjusted" business woman in Westchester County, and the date is 1952.

No further comment is necessary!

* * *

The cases cited above could be multiplied over and over from the records of many hospitals. Watching breast lumps and waiting for hemorrhage to cease before making pelvic examinations are dooming many women to needless suffering and often to premature deaths. Examination during pelvic hemorrhage holds the distinct advantage of being able to accurately localize the source of the bleeding and any solitary lump in the breast persisting after the next menstrual period following its discovery demands prompt and definite diagnosis.

Professional cancer education has stressed these points year after year; still they are neglected by far too many physicians in their daily practice. Is too much emphasis being given to professional cancer education? From the cases cited above and from many other similar cases that could be produced, the answer to this question must be in the negative. It is up to each physician to answer this question through his handling of his own cancer patients.

Since it is clinically impossible to distinguish between a benign solitary adenoma and a low grade carcinoma of the thyroid, discrete adenomas should be removed completely by excising the entire lobe on the affected side.

* * *

Thorough and complete removal of thyroid carcinomas and their regional metastases is the safest and most dependable treatment now available.

* * *

The most radical operations performed within a few weeks or months of the onset of undifferentiated carcinomas of the thyroid have failed consistently to effect cures.

* * *

Roentgen therapy is of little value in the well-differentiated carcinomas of low malignancy of the thyroid and should not be given prophylactically to prevent the recurrence of tumors which apparently have been excised completely.

MEAT... and the Cholesterol Content of the Diet

An essential constituent of human tissue, contributing to the normal functioning of all cells, cholesterol has been widely discussed as a factor in the etiology of atherosclerosis. Yet this lipid is required in many metabolic processes, and, furthermore, evidence is lacking that withholding cholesterol from the dietary is effective in preventing atherosclerosis.

In a recent plea for a return to the basic fundamentals of nutrition in the prophylaxis of atherosclerosis, it was emphasized that to eliminate cholesterol from the diet would mean to eliminate such animal foods as meat, milk, eggs, etc.* However, nutritionists are unanimous in asserting that these protective foods contain basic essential nutrients required for good nutrition and that to deny them would be "equivalent to the negation of practically all that nutrition science has taught us in the past."

According to these authors,* elimination of animal foods from the diet to prevent the development of atherosclerosis is unjustified on the basis of present day knowledge. They state that "there certainly is no evidence that meatless, milkless, and eggless diets should be recommended as desirable to the general public."

Meat, America's favorite protein food, always has been and continues to be an important dietary source of biologically complete protein, B vitamins, and iron. Few indeed are the conditions in which its use must be interdicted.

*Hegsted, D. M.; Mann, G. V., and Stare, F. J.: Comments on Cholesterol, Editorial, Postgrad. Med. *11*:454 (May) 1952.

The Seal of Acceptance denotes that the nutritional statements made in this advertisement are acceptable to the Council on Foods and Nutrition of the American Medical Association.

ACCEPTED COUNCIL ON FOODS AND NUTRITION AMERICAN MEDICAL ASSOCIATION

American Meat Institute
Main Office, Chicago...Members Throughout the United States

Editorial Comment

MICHIGAN STATE MEDICAL SOCIETY ANNUAL SESSION
SHERATON-CADILLAC HOTEL—DETROIT
September 24-25-26, 1952

VOLUNTARY PENSIONS FOR PHYSICIANS

Elsewhere in this issue (page 391) is an analysis of the Keogh-Reed bills (H. R. 4371 and H. R. 4373), which would encourage by tax deferment a voluntary pension system. This article is an abstract of the testimony given on May 13, 1952, in Washington at the hearings of the House Committee on Ways and Means by Frank G. Dickinson, Ph.D., for the American Medical Association. Similar encouragement is now given to employed persons under Section 165 and related sections of the Federal Internal Revenue Code. An editorial on this subject appeared in *The Journal* recently, but it did not present an analysis of what might reasonably be expected under the terms of the bill in the matter of pensions. The current article provides that analysis for the benefits of physicians, professional persons generally, and those interested in the pension plight of the self-employed.

On the basis of recent surveys by the United States Department of Commerce of the incomes of physicians, lawyers, and dentists, it has been estimated that the average monthly pension starting at age seventy that could be reasonably expected under this bill would be $208 for physicians, $146 for lawyers, and $140 for dentists. If the proposed past-service credits feature were adopted by the Congress the average expected pension starting at age seventy-five—not age seventy—for those now aged fifty-six would be $131 per month for physicians, $121 for lawyers, and $72 for dentists. The tax savings resulting from deferring the taxes to the low income retired years would probably not average more than one-fifth of these annuities.

As a result of his analysis, the Director of the Bureau of Medical Economic Research expresses the view that the loss in revenues to the Treasury Department will be moderate. They will be small in comparison with the amounts now being excluded by employers for the financing of approved pension plans for their employes. He also points out to those who labeled this bill a "rich man's" bill that under employer pension systems the amounts contributed by the employer are greater for the higher paid employes than for the lower paid employes. Most persons are well past forty years of age and approaching the peak earning period of their lives before they think seriously about setting aside some of their income for retirement purposes. This greater prospective use of the bill by older professional persons is a phenomenon of age rather than of higher income. For persons in the same age group Dickinson expresses the view that the propensity of the professional man and his wife to save for old age will probably be the major factor in determining their decision to exclude from current taxable income the maximum percentage of their earned income permitted under this bill. For these reasons it is apparent that the charge of critics that this is a "rich man's" bill are not well founded.—Editorial, *J.A.M.A.*, May 24, 1952.

PRINCIPLES, NOT PERSONALITIES

The 1952 Presidential campaign gathers steam with each passing day. In the excitement about favorite sons, "dark horses," and popularity polls, it is easy to be distracted from the significant issues of our day. Who is elected is important. But of even greater importance is the one basic issue:

Do we want our government to be the servant of the people? Or do we want it to be master over us?

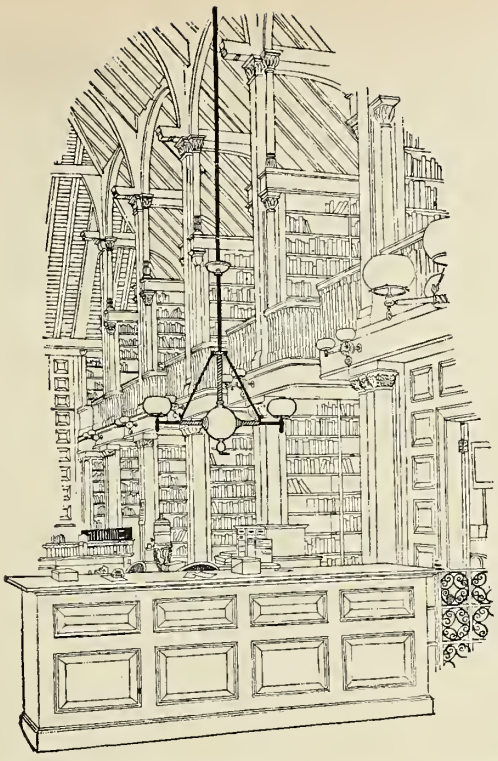
Should we allow the Federal government in Washington to acquire more and more power? Or should we stand pat on the principles of our Constitution which specified that any powers not expressly given to federal officials were to remain with the individual citizens and their local governments?

Shall we permit Federal officeholders to install a system of compulsory, government-guaranteed "security?" Or shall we insist that personal responsibility for one's own welfare brings increased material well-being—a principle that America has proved to be the most effective that the world has ever known in the field of government?

Do we want taxes to go up and up, taking away from the wage-earner more and more of the fruits of his labor? Do we want corruption to continue destroying the people's faith in their public officials? Do we want inflation to so completely destroy the value of our medium of exchange that it is hardly safe to be thrifty?

(Continued on Page 822)

New aureomycin minimal dosage for adults—four 250 mg. capsules daily, with milk.



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Aureomycin has been reported to be effective against susceptible organisms in the following conditions frequently seen by otolaryngologists:

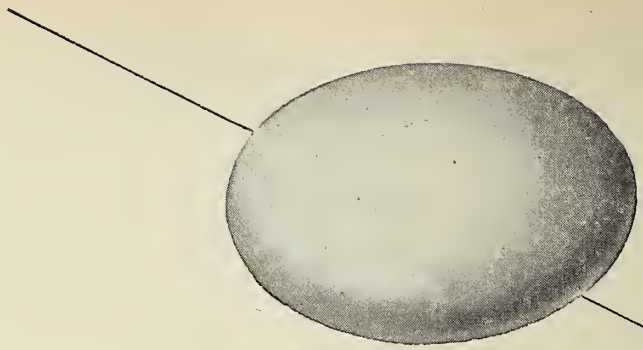
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Mastoiditis • Pharyngitis • Sinusitis • Tonsillitis

Throughout the world, as in the United States, aureomycin is recognized as a broad-spectrum antibiotic of established effectiveness.

Capsules: 50 mg.—Bottles of 25 and 100; 250 mg.—Bottles of 16 and 100.
Ophthalmic: Vials of 25 mg. with dropper; solution prepared by adding 5 cc. of distilled water.

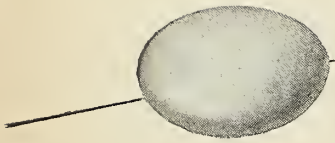
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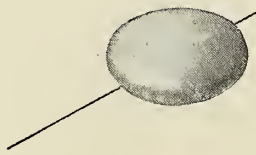
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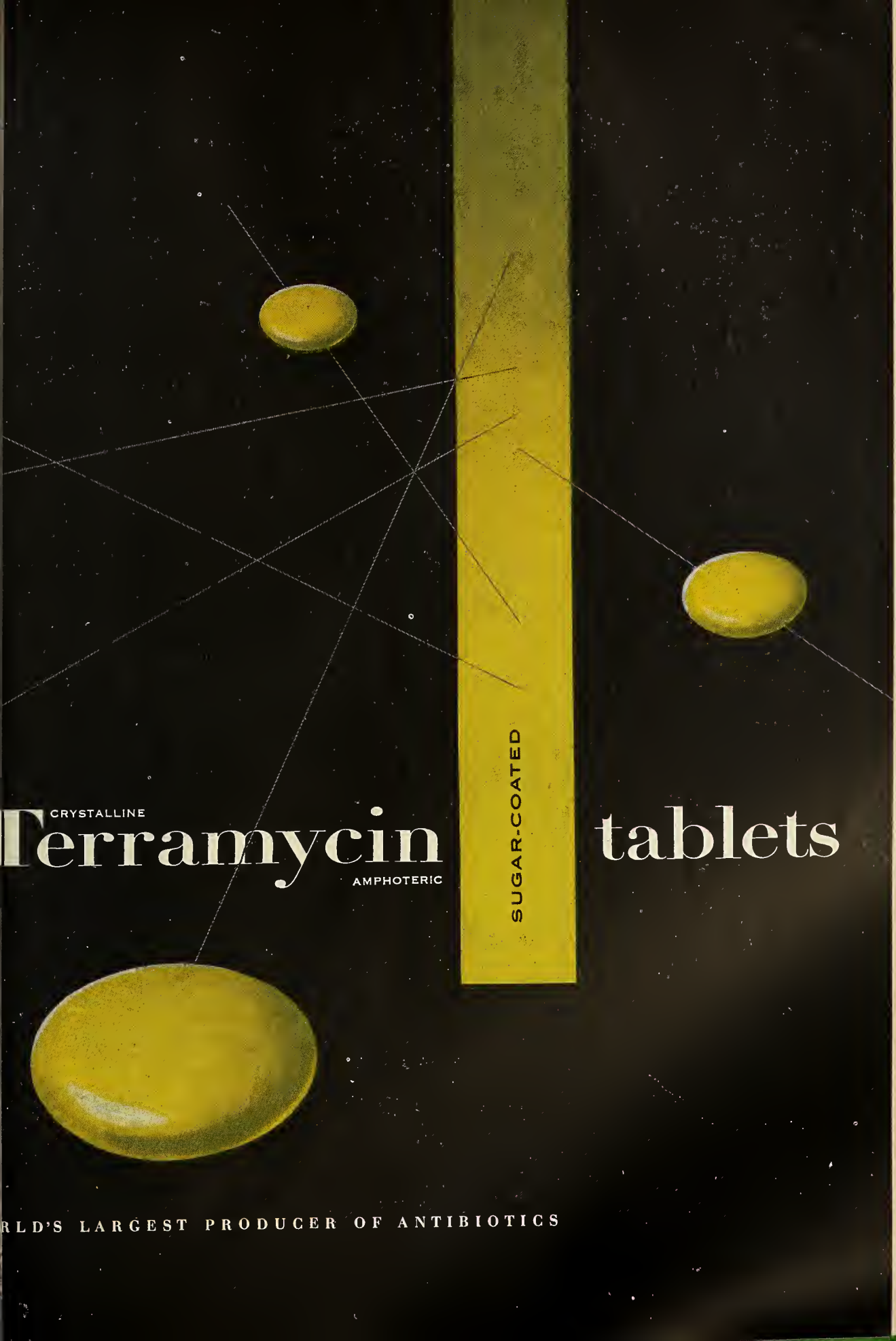
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RLD'S LARGEST PRODUCER OF ANTIBIOTICS

PRINCIPLES, NOT PERSONALITIES

(Continued from Page 818)

Do we want the Federal government to have such gross misconceptions of its "duty" that it completely separates the physician from his patient and subjects both to its advice and control regarding the care of the sick?

Shall our America be the land of opportunity, of individual freedom, of personal responsibility, or should this be merely a land of uneasy, forced security?

These are part and parcel of the fundamental issues in America today. These issues remain regardless of the individual or party in power. Experience has shown us that the growth of government in any field, once started, usually goes forward regardless of the party in power or the amount of resistance.

We know that the election or appointment of a man to public office does not endow him with wisdom or compassion. It can only endow him with power. It is this power that creates welfare states, socialist states, and dictatorships, not who is elected or how he is elected.

Unless we put the government back into the place assigned it by our ancestors as a servant of the people, we will miss the greatest opportunity of the coming election.—Editorial, *The Wisconsin Medical Journal,* May, 1952.

STATE MEDICINE GETS A SETBACK

A bill increasing payments to 4½ million old-age and survivor insurance beneficiaries under the social security program was beaten in the house, much to the surprise of the Washington correspondents, who expected the measure to have easy sailing in this election year. Brought to the floor under a procedure requiring two-thirds majority for passage, the vote was 149 for the bill and 140 against. It needed 193 votes of the 289 cast.

Opponents of the bill, mostly Republicans and southern Democrats, explained they were not against the proposal to increase benefits. Their opposition arose from a "sleeper" provision granting the social security administrator authority to appoint physicians to examine disability claimants.

The bill's opponents pointed out that this would put the government's foot in the door of socialized medicine. The first corps of politically controlled doctors would be organized, the first government medical regulations would be set forth.

The injection of this provision in an otherwise worthy piece of legislation was a trick. Now that the bill has been blocked, the Democrats are talking about letting it die so they can blame the Republicans in election speeches beamed at retired workers.

That phony issue may as well be disposed of right now. The reason that the bill required a two-thirds vote for passage was that it was brough up under a suspension of the rules, restricting de bate and barring any amendments. Oscar Ewing and his socialized medicine gang thought that, eve if their sneak play was detected, the house woul swallow it rather than vote against the pensio increase. If the Democratic majority doesn't bring up the bill under normal procedure, without th objectionable section, it will be they, not th Republicans, who are guilty of denying pensioner an increase.—Editorial, *Chicago Tribune,* Ma 24, 1952.

TAX FACTS

An interesting bit of research by the Council of Stat Chambers of Commerce shows that the high cost of run ning the Government cannot be met by "soaking th rich."

An individual with a taxable income of $100,000 a year now pays about $67,000 in taxes. There are s few incomes in the country which exceed $100,000 that if the Government were to impose a 100 per cent tax o that portion of such incomes in excess of $100,000, i would net only $34 million a year above what it now gets. That sum is about enough to run the Govern ment for three and one-half hours.

If the Government confiscated all individual income in excess of $10,000 a year, the additional tax revenu would amount to $3.1 billion, or enough to run th Government for two weeks under the proposed 195 budget.

If Uncle Sam were to take all taxable income earne by individuals in excess of $6,000 a year, the extr yield would be less than $6 billion, or about enoug to pay for half of the foreign aid proposed by the Presi dent for 1953.

Estimates of the Joint Committee on Internal Reve nue Taxation show that if taxes are raised again, thos earning $10,000 or less will pay 74.8 per cent of th increase.

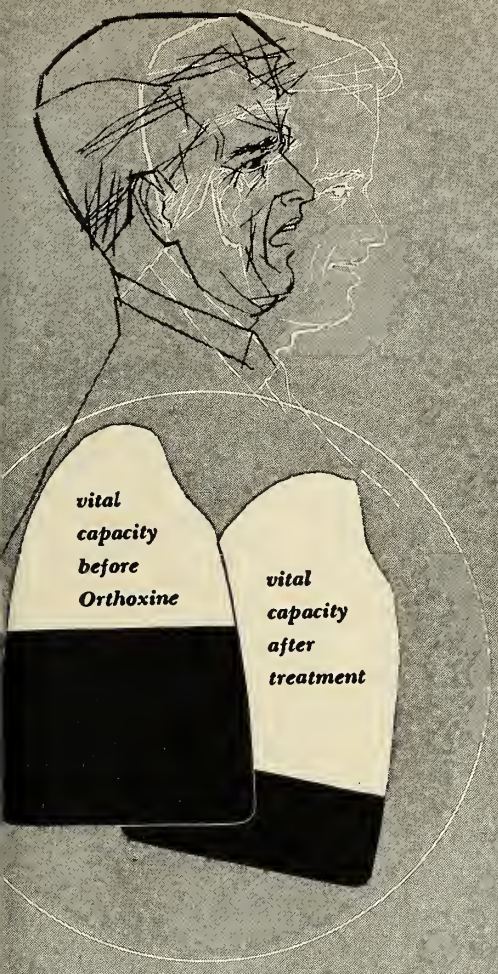
Since the Federal tax rates on large incomes now g as high as 92 per cent, little remains to be taken fro that source.

Under 1915 tax laws, a family of four with a ne income of $58,000 paid a Federal income tax of $1,000 Under 1952 laws, a $1,000 tax is levied on an income of $6,840.

When you realize that the Federal Government toda employs 2,500,000 people at a cost of more than $66 million a month; that one of every five citizens receive some form of income from the Government; that $1 ou of every $4 we earn goes for taxes to support the Federal Government and that about $1 of every $1 spent is being wasted, it's time to get mad.

We have twenty-nine Federal agencies lending money, twenty-eight handling welfare projects, sixteen in wild life preservation, and fifty compiling statistics.

One agency has enough light bulbs to last ninety three years, and another enough loose leaf binders to last 247 years. One bureau has twenty-four super visors for every twenty-five employes.



an answer to asthma

Q. Is there a sympathomimetic agent that will give relief from asthma without causing vasopressor and psychomotor stimulation?

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For Adults: ½ to 1 tablet (50 to 100 mg.)

For Children: half the dose

For Both: Repeat every 3 to 4 hours as required

* *Trademark, Reg. U. S. Pat. Off.*

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Federal Medicine

GENERAL EISENHOWER

In April we published a statement from Senator Lodge, the Eisenhower chairman, regarding the general's stand on socialized medicine. Since his return to America the general made the following statement. We are publishing it to be entirely fair:

Q.—I was told by a prominent physician in Washington that the doctors are being urged to oppose you because you are for compulsory health insurance. Are you for compulsory health insurance?

A.—Well, I am not going to answer too specifically, because what could be in a bill labeled compulsory health insurance? I am not so certain.

But I can tell you this: I am quite certain over the years that I was at Columbia, no one spoke out more than I did against the centralization of power in Washington, against bureaucratic government and submitting our lives toward a control that would lead inevitably to socialism, because, you see, beyond pure socialism, I believe, lies pure dictatorship, and you can't escape it.

Now, I do believe that every American has a right to decent medical care.

When I went to Columbia I found one thing: that medical education has become so expensive that it is embarrassing great universities that are privately supported and embarrassing them very badly—so badly that some of them almost in despair are turning to the Government for help to oppose that system.

I helped to organize and supported an organization of private citizens, insisting that we must in these private universities support medical education by private means, because if we didn't it would be the first step toward the socialization of medicine, and I am against socialization.

FSA SAYS PUBLIC "IS BECOMING MORE INSISTENT" ON NATIONAL HEALTH INSURANCE

The Federal Security Administrator says *the public is becoming "more insistent that a form of national health insurance become a reality"* and he adds: "My friends, you will get it." His prediction was made in an address to the New Jersey State Federation of Labor.

He told the labor convention: "But our work is far from done. The battle for security is only partly won. There are still big gaping holes in the fence we are building to protect your little bit of heaven. One of the biggest holes is the insecurity produced by illness . . . For the past few years we have been fighting to provide the people of this country with security against the catastrophe of illness. We have been advocating a simple, national health insurance plan, along lines simila to social security."

Then the FS Administrator went on to say "The battle has indeed been acrimonious . . . Th noble profession of medicine was traduced and th reputations of the physician became a dish rag c politics. The honest, decent medical practitioner were compelled under threat of expulsion to cor tribute two million dollars to a smear campaig . . . I doubt if the medical autarchy will be able t tax its members anew for another campaign agains the health of the people. There is smoldering re sentment among the rank and file of the medica profession. The honest, sincere, lovable prac titioners do not wish to see their names befoule by the hucksters of Hippocrates . . ."

In the same speech the FS Administrato acknowledged that *"this country had made fabulou strides in health,"* that since 1932 life expectanc has increased ten years and that " we have virtuall conquered the most infectious diseases."

DEFEAT OF HR 7800

Oppose Socialized Medicine. — America Medical Association officials have announced tha the profession is not opposed in any way to in creased benefits for social security beneficiarie but is opposed to socialized medicine, and wi oppose it in any form and in any bill or any typ of legislation.

Following the defeat of H.R. 7800 the pre romped all over the Republicans. loudly assertin they had voted against the aged when, in reality everyone in the House knew the vote had bee against socialized medicine. Indeed, the advers vote was not wholly on party lines. Over 75 pe cent of the votes against H.R. 7800 were cast b Democrats.

Enactment of H.R. 7800 would have opene the door to socialized medicine. The plot t sneak the measure through was one of th cleverest concocted so far by the Socialists. I was an extremely narrow escape from the in auguration of federal control over physicians an their patients.

FREE HOSPITALIZATION

Free hospitalization for all persons eligible fo social security benefits, the recommendation mad by the Federal Security Administrator is pro vided for in bills just introduced before Congres The proposal calls for federal grants to states c

(Continued on Page 826)

High Potency Vitamin B_{12} for Neurological Diseases

Information on the effectiveness of Vitamin B_{12} in cases of neurological diseases is available in the Journal of the American Medical Association, February 23, 1952, Page 667
and in the Journal of Neurology, March-April 1952, Pages 1931-9.

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FREE HOSPITALIZATION

(Continued from page 824)

hospitalization funds in proportion to the number of social security beneficiaries. The states could enter into contracts directly with approved hospitals or with voluntary nonprofit health insurance plans such as Blue Cross. As noted in our previous newsletter the proposed program, by including dependents and survivors, would go much further than merely providing hospitalization for the aged.

BRITAIN SCALES DOWN SOCIALIZED HEALTH PLAN

LONDON—AP—Britain's socialized medicine program will be scaled down Sunday.

For the first time in four years, Britons will have to pay directly for some health services, such as prescriptions, dental treatment, false teeth and wigs.

Winston Churchill's government cut back the tax-supported program to save an expected $56,000,000 a year.

The hard core of the program is not destroyed, however, and Health Minister Ian MacLeod said in a speech "the government does not declare, and it is not part of conservative policy or philosophy, that charges must remain a permanent part of the national health service."

Socialized medicine was the most popular measure of the former Labor Government. Its principle has become widely accepted.

About 95 per cent of the people use the health service. About 95 per cent of the country's 11,000 dentists, 90 per cent of the 23,500 general medical practitioners and practically all the 16,000 druggists and 7,000 opticians participate.

The new charges include: up to $12.60 for false teeth, up to one pound $2.80 for a course of dental treatment, 14 cents for each prescription, $8.40 for surgical boots, $2.80 for surgical supports, and varying costs for a private room in a hospital for many cases.

There still will be no direct charge for a doctor's services, surgery, hospital care, or laboratory work. —*Detroit Free Press,* June 12, 1952.

SOCIAL SECURITY AND OLD-AGE ASSISTANCE

During the fiscal year ending June 30, 1951, total receipts amounted to $3,411,489,779.32—nearly $3.5 billion. What a bonanza the Social Security taxes have proved to be! In a single year, the Federal Government extracted from the people Social Security taxes amounting to three times as much as the entire annual cost of Government prior to World War I. The 1951 Social Security "take" just about equalled what it cost to run the Government each year in the golden twenties.

A mere $1,498,100,000 went to benefit payments, while $70,400,000 was spent on administration. Thus less than half of what was taken in was spent for beneficiaries; the remainder was immediately syphoned off through the "special issue" bonds.

Only 59 per cent of those who are eligible for OASI are actually receiving benefits. Ultimately only two-thirds of those who are eligible for benefits will actually receive them. Of 12,700,000 persons sixty-five and over last June, only about 3.5 million were receiving OASI benefits. *Only one aged person in seven benefits under OASI because of restrictive clauses in the law. This is the Administration's vaunted insurance program for the aged!*

FEDERAL LEGISLATION

Bills for a bipartisan commission to study existing public and private old-age and retirement benefits have been introduced in Congress. The sponsors of the bill maintain that the hundreds of federal, state, and local old-age and retirement programs are "failing to provide the aged of our country with the protection they need." If authorized by Congress, the Commission would have the responsibility of studying the character and amount of present benefits and plans, recommending changes in the federal laws with regard to private, local, state, and federal systems, and of estimating the cost of providing recommended increases in benefits, as well as methods to be used to finance the increased benefits.

* * *

Military Personnel and U. S. Public Health Service Doctors Receive Pay Increase.—Completion of Congressional action means a pay increase, probably retroactive to May 1, for all military personnel (including reserves and retired) and commissioned members of the U. S. Public Health Service. If President Truman signs the bill before June 1, the increases will appear on pay checks for May. The conference report was approved unanimously by both House and Senate (333 to 0 in House, also unanimously in Senate, but only six Senators present). *Base pay will be increased 4 per cent and housing and subsistence allowance 14 per cent.* It is estimated the annual cost will be $484 million.

* * *

Regulations and Rulings.—Federal Security Agency has issued the final standards for five varieties of bread—white, milk, enriched, whole wheat and raisin bread—specifying the ingredients allowed in each type. Chemical bread "softeners" are not approved, because, FSA says, they tend to deceive the consumer as to the age of the bread and they have not been tested sufficiently.

* * *

Wage Stabilization Board has placed paid sick leave benefits under jurisdiction of its Health and Welfare Committee. Formerly these were considered with other "fringe" benefits but under the new regulations all new

(Continued on Page 861)

protein?

60%

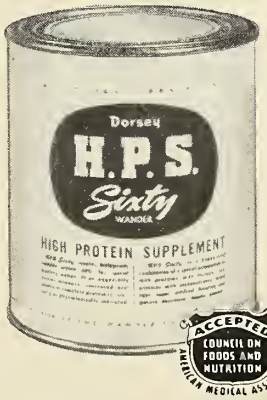
yet as acceptable to the patient as a tasty milk shake

When the protein intake must be increased beyond the amount an acceptable diet can supply, **H.P.S.** *Sixty* proves especially valuable. Providing 60% protein, 1.5% fat, and 27% carbohydrate, it makes a delightful beverage with water or milk, readily acceptable to the patient even when anorexia prevails.

Prepared with water according to directions (6 oz. water, 1½ oz. **H.P.S.** *Sixty*), three servings daily furnish 77 Gm. of biologically complete protein. When skim milk or whole milk is used instead of water, three servings provide 96 Gm. or 95 Gm. of protein respectively.

H.P.S. *Sixty* is processed from milk protein concentrate, soy protein, whole egg powder, powdered sugar and flavoring. Its proteins are intact; hence it is not burdened by objectionable odor. Valuable for use when whole protein can be utilized, **H.P.S.** *Sixty* may be indicated in the dietary management of undernutrition, peptic ulcer, hepatitis, chronic diarrheal states, pregnancy and lactation, and following burns and other injuries which raise the protein needs. Caloric equivalent, 3.6 per Gm., 102 per ounce.

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and 4 lb. tins.

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265 ARMY MEDICAL SERVICE RESERVISTS INCLUDED IN SUPPLEMENTAL CALL TO ACTIVE DUTY

Two hundred and sixty-five officers of the Army Medical Service Reserve will be ordered into active military service in July, the Department of the Army has announced. This is in addition to the original call up of 290 officers made in March.

Included in the new group are 232 physicianss, twenty-five dentists and eight veterinarians. Quotas have been assigned to each of the six Army areas in the continental United States, as well as U. S. Army, Pacific, and U. S. Army Caribbean.

For the first time in the history of the Army Dental Corps, dentists with a Priority II rating will be called. This is due to the fact that the listing of officers available under Priority I has been exhausted.

Under the law, Priority I registrants are defined as those educated at Government expense and others deferred from service to pursue a medical or dental education, who spent less than ninety days on active service in World War II following their training. Priority II registrants differ only in that they have spent more than ninety days but less than twenty-one monthss on active service in World War II following their training.

The Army is selecting those with the least amount of creditable service first and no one with more than twelve months of previous service will be called. Physicians and veterinarians will continue to be selected entirely from the Volunteer Reserve, classified as Priority I.

ARMY TESTS NEW PLASTIC BAG TO REPLACE GLASS BOTTLE AS WHOLE BLOOD CONTAINER

New plastic bags may replace glass bottles as containers of whole blood for military use if current tests by the Army Medical Service confirm that the plastic holders facilitate transfusions and substantially reduce the bulk of shipments.

Major General George E. Armstrong, MC, Army Surgeon General, reports that the plastic containers have proved equally valuable in both field trials and hospital use. Blood packaged in the 6 x 8-inch bags occupies only one half the space required by glass bottles now in use and can be airdropped to troops in combat without breakage.

Physicians at Brooke Army Medical Center, Fort Sam Houston, Tex., and Walter Reed Army Medical Center, Washington, D. C., report arterial transfusions are easier and safer to give when whole blood can be forced into the patient's bloodstream by direct hand pressure on the plastic container. This eliminates the need for special apparatus to build up pressure with the attendant danger of air entering the system.

Determination of the practicality of the new containers for Army-wide use will be made after improved models have been evaluated at Brooke, Walter Reed and two Air Force and two Navy hospitals.

The bags are also used for collecting blood from donors at the test centers. Although they do not have the vacuum pull incorporated in the bottles, the plastic units can fill in eight to sixteen minutes with the aid of gravity and the donor's muscular efforts.

Air shipment of whole blood to Korea and other overseas areas will be greatly facilitated because of the small weight and bulk of the plastic containers compared to the glass bottles. Storage of the empty bags will require one quarter of the space occupied by the glass bottles.

Each bag comes collapsed around 75 cc. of anticoagulant, ready to receive blood from a donor. One type comes with donor tubing attached which may be used as a hanging device; a second has a measuring device on its side to indicate the amount of blood it contains.

FEDERAL CIVIL DEFENSE FUNDS USED LARGELY FOR MEDICAL PURPOSES

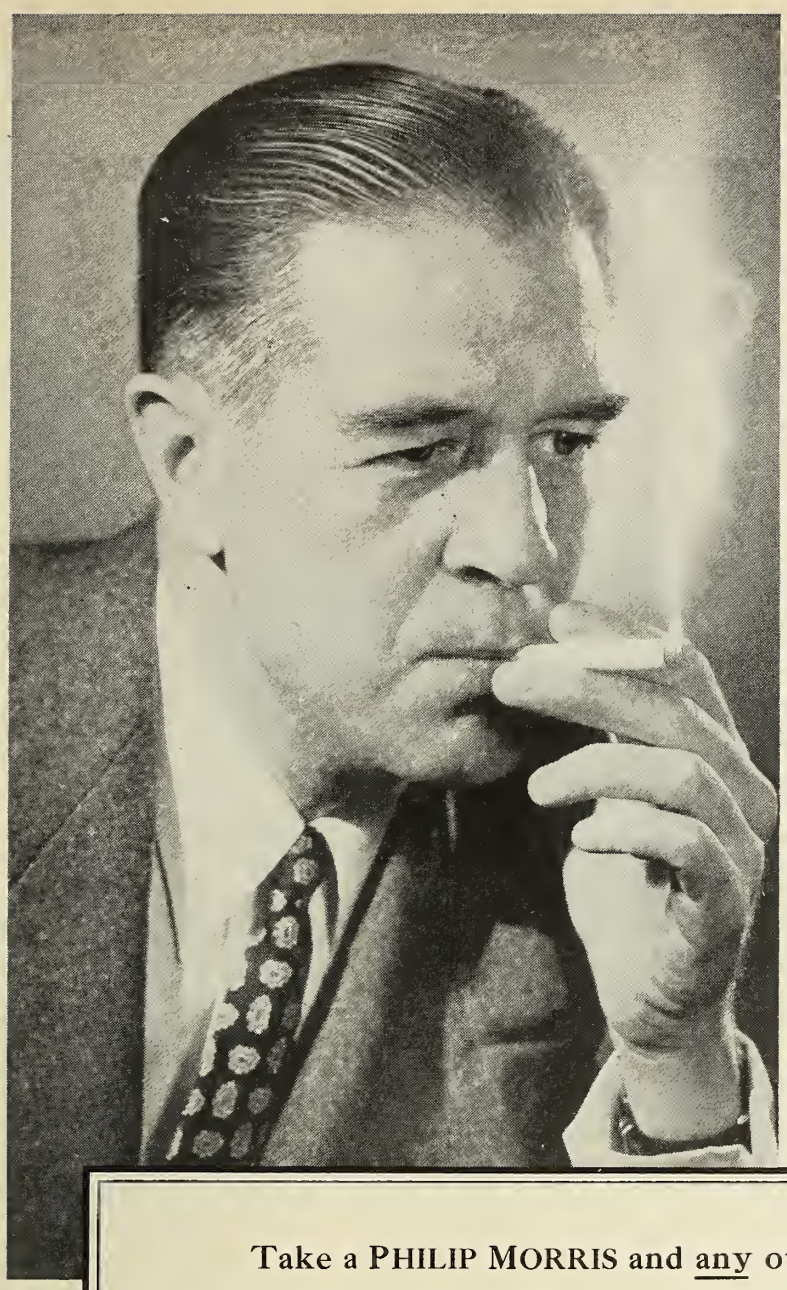
Approximately *70 per cent* of all federal money spent on civil defense is going for medical purposes, principally matching grants to states for local medical stockpiling and all-federal regional stockpiles. This breakdown of Federal Civil Defense Administration activities is contained in Administrator Millard Caldwell's annual report, covering the first full year's operations of FCDA. So far FCDA appropriations for all purposes have totaled about $100 million. Of this, $50 million is earmarked for all-federal medical purchases. $20 million will be used either for federal medical purchases or matching grants to states.

By next June, the report estimates that about $90 million in medical supplies will have been procured or will be on order, the extra $20 million to come from non-federal sources.

During 1951, FCDA prepared and sent to regional, state and local civil defense directors specifications for about 200 individual medical items. Using these specifications, state and local civil defense organizations may do their own ordering, or order through FCDA, which makes use of the Armed Services Medical Procurement Agency for purposes of co-ordination and economy.

The report says that within the next year a total of

(Continued on Page 830)



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FEDERAL CIVIL DEFENSE FUNDS USED LARGELY FOR MEDICAL PURPOSES

(Continued from Page 828)

fifty-eight regional warehouses will be available for stockpiling of federal supplies, including engineering as well as medical. In federal warehouses, a system of "unitizing" is used, and FCDA officials are encouraging state and local officials to employ a similar technique. On this the report says, "Supplies must be warehoused in such a way that they are immediately available at time of emergency. This requires 'unitizing.' Instead of all items of a given type, such as surgical instruments, being stored in one area of a warehouse, items making up a unit are stored together. For example, present plans call for storage of medical supplies and equipment in units necessary for a 200-bed emergency hospital." States are being urged to store their own supplies in units sufficient to care for 1,000 casualties.

In case of an emergency, the local community will have to depend on its own medical supplies and services for the first few hours, awaiting the arrival of medical units from the nearest federal regional warehouse.

On the federal level, plans are being made for exchange of perishable medical supplies with other government agencies, while states expect to rotate their own perishable items with state hospitals and other institutions.

ARMY SELECTS SENIOR MEDICAL STUDENTS FOR INTERN PROGRAM

Appointment of 146 senior medical students for the Military Intern Program of the Army Medical Service was announced by Major General George E. Armstrong, Army Surgeon General.

The Program, scheduled to get under way July 1, provides that medical students, upon graduation, can be commissioned as first lieutenants in the Medical Corps Reserve and serve their internships in Army hospitals.

Representing fifty-one medical schools and colleges, the students will be assigned to the ten Army teaching hospitals in the United States and to Trippler Army Hospital in Hawaii. Ninety-eight of those selected, including the three women in the group, have previously served in the armed forces.

Seventy-five per cent of the students applying have been assigned to the first hospital of their choice. Of those appointed in this list four are to go to Percy Jones General Hospital at Battle Creek.

The following Michigan students have been accepted, and assigned as indicated: Charles M. Ebner, Grosse Pointe—Letterman; Loyal W. Jodar, Detroit—Fitzsimons; William H. Owen, Detroit—Walter Reed; William E. Rush, Detroit—Letterman; Jack C. Todt, Detroit—Trippler.

Those being assigned to Percy Jones are: Walter H. Hanna, Breckinridge, Texas; Daniel S. Snow, Rochester, Pa.; Estil Y. Strawn, St. Joseph, Mo., and Joseph A. George, Jefferson, La.

WAR MANPOWER COUNCIL URGES MILITARY DEFERMENT THROUGH ONE YEAR OF RESIDENCY

The War Manpower Council, a citizens' organization financed by the Ford Foundation, has recommended that physicians be deferred from military service until completion of one year of residency training. The Council's report, *Student Deferment and National Policy,* lists this among its 14 recommendations made to Defense Department, Selective Service and other government agencies.

Currently, medical students are deferred through one year of internship, by which time they are subject to the Doctor-Draft law.

The Council also suggested that: (a) deferment of young fathers be ended, (b) present student deferment on the basis of aptitude tests and class standing be continued, (c) the military make the best possible use of its own scientific and technical personnel by turning many jobs over to civilians and (d) the military check into its procurement policy to see if it is using too great a proportion of scientific and engineering school graduates as line officers.

Neither Defense Department nor Selective Service has commented on the recommendations but both are studying the proposals.

COST OF LIVING

The following set of figures should be in the mind of every doctor. During the last decade the cost of living went up 69 per cent. The total hospital bills went up 67 per cent. Many of these, of course, depend upon the cost of food and wages. The cost of prescriptions only went up 37 per cent and cost of doctors' fees only went up 38 per cent. These figures are from the Department of Labor. We should all be able to quote them, and we should do so frequently.

In ten years the cost of medical care has not risen nearly as much as the cost of living:

Cost of living	Up 69%
Hospital bills	Up 67%
Cost of prescriptions	Up 37%
Doctor's bills	Up 38%

Hospital, surgical and medical insurance coverage is as follows:

Hospital insurance	Over 75 million people
Surgical insurance	About 55 million people
Medical insurance	Over 20 million people

RELATIVE VALUES

Many times we hear the remark that large corporations pay their executives tremendous salaries and bonuses. One of the radio commentators Tuesday evening, April 22, 1952, in reporting the hearings about the steel seizure, mentioned the testimony of Richard Fairless, President of U. S. Steel, who in 1951 was paid about $260,000, an increase of 80 per cent over his pay in 1940. However, taking into consideration the changes of income tax assessments, instead of getting more money he is actually being paid 4 per cent less than in 1940—that is, his actual "take home pay" is 4 per cent less.

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*Clein, Norman W.: Cow's Milk Allergy in Infants. Ann. Allergy 9:195 – 1951

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The JOURNAL

of the Michigan State Medical Society

Issued Monthly Under the Direction of the Council

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Disseminated Coccidioidomycosis

By Henry A. Chapnick, M.D.
Detroit, Michigan

THE PREVALENCE of a respiratory infection associated occasionally with erythema nodosum has been known to California physicians for many years as "Valley Fever," "Joaquin Fever" and "California Fever." It wasn't until 1937 that Dickson and Pierson[3] of Stanford University elucidated the relationship of this respiratory infection with coccidioidal granuloma. It had been thought until then that coccidioidosis, by which term only the disseminated or granulomatous type was meant, was invariably fatal. One of their patients, a laboratory worker, acquired a coccidioidal infection while studying an old culture of coccidioides immitis. To their surprise, the patient got well. Subsequently, it was found that the majority of residents in endemic regions are skin sensitive to coccidioidin, an extract of coccidioides immitis. Thus Gifford and her associates[7] tested 2,718 children in Kern County, California, and found over 50 per cent of them skin sensitive. Out of the relatively large number of patients having this "Valley Fever," a few develop pulmonary lesions, consisting of cavitation, pneumonitis, mediastinal widening and pleural effusion. Most of these do well. It has been estimated that one out of 500 cases of coccidioidomycosis will develop the disseminated type. Thus out of "several thousand"[8] men who were exposed for two weeks to dust in an endemic area, only seventy-five came down with the primary pulmonary disease. Of these, only three developed cavities, and all were reported as cured. In one of these, blood transfusions from a donor who had recovered from coccidioidomycosis was suggestively a factor.

It is the disseminated type which has aroused great interest in recent years. Other endemic foci than the Joaquin Valley are known. Cases have been reported from San Bernito County, California, southern Arizona,[10] southern Utah, western Texas[2] and northern Mexico.[9] Other known foci are Argentina,[11] Italy[12] and the Hawaiian Islands.[5] It has been suggested that other arid zones of the globe, such as northern Africa, the Near East and Australia, deserve closer scrutiny. That the incidence rate of disseminated coccidioidomycosis among troops who were trained in the southwest United States was small is indicated by the fact that only ninety-five cases of disseminated coccidioidomycosis were reported.[6] Because of the slow progress of the disease in some patients, the disease may not become manifest for months or even several years.

The granulomatous form of this disease was first described by Posada and Wernicke[17] in 1892. Rixford[13] described the first case in the United States in 1894. Since then, until 1939, 578 cases, with 278 deaths, have been recorded. The disease is known to affect cattle,[1] sheep, dogs and rodents,[4] in fact, rodents are thought to serve as a reservoir for the causative organism.

The causative organism is the diphasic fungus coccidioides immitis, which should not be confused with the protozoan coccidium resembling coccidioides immitis. It was because of this resemblance that Posada felt the organism to belong to the coccidia group and accounts for the name of the disease. From lesions of the disseminated type, as well as from sputum of the primary pulmonary type, spherules with double refractile walls can be isolated. These spherules multiply by endosporulation. In time, the capsule ruptures and endospores are liberated. The endospores in turn form

mycelia. The mycelia segment and break into small particles, chlamydospores. Pus inoculated on culture media or left in a container will form a mould containing myriads of chlamydospores. It is in this latter form that the coccidia are extremely infectious.

The similarity between tuberculosis and coccidioidomycosis is pointed out by Smith.[16] Thus, both diseases are acquired through the respiratory tract, both develop allergic sensitization, in both the sensitization disappears when the disease becomes disseminated, both produce pulmonary calcification, both show protean clinical forms. It should be pointed out, however, that, whereas in tuberculosis pulmonary cavitation is not felt to be a primary infection, in coccidioidomycosis it may be, and that while the preponderance of opinion is that exogenous re-infection is the cause of pulmonary tuberculosis cavitation, disseminated coccidioidomycosis is felt to be due to endogenous re-infection.

With the exception of the gastrointestinal tract, case reports have detailed involvement of every organ in the body. Pulmonary cavitation and pleural effusion subsequently proved to be due to coccidioidomycosis have been treated for tuberculosis. The disease has been confused with lymphoblastoma because of the mediastinal widening. Peritonitis,[15] arthritis[14] and osteomyelitis have been described. Of interest is the coccidioidal granulomatous meningitis that mimics brain and spinal cord tumors. The following three cases demonstrate the difference in the rate of progression of this disease, the varied clinical manifestations and the diagnostic problems involved.

Case 1.—A twenty-nine-year-old soldier acquired a protracted attack of "flu" in October, 1943, immediately following maneuvers in Arizona. In the next six weeks he lost 30 pounds of weight. Examination then was negative, but a chest x-ray in January 1944 revealed a widened mediastinum which, in the presence of an equivocal coccidioidin skin test and absent tubercle bacilli in the sputum, was interpreted as a mediastinal lymphoblastoma. A blood count at that time showed 10,000 to 18,000 white cells, with an eosinophilia ranging from 3 to 27 per cent. The sedimentation rate was 40 mm. per hour. In February, 1944, the patient began complaining of headaches. He had hyperactive reflexes and tremors of the fingers of both hands. Spinal fluid studies revealed a total cell count ranging from 51 to 320 per cm., with a relative lymphocytosis. Spinal fluid sugars ranged from 13 to 33 mg. per cent, protein varied from 74 to 1,618 mg. per cent, colloidal gold 5555555555. Spinal fluid cultures were negative for coccidioides immitis. Virus neutralization studies were negative for lymphocytic choriomeningitis, Western equine encephalomyelitis, and the St. Louis type encephalitis. Skin tests for coccidioides were negative. The chest x-ray became normal.

Gradually the headaches became more severe. In July, 1944, he began complaining of a sharp pain in his neck, radiating to both arms. He began showing atrophy of the shoulder muscles, neck rigidity and a positive Kernig. In August the Queckenstedt was noted to be positive. The neck pain became more severe. A myelogram showed complete block at the level of the fifth cervical vertebra. Papilledema became apparent. A laminectomy was done in October, 1944. At operation, the dura was definitely adherent to the arachnoid and the latter to the pia. The arachnoid was studded with multiple pearly granules resembling tuberculosis. The fourth and fifth roots were densely incarcerated in the fibrous tissue. On the right side of the cord, about the fifth cervical level, several small cysts containing about 1 cc. of fluid were present. The arachnoid in this region was released as much as was possible. Following the operation, this patient was somewhat relieved of his pain but the paralysis progressed until the upper extremities and chest muscles became completely paralyzed and atrophied. The above findings were associated with absent reflexes of the upper part of the body, absent abdominal reflexes and loss of vibratory sensation. Then his lower extremities became spastic, there was a persistent patellar and ankle clonus and a bilateral Babinski. The patient received sulfadiazine, penicillin and potassium iodide, without producing any change in the onward progression of the disease.

Granulomatous tissue was removed from the base of the brain, showed typical coccidioidal spherules. A complement fixation test, done in Dr. Charles E. Smith's laboratory at Stanford University, was positive for coccidioidomycosis. He gradually became completely paralyzed, developed renal stones and a kidney infection and finally died of pneumonia.

Postmortem examination revealed involvement of the brain, lungs and long bones in a granulomatous process typical of coccidioidomycosis.

Case 2.—A thirty-five-year-old soldier began having severe headaches in August, 1944. This, however, did not prevent him from participating in the Normandy campaign. This patient trained in the Mojave Desert from November, 1943, to January, 1944, at the end of which time he had a severe cold, for which he was hospitalized for ten days. He had no further trouble until August, 1944. In fact, it was not until after he was hospitalized for a knee injury in December, 1944, that he called the medical officer's attention to headaches and defective vision. At that time the patient showed definite papilledema. Spinal fluid examination revealed a pressure of 400 to 440 with no evidence of blood, a cell count of 400 to 690, initially showing 86 per cent lymphocytes, 3 per cent polymorphonuclear cells and 11 per cent eosinophiles, a total protein ranging from 190 to 240 mg. per cent, and a spinal fluid sugar varying from 15 to 40 mg. per cent. Inoculation of the spinal fluid into guinea pigs and spinal fluid cultures were negative. Spinal fluid

sediment revealed several bodies very suggestive of coccidioides immitis. An encephalogram showed a right internal hydrocephalus and was interpreted as consistent with a diagnosis of chronic arachnoiditis. The patient was transferred to another general hospital in the United States, where it was thought that the patient had a pineal tumor and was sent to Percy Jones General Hospital for x-ray therapy.

On admission to Percy Jones General Hospital the patient no longer had any complaints. His headaches disappeared following the encephalogram done in the previous hospital. Examination revealed a well-developed and apparently healthy man, a papilledema of three diopters on the left and four diopters on the right, an absent right knee jerk and bilaterally decreased ankle and left knee jerks. Coccidioidin test 1:100 was 1-plus; spinal fluid findings did not differ from the one done overseas except that the gold curve was 0000000000. The sedimentation rate was 5 mm. for sixty minutes, and the blood count and urine examinations were negative. A complement fixation test was done at Dr. C. R. Smith's laboratory and was positive 1:10. It was Dr. Smith's opinion that this low titre, in the absence of a paretic gold curve, suggested that the infection was not progressive. The patient was given penicillin, 40,000 units every three hours, for 120 doses, without in any way affecting his vision. In fact, the papilledema and blind spots slowly progressed. To save the patient's vision, it was suggested to him that a ventriculostomy be done, but because of the patient's sense of well being, he preferred to "let sleeping dogs lie."

Case 3.—A twenty-six-year-old Negro soldier came on duty from Alabama to Fort Huachuck, Arizona, in December, 1944. In October, 1944, he began to cough, began to have some dyspnea and a sense of pressure in the chest. A nodule appeared on the lower portion of the right side of the neck anteriorly. He gradually lost weight and strength. He was hospitalized early in February, 1945, and a chest x-ray at that time revealed accentuation of the hilar shadows. Another chest x-ray taken on February 26, showed mediastinal widening and was interpreted as a lymphoblastoma because of a negative tuberculin and coccidioidin tests. A biopsy of the right supraclavicular node showed granulation tissue with heavy infestation with coccidioides immitis. White blood counts done during February showed a cell count varying from 3400 to 12,000 and an eosinophilia of 6 per cent on one occasion. From March until July, the white count varied from 11,700 to 15,100, with no eosinophilia. On July 3, the white count was 15,500, polymorphonuclear cells 66 per cent, lymphocytes 15 per cent, and eosinophiles 19 per cent. Complement fixation test done by Dr. C. E. Smith of Stanford University in March was positive 1:64, and a third one was 1:256. Precipitin tests were negative. The patient was transferred to Percy Jones General Hospital on July 29, 1945. Examination revealed a markedly emaciated Negro, acutely ill, complaining of severe pain in his back and over both iliac bones. He had a fecal odor about him, even though he was not incontinent. He had fluctuant masses about 9x10 cm. in diameter over both sacro-iliac bones, over the right scapula and a somewhat smaller one over the left ninth rib anteriorly. There was a draining wound in the right supraclavicular area where a biopsy had been done four months earlier. There were many fine râles throughout the right chest. The abdomen was rigidly held so that examination was not satisfactory. Material from one of the fluctuant masses revealed a pure culture of coccidioides immitis. X-ray examination revealed no evidence of bone destruction until June 7, when a destructive process was noted in the left ninth rib in the anterior axillary line. On the 23rd of June, involvement of the crests of both iliac bones and left scapula was noted. The patient ran a low grade fever, complained bitterly of pain in the joints and abdomen, and died on August 6, 1945.

The autopsy showed draining sinuses originating in both clavicles, ribs and in the pelvic bones. Necrotic material could be scooped out of the iliac bones. There was also diffuse involvement of his lungs.

Discussion

These three cases illustrate the marked difference in the rate of progress of this disease. In Case 2 there were no symptoms until eight months after exposure. While his complaints were relatively mild, he had abundant objective evidence of cerebral involvement. His low complement titre and normal sedimentation rate suggested that the disease process progressed rather slowly. In contrast is the third patient who had evidence of disseminated coccidioidosis four months after the initial exposure and progressed on an inexorable course until he died of the disease ten months from the time of exposure. Case 1 represents a rate of progress that is intermediate between Cases 2 and 3.

Case 2 would also tend to corroborate the view of those who hold that re-infection is endogenous. Following his exposure in the Mojave Desert and the respiratory infection that followed, the patient left that endemic area for the battlefields of France. He was asymptomatic for eight months, at the end of which time he began complaining of headaches. During the asymptomatic interval, the only sources of re-infection were his own latent foci. That the patient might have had meningeal involvement even at the time he left the Mojave Desert, but that the process was very slow, is clinically not probable though it cannot be definitely excluded.

Mention has already been made of the manifold clinical forms of this disease. This is further illustrated by the three cases here reported. In each one the absence of coccidioidin skin sensitivity was accepted as evidence against disseminated coccidioidomycosis. Important as this test is in the

diagnosis of the primary form, it does not exclude the disseminated type; indeed, its very absence may be taken as evidence of dissemination, providing there is other collateral evidence of a coccidioidal infection. The presence of pulmonary cavitation and the persistent absence of tubercle bacilli in the sputum should guard one against a hasty diagnosis of tuberculosis. A careful search for coccidioidal spherules should be done. The presence of an eosinophilia during the course of an obscure ailment with fever in a patient who was in an endemic area should strongly suggest coccidioidomycosis. A positive complement fixation and preciptin test would be confirmatory.

In both Cases 1 and 2, we noticed spinal fluid leukocytosis, low spinal fluid sugar and a markedly increased protein. These findings are not specific for coccidioidomycosis, and have also been found in torulosis involving the meninges. We do wish to emphasize, however, the spinal fluid eosinophilia. Cases 1 and 2 showed it on several occasions, especially after we began looking for it. In only one other case report is this finding mentioned, but its possible clinical significance was not emphasized. In view of the granulomatous character of the meningitic lesion, one might expect spinal fluid eosinophilia in such infections as torulosis and blastomycosis of the meninges. A differential count of the spinal fluid may thus direct the clinician to a diagnosis of a meningeal granuloma.

Lymphoblastoma has at times been a stumbling block, especially in the primary type. Knowledge of recent exposure to a coccidioidal infection, a positive sputum, a positive coccidioidin skin test, rapid changes over a short period of time and the mediastinal appearance of the lesion, and biopsy, should aid in making the correct diagnosis.

There is considerable confusion in the literature in regard to the nomenclature of this disease. Dixon rightly suggested that a distinction be made between the primary and the disseminated type. In the primary type the respiratory tract is involved in varying degrees of severity. Other organs are involved only if dissemination occurs. It is therefore a paradox in terms to speak of primary meningeal coccidioidomycosis. If it is primary, it is not meningeal; and if it is meningeal, it is not primary.

The term coccidioidal granuloma has been used interchangeably with disseminated coccidioidomycosis. While it is true that all coccidioidal granulomas are of the disseminated type, not all types of disseminated coccidioidomycosis manifest themselves as granulomas. The necrotic character of disseminated coccidioidomycosis is well illustrated in Case 3 herein reported. We therefore suggest that the term "primary" and "disseminated" coccidioidomycosis be used and that the term granulomatous be used only if clinical manifestations warrant it.

Summary

1. Three cases of disseminated coccidioidomycosis are reported, two with cerebral involvement and one with widespread necrotic manifestations.

2. Eosinophilia of the spinal fluid is suggested as a possible diagnostic aid in diagnosis of meningeal granulomatous coccidioidomycosis.

3. The clinical mimicry of this disease of lymphoblastosis, tuberculosis and brain tumor is demonstrated.

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Annular Pancreas

Report of a Case

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ANNULAR PANCREAS is a developmental or congenital anomaly in which a firm ring of grossly recognizable and apparently normal pancreatic tissue completely encircles the descending or second portion of the duodenum and is continuous with the head of the pancreas, without demarcation. This anomaly frequently produces no symptoms, the presence of annular pancreas being an incidental finding at autopsy. In surgical cases recorded, the second portion of the duodenum embraced by the encircling pancreatic ring is constricted, causing clinically partial duodenal obstruction. Dilatation and hypertrophy of the proximal duodenum and frequently of the stomach will then result (Fig. 1).

Abnormal Anatomy

The annular process arises from the dorsal portion of the head of the pancreas where it is thickest (0.5 to 2.5 cm.) and widest (1.0 to 4.5 cm.). The ring progresses to the right of the greater curvature of the second portion of the duodenum, gradually tapering in dimension, crossing the anterior surface to fuse with the uncinate process.

The annular pancreas cannot be distinguished histologically from the normal pancreas, as it possesses islets of Langerhans, acinar glands and a duct system with a main channel and tributaries. The principal duct of the ring formation arises anteriorly and courses from left to right with increasing caliber, through the ring of pancreatic tissue surrounding the duodenum, to the head of the gland posteriorly, where it usually passes posterior to the common bile duct and opens into the main pancreatic duct of Wirsung (Fig. 1).

In some autopsy specimens the united annular and duct of Wirsung may have no connection with the dorsal anlage duct that drains the body and tail of the pancreas. The duct of Santorini remains intact and serves as the main pancreatic duct

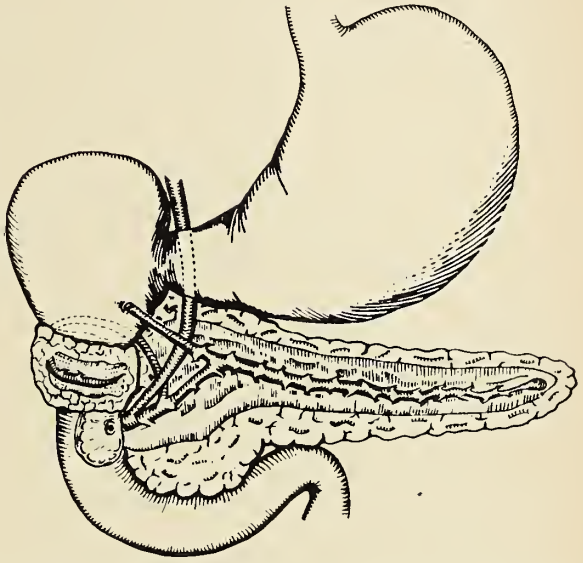


Fig. 1. Diagrammatic drawing of the more common findings in a case of annular pancreas. Note the large dilatation of the first portion of the duodenum with the ring portion encircling and constricting the second portion. The pancreas has been dissected to expose the duct system more commonly reported.

emptying into the duodenum at a normally situated papilla minor.[21] The duct of the annulus may empty into the common bile duct independent of either pancreatic duct.[8,27]

Embryology

Normally, two outpouchings from the entodermal lining of the duodenum can be noted in the human embryo of 3 to 4 mm. One bud pushes out from the dorsal wall into the dorsal mesentery just proximal to the hepatic diverticulum. This dorsal anlage grows across the body toward the left, until it reaches the spleen, giving rise to the body, tail and the ventral portion of the head of the adult gland.

The ventral pancreatic bud appears in the inferior angle between the gut and hepatic diverticulum and may be more or less bi-lobed, left and right. The ventral bud remains smaller and its short ventral duct is carried away from the duodenum by the lengthening common bile duct from which it then arises directly. Unequal growth of the duodenal wall, rotation of the stomach and duodenum with elongation of the bile duct to the

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right brings the ventral pancreas up into the dorsal mesentery to approach and ultimately fuse with the dorsal pancreas. The ventral pancreas then forms the dorsal portion of the head and more or less of the uncinate process of the pancreas. The tip of the ventral pancreatic duct unites and anastomoses with the main stem of the dorsal duct. This united duct is then known as the main pancreatic duct of Wirsung which empties into the duodenum at the ampulla of Vater, beside or in the common bile duct. The remaining proximal portion of the dorsal pancreatic duct may atrophy, but usually persists and opens into the duodenum above the ampulla of Vater and is recognized as the accessory pancreatic duct of Santorini.

The embryology or origin of the annular pancreas has been thoroughly discussed by McNaught,[21] Howard[15] and Cunningham.[8] These authors quote freely from the reports of earlier investigators, especially Lecco.[16] In summary, the annular ring of pancreatic tissue is a persistence of the left half of the ventral anlage. The tip remains fixed to the duodenal wall in an anterior position and becomes stretched around the right side of the duodenum upon migration of the remaining portion of the ventral pancreas.

McNaught[22] and Cunningham[8] describe a method of injection and visualizing the duct system in autopsy specimens and urge that all specimens be so studied and reported.

Incidence

In 1933, McNaught[21] compiled forty cases of annular pancreas, of which thirty-three were autopsy or anatomical reports and seven operative case reports. Since then there has been added to the literature an additional six autopsy and twenty-one operative case reports, for a total of sixty-seven cases.

Recently, Payne[24] in a surgical review of annular pancreas tabulated eighteen operative case reports. To this list should be added ten additional surgical cases: the single cases of Llorco,[19] Markowicz[20] and Haden,[14] three cases of Ravitch[25] and two each of Conroy[7] and Glover.[11]

Sex and Age Incidence.—Sex: Of the total sixty-seven surgical and autopsy cases reported, thirty-nine were males, fifteen females and no sex recorded in thirteen cases.

Age: In the reported surgical cases, seven were within the newborn period, one three and one-half years and the remainder were adults from nineteen to seventy-four years old.

Clinical Findings

In almost all twenty-eight cases submitted to surgery, the patient presented signs and symptoms of acute or chronic duodenal obstruction. This obstruction resulted from the annular pancreas causing constriction of the second portion of the duodenum, with pronounced dilatation in the first portion. Other associated lesions have been described: benign gastric ulcer on the lesser curvature,[1,3,9] chronic interstitial pancreatitis,[4,20] hemorrhagic pancreatitis,[2] duodenal ulcer,[7,19,20] obstructive jaundice,[4,25] and dilatation with hypertrophy of the stomach in ten cases. Cases reported in the newborn have frequently demonstrated other congenital anomalies[11,13,25] (third case).

X-Ray Examination

Upper gastrointestinal x-ray study was reported in twenty-one cases. All reports gave an impression of partial or complete duodenal obstruction of the second portion, and in fourteen cases an associated dilatation of the first portion. In four cases the proximal duodenum was so dilated that it was interpreted roentgenologically as the dilated pyloric end of the stomach[7**,15,23,25**]

The causes of the duodenal obstruction was variously ascribed to diverticulum,[7*,15,27,28] stenosing duodenal ulcer,[3,19,20,23] adhesions,[7**,30] malignancy,[9] aberrant vessels,[24] diaphragm,[25**] "congenital,"[5] atresia,[25***] possible annular pancreas,[4,25*] definite annular pancreas,[14,17] and unknown,[1,12,13]

Treatment

The surgical procedures available and used to alleviate the acute or chronic duodenal obstruction were three: (1) direct attack on the constricting ring, (2) a short-circuiting anastomosis around the obstruction, (3) a combination of the preceding two (Table I).

Direct Attack on the Constricting Ring.—In eight cases the constricting ring was either divided or resected. Four patients[12,14,17,24] had an uneventful recovery, but all have continued with a low-grade duodenal obstruction without further

*First case in reference cited.
**Second case in reference cited.
***Third case in reference cited.

TABLE I. CASES OF ANNULAR PANCREAS TREATED BY OPERATION

Ref. No.	Reported by	Sex Age	Operation	Result	Remarks
11	Glover and Barry, 1949, case seven	Female 5 wks.	Partial resection or division of the ring.	Recovery, but continued vomiting.	Re-exploration in 4 days, gastrojejunostomy gave relief.
12	Goldyne and Carlson, 1946	Male 26 yrs.	Same	Symptomatic cure.	Post-op. X-ray: Persistent gastric and duodenal residue.
14	Haden 1950	Male 3½ yrs.	Same	Recovery, but occasional complaint of abdominal pain.	Post-op. X-ray: Slight dilatation of first portion and partial persistence of the defect in the second portion of duodenum.
15	Howard 1930	Female 46 yrs.	Same	Recovery, pseudo-cyst developed.	Incision and drainage of pseudo-cyst.
17	Lehman 1942	Male 23 yrs.	Same	Recovery, but persistent symptoms of obstruction.	Post-op. X-ray: Persistent deformity of the duodenum.
18	Lerat 1908	Female 46 yrs.	Same	Recovery	Pancreatic fistula closed spontaneously.
24	Payne 1951	Male 32 yrs.	Same	Recovery, but developed ulcer symptoms.	Post-op. X-ray: Dilated second portion of duodenum with retention.
25	Ravitch and Woods, 1951, first case	Male 67 yrs.	Same	Recovery, but symptoms recurred.	Re-exploration revealed scar tissue over excised ring area causing obstruction. Ant. Duodenojejunostomy for relief.
7	Conroy and Woelfel, 1951, first case	Male 30 yrs.	Partial resection of the ring plus exploratory duodenotomy of the first portion.	Cured	Redundant portion of duodenum was resected.
4	Brown, Bingham, Cronk, 1948	Female 53 yrs.	Same	Died	Sub-diaphragmatic abscess, duodenal fistula. Post. gastroenterostomy on the 22nd post-op. day.
30	Zeck 1931	Female 31 yrs.	Partial resection of the ring plus Heincke-Mikulicz plastic enlargement of constricted duodenum.	Recovery	Small pancreatic fistula healed spontaneously.
5	Burger and Aldrich, 1949	Female 4 days	Same	Died, 9th post-op. day.	Developed bile stained wound drainage.
29	Vidal 1905	Male 3 days	Gastroenterostomy	Cured	Associated congenital atresia of duodenum.
28	Truelson, 1940 second case	Male 35 yrs.	Same	Cured	Included duodenotomy.
7	Conroy and Woelfel 1951, second case	Female 26 yrs.	Same	Cured	Developed intestinal sprue.
3	Brines 1931	Male 44 yrs.	Same	Died, 16th post-op. day of respiratory infection.	Annular pancreas first recognized at autopsy.
10	Dos Santos 1906	Female 26 yrs.	Same	Died, 9th post-op. day of respiratory infection.	Same.
26	Smetana 1928	Male 74 yrs.	Same	Died, immediately post-op.	Same.
2	Brines 1930	Male 35 yrs.	Exploratory laparotomy and drainage.	Died, immediately post-op.	Annular pancreas first recognized at autopsy. Marked hemoperitoneum and pancreatitis.
19	Llorca and Barrios 1950	Male 19 yrs.	Peon-Bilroth I gastric resection.	Recovered	Post-op. X-ray: Persistent narrowing of the duodenum.
25	Ravitch and Woods 1951, third case	Male 6 days	Gastroduodenotomy	Cured	Marked congenital deformities of viscera and mesenteries.
13	Gross and Chisholm 1944	Female 3 days	Duodenojejunostomy	Cured	Incomplete rotation of colon.
25	Ravitch and Woods 1951, second case	Female 3 days	Same	Cured	None.
11	Glover and Barry 1949	Female premature 2½ lbs.	Same plus division of ring.	Died, 4th post-op. day.	Stenosis of duodenum.
9	Custer and Waugh 1944	Male 74 yrs.	Sub-total gastric resection with gastrojejunostomy.	Cured	Associated benign gastric ulcer.
1	Baker and Wilhelm 1950	Male 59 yrs.	Same	Cured	Associated benign gastric ulcer.
23	Ohlmacher and Marshall, 1950	Male 27 yrs.	Same	Cured	Huge dilatation of the duodenum, pylorus and stomach.
20	Markovitz and Dionisi, 1950	Male 41 yrs.	Same (partial resection of ring.)	Cured	Associated perforating duodenal ulcer.
	Bailey and Bovill 1951	Male 26 yrs.	Same	Cured	Annular pancreas encircled both first and second portions of the duodenum.

treatment. In a five-week-old infant, dividing the encircling ring of pancreatic tissue failed to relieve the duodenal obstruction. It was necessary on the fourth postoperative day to re-explore and bypass the obstruction by gastrojejunostomy.[11] One patient[25]* developed a postoperative pancreatitis and obstruction due to fibrotic tissue replacement of the resected ring. This later required anterior duodenojejunostomy for relief of the obstruction. Another case[18] showed a transient pancreatic fistula that closed spontaneously. The remaining patient[15] developed a pseudocyst that required incision and drainage.

*First case in reference cited.

Resection of the Ring, Plus Exploratory Duodenotomy of the Proximal Portion Was Reported in Two Cases.—One patient healed without incident.[7*] In the second case[4] annular pancreas

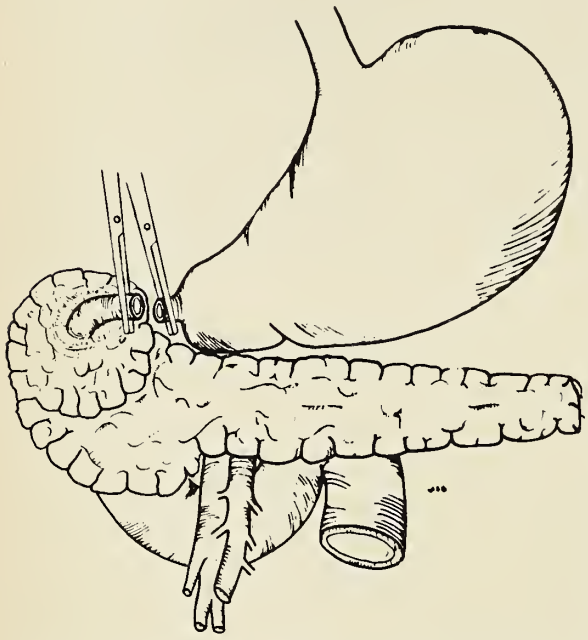


Fig. 2. Diagrammatic drawing of the case reported by the authors of an annular pancreas encircling the first and second portions of the duodenum. Note the hypoplastic duodenum uncovered by dissection of the pancreas.

was not recognized and cholecystectomy failed to give relief of her symptoms. Four weeks later, exploration revealed the annular pancreas, which was resected, plus duodenotomy and common duct exploration. On the twenty-second postoperative day a duodenal fistula was treated by posterior gastroenterostomy; the patient expired.

Resection of the Ring, Plus Plastic Enlargement of the Narrowed Duodenum.—Resection of the ring alone, in two cases, failed to relieve immediately the narrowed duodenum and a Heincke-Mikulicz plastic procedure was done. One case[30] healed without incident, except for a small pancreatic fistula that closed in a few days; while the second,[5] a newborn, developed a bile-stained wound drainage and expired on the ninth postoperative day.

Short-Circuiting Anastomosis.—Short-circuiting anastomosis around the duodenal obstruction has been accomplished by either a (1) gastrojejunostomy, with or without gastric resection, (2) duodenojejunostomy, or (3) duodenogastrostomy.

Gastrojejunostomy Was Employed in Six Cases.—The first surgical case recorded (Vidal[25] in 1905) in a newborn infant, with an associated atresia of the duodenum, was successfully treated by gastroenterostomy. Two additional successful cases in adults are noted.[7**,28]

Respiratory infection resulted in death in two cases,[3,10] while another died immediately postoperatively.[26]

Subtotal Gastric Resection.—This procedure was done in four cases, by Custer[9] and Baker[1] because of an associated benign gastric ulcer; by Markovitz[20] for a perforating duodenal ulcer on the posterior wall; by Ohlmacher[23] because there was a huge dilatation of the duodenum, pylorus and stomach. Baker included a duodenojejunostomy, while Markovitz also resected the annular ring. All four patients responded without complication. Llorca[19] was completing a Peon-Bilroth I procedure when the annular pancreas with marked duodenal constriction was noted. No other procedure was done. Postoperatively, x-ray showed a persistent narrowing at the level of the second portion of the duodenum without a clinical manifestation.

Gastroduodenostomy.—Gastroduodenostomy was elected by Ravitch[25] in a newborn (third case) because of marked congenital deformity of the position and mesenteries of the abdominal viscera. The patient responded without complication.

Duodenojejunostomy. — Duodenojejunostomy was performed by Gross[13] and Ravitch[25**] in newborns, with excellent results. A 2½-pound premature infant with annular pancreas and duodenal stenosis died the fourth postoperative day following dividing the ring and duodenojejunostomy.[11]

Case Report

J.M.P., a twenty-six-year-old white man, single, was admitted to the Veterans Administration Hospital, Bay Pines, Florida, on September 22, 1950. He gave a history that he had received a medical survey and discharge in July, 1945, from the U. S. Navy, for "stomach trouble." Since discharge from service, the patient had

*First case in reference cited.

**Second case in reference cited.

not been on any medical therapy except a bland diet. The present illness began about five weeks prior to admission, when he noted loss of appetite, "gas pains," "bloatedness" and mild epigastric pain, all relieved by vomiting. On three occasions he vomited a small amount of blood, associated with transient melena. Past history was insignificant, and failed to reveal any childhood abdominal complaints or feeding problems.

Physical examination revealed an undernourished male, weighing 134 pounds. The examination was essentially negative. The gastric analysis showed a free HCl of 51° and a total acidity of 68.5°. X-ray examination revealed a narrowing of the post-bulbar segment of duodenum associated with spasm of the duodenal cap. At six hours there was gastric retention. Findings conform with a diagnosis of partial obstruction of the post-bulbar area of duodenum (Fig. 3). Gastroscopic examination was negative.

Course in the Hospital.—The patient was placed on conservative medical management. Overnight gastric drainage varied from 1,000 to 4,000 cc. The patient was transferred to the Surgical Service with the diagnosis of pyloric obstruction, probably due to cicatricial changes secondary to a duodenal ulcer.

The patient was operated upon on November 13, 1950. Exploration revealed the gall bladder and the porta hepatis obscured by a fold of peritoneum that extended from the liver edge to the lesser omentum and the hepatic flexure of the colon. This abnormal fold of peritoneum was incised along with the gastrocolic and gastrohepatic ligaments. The pylorus ended in the center of a mass of grossly recognizable pancreatic tissue that completely surrounded the duodenum. This pancreatic mass was continuous with or a part of the head of the pancreas. The neck, body and tail of the pancreas were normal in size and position. The pancreatic mass was dissected from the duodenum for a distance of 3 cm. distal to the pylorus. Further exposure of this area was not done as the location of the terminal biliary and pancreatic ducts was unknown. The duodenum exposed by dissection was small, being 1.3 cm. in external diameter and 0.7 cm. internal diameter (Fig. 2). Further exploration revealed this mass to encircle the first and second portions of the duodenum. The pancreatic mass was then recognized as an annular pancreas which was encircling and constricting the first and second portions of the duodenum and producing obstruction of the duodenum at the pylorus. A sub-total gastric resection was then accomplished by an anterior Polya-Hoffmeister procedure. The patient made an uneventful postoperative recovery and was discharged November 27, 1950.

Discussion

The case presented differed anatomically from annular pancreas as defined; the ring of pancreatic tissue encircled the first and second portions of the duodenum. In addition, the proximal portion of the duodenum exposed by dissection from the pancreas was hypoplastic. There were present abnormal peritoneal folds which obscured the hepatico-duodenal area. It was only after incising these folds that the duodenum with the encircling pancreatic tissue could be visualized. A review of cases presented in the literature reveals a frequent nota-



Fig. 3. X-ray showing the dilated stomach with retention.

tion of similar folds or adhesions. When fusion folds of peritoneum are encountered in this area, one should be cognizant that associated congenital anomalies of the gastrointestinal tract may be present. Six cases of annular pancreas[2,3,10,21,23,26] were not recognized at surgical exploration and were later demonstrated at autopsy.

The seven cases reported in the newborn demonstrated that annular pancreas must be considered in the causes of duodenal obstruction. It has been found singular or associated with other anomalies of the gastrointestinal tract.

Gross stated that duodenojejunostomy is the procedure of choice in the surgical treatment of duodenal obstruction caused by annular pancreas

as "it completely relieves the duodenal obstruction, does not interfere in any way with the gastric function and does not possess any of the hazards of cutting the pancreatic ring with its attendant danger of fistula, et cetera." This agrees with the conclusions stated by Howard, Lehman and Zeck. Gastroenterostomy alone and subtotal gastric resection have given good results. Following the use of these by-passing procedures, one may conclude that there was adequate drainage of the proximal loop, otherwise, complications would have resulted from acute or chronic duodenal stasis.

Summary

A case of annular pancreas that encircled the first and second portions of the duodenum, causing duodenal obstruction, and treated successfully by subtotal gastric resection, is presented. There was associated a marked hypoplasia of the first portion of the duodenum. Twenty-eight other cases of surgically treated annular pancreas have been reviewed and the treatment discussed.

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BRITISH MEDICAL PLAN SLIDING DOWNHILL

The once-famous and highly tooted British health plan is running into more trouble.

Newspapers reported recently that Churchill's government has introduced legislation to cut the cost of Britain's socialized medicine scheme by 21 million pounds or $58,800,000 a year.

The cut is being accomplished by sharply modifying the "free" provisions of the service. Under new provisions patients will have to pay.

The bill seeks to impose a charge of one pound ($2.80) for a course of dental treatment. A shilling (14 cents) charge will be imposed for drugs supplied through hospital outpatient departments.

Before going out of office last fall, the Labor party, which gave birth to the socialized medicine scheme, made the first big modification in the plan. The Laborites required patients to assume half the cost of false teeth and spectacles. Now patients also will have to pay half the cost of such items as wigs, hearing aids, surgical boots and elastic stockings if the bill goes through. And the Conservatives, with a majority of fourteen, are expected to push it through.

The New Versus the Old in the Treatment of Syphilis

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IT HAS NOW been about eight years since Mahoney, Arnold and Harris treated the first four syphilitic patients with penicillin. Shortly thereafter a systematic study of the treatment of early syphilis by penicillin alone and in combination with other agents, such as fever, arsenicals and bismuth was inaugurated under the auspices of the Penicillin Panel of the Subcommittee of Venereal Diseases of the National Research Council. According to Chairman Moore, "This drug proved to be effective in syphilis in 1943, had been adopted by the U. S. Armed Forces by late 1944, and was in sufficient supply to become a factor in civilian life by 1946."

In 1944, it was my privilege to present at this meeting some of the early results at the Chicago Intensive Treatment Center under the auspices of Dr. Herman N. Bundesen, president of the Chicago Board of Health. I would like now to survey the worldwide over-all picture since the advent of penicillin, to present the individual and collective advantages of this and other antibiotic therapy, and to call attention to the disadvantages, if any.

First of all, it is appropriate to reiterate the statement of Thomas: ". . . while modern treatment of syphilis is becoming relatively simple, the disease itself continues to be extremely complex and treacherous. Many problems in syphilis remain unsolved, and we do not yet have an adequate understanding of the disease." In the old syphilology, not only was the disease itself complex and treacherous, but so was the treatment; hence, prolonged special training was necessary and constant vigil during treatment was imperative. We should not permit ourselves to be lulled into a false sense of security because of the relative simplicity and safety of treatment when we cannot even culture a virulent Treponema pallidum.

Administration of Penicillin

The early water-soluble crude penicillin had to be given every few hours around the clock, which necessitated hospitalization. The dose and dosage have been constantly increased so that there is a lag between administration of the drug and publication of treatment results. Cohn et al stated that it is best to administer a surplus amount of the drug. Purification of the product along with introduction of material which slowed absorption has decreased the necessary frequency of injection. The drug of choice at the moment is penicillin procaine in oil with aluminum monostearate (PAM), which is injected intramuscularly in doses up to 2.4 million units. At the Chicago Intensive Treatment Center, Rodriquez et al treated seventy-one patients with darkfield-positive early syphilis by a single injection of 2.4 million units of this material, 4 cc. being given into each buttock. All patients showed adequate blood levels of penicillin for four days. The percentage of satisfactory levels gradually decreased on subsequent days, but, even on the eleventh day, 3 per cent showed such levels. This decreasing level may be fortified according to the recommendation of Curtis et al of four additional injections of 600,000 units every four days. Penicillin is the first antisyphilitic drug that can be administered with impunity all the way from pediatric through geriatric practice. It is well tolerated by normal individuals, and has been given to nephritics by Merklen et al and Baliera et al with no untoward effects. In addition to the usual method of administration by intramuscular injection, it can also be given orally. Buerk and Tucker treated a hemophiliac by 500,000 units every two hours for a total of 48.0 million units in eight days. The Syphilis Study Section of the National Institute of Health stated that five times as much must be given by mouth as intramuscularly. Robinson and Robinson were disappointed by results of oral administration of 100,000 units of penicillin three times daily in buffered tablets to pregnant women with early syphilis. This dose is much smaller than proposed in the aforementioned recommendation.

Reactions to Penicillin

Reactions to penicillin, infrequent and, for the most part, inconsequential, have decreased in the last four years, largely as a result of purification and chemical alteration of the drug. Penicillin in oil and beeswax produced local urticarial reactions in almost everyone. With PAM, local reactions are negligible. Systemic urticarial eruptions have been experienced from most forms of penicillin,

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less commonly from PAM, usually mild in degree, and ordinarily respond to antihistaminies. More stubborn outbreaks may be relieved by adrenaline or epinephrine, cortisone or ACTH. Other reactions appear in the form of erythematous, vesicular, desquamating eruption, serum-sickness-like eruption, eczema from epidermal allergy, and anaphylactic shock. The last named was recently reported by Everett following instillation of penicillin into the maxillary sinuses. These reactions are treated by the means just mentioned, along with appropriate local measures.

Herxheimer reactions are common in early syphilis. Moore, Jr., et al reported 39 per cent in patients with seronegative primary syphilis and 43 per cent in seropositive primary syphilis, and in 74 per cent of paretic patients. Putkonen and Rehtijärvi observed such a complication in fifteen of sixteen patients with primary syphilis and forty-nine of fifty-five with secondary syphilis. In congenital syphilis, all but one of the early cases showed intense febrile reaction. The temperature rises at the earliest in four hours after the first injection, reaches its maximum usually after six to ten hours and returns to normal within twenty-four hours. Such a reaction does not contraindicate further treatment by penicillin. Kadison et al recently reported on P-92 penicillin, a salt of 1,2, diphenyl-2methylaminoethanol, which produced as good therapeutic results but fewer reactions than did procaine penicillin. In penicillin intolerance, as shown by positive intradermal or patch test, Thomas suggested substitution of aureomycin, 4 gm. daily, for ten to fourteen days.

Resistance to Penicillin

In contrast to the well-known treponemal resistance to arsenical therapy in some patients, Guthe and Reynolds stated that there is no important evidence of treponemal resistance to penicillin. However, Boak and Carpenter noted a wide variation in sensitivity of five strains of Treponema pallidum in animals. Arnold found one batch of penicillin G to be twice as efficacious as the average in treatment of rabbit syphilis.

Prophylaxis

During the early arsenical era, prophylaetic and abortive treatments of early syphilis were practiced. Later, because of relapses, the prevailing opinion was that, after exposure, therapy should not be administered until the appearance of definite signs of the disease. My own preference was for administration of an arsenical if the patient was seen within forty-eight hours after exposure. After a longer period, the individual was merely observed. Of course, all exposed persons, whether treated or not, must be watched for several months. Alexander and Schoch believe that exposed individuals should be treated. They reported results of administration to 148 persons who had been exposed to infectious individuals of 900,000 units of penicillin, 3.0 cc. of bismuth ethylcamphorate and 0.05 to 0.06 gm. oxophenarsine hydrochloride, all given at one visit. Only six of the 148 persons developed syphilis, in contrast to 100 of 161 individuals similarly exposed but not treated. Curtis et al stated: "Thus it is now possible to treat successfully primary and secondary syphilis patients as well as persons exposed to infectious syphilis with a single injection of 2.4 million units of penicillin procaine with aluminum monostearate at a single clinic or office visit."

Treatment of Early Syphilis

Thomas stated that the treatment of early syphilis should be completed in not less than four days and not more than eight days. Curtis et al recommended an initial dose of 2.4 million units, followed by four injections of 600,000 units every four days, for a total of thirteen days. They advised repetition of the course in six to eight weeks if results are unsatisfactory. Robinson and Robinson gave penicillin at weekly intervals for thirty-five weeks, and only 18.6 per cent of forty-three patients completed the course, even though treatment was free, surely a potent argument for shorter courses. For true relapse, Thomas suggests giving double the initial amount of penicillin.

Because of rapid and pronounced alteration in the titer of serologic tests during and following therapy by penicillin, quantitative techniques are more necessary than with older treatments, and are now considered indispensable.

As with the older methods of treatment, results from penicillin vary with the stage of the disease. Rodriquez et al obtained 100 per cent of apparent cures in sero-negative primary syphilis, 78.9 per cent in sero-positive primary and 53.4 per cent in secondary syphilis from a single dose of 2.4 million units. Moore called attention to the as yet irreversible 10 per cent of failures in early syphilis. He emphasized, as have Thomas and Landy, that fewer relapses and reinfections oc-

curred after prolonged arsenic and bismuth treatment than following penicillin, but believe that these advantages are more than counter-balanced by better control of the disease with rapid treatment by penicillin. Curtis et al reported 95 per cent success in early syphilis, a figure that was lowered to 90 per cent by relapses.

Treatment of Late Syphilis

Curtis et al recommend administration of 600,000 units daily or twice weekly for a total of 6.0 million units for treatment of late syphilis, including cutaneous, mucosal and visceral complications. In cutaneous and mucosal syphilis, penicillin does double duty in destroying both treponemes and secondary invaders.

Relative to cardiovascular syphilis, Barnett and Small concluded that antisyphilitic treatment probably improves the prognosis to some extent at any stage, but best results are obtained before the onset of symptoms, and penicillin is progressively less useful as the disease progresses. The dreaded therapeutic paradox in cardiovascular and hepatic involvement is not feared as much as previously. Webster et al stated that risk of therapeutic paradox has been overrated, and Moore stated that risk of therapeutic paradox in the course of penicillin treatment is minimal. Wheeler and Curtis stated: "There can be found in the literature no certain evidence of harmful results from penicillin treatment of cardiovascular syphilis." They reported that no convincing evidence of adverse effect in the form of the Herxheimer reaction or therapeutic paradox was observed in 21 previously untreated patients with cardiovascular syphilis to whom they gave penicillin. They concluded that preparation with iodides and bismuth is unnecessary. Lees, however, has seen therapeutic paradox in cardiovascular syphilis and suggests such preparation. Whorton and Denham reported sudden death on the fifth hospital day of a twenty-seven-year-old Negress with gummatous syphilitic aortitis. Penicillin was started in dose of 140,000 units every three hours. She died suddenly twenty-seven hours after treatment was started and she had received 1,400,000 units. Anatomic diagnoses were gummatous syphilitic aortitis with acute inflammation consistent with the Jarisch-Herxheimer reaction, pulmonary embolism and others. Preparation with bismuth and iodides might not have saved her life, but the necessary time would certainly not jeopardize the beneficial action of penicillin.

Curtis et al emphasized that compensation must be restored before penicillin therapy for cardiovascular syphilis. After this has been accomplished, 600,000 units are given twice weekly for five weeks, for a total of 6.0 million units. Webster et al gave 300,000 units daily for fourteen days and semiweekly for ten weeks, for a total of 10.2 million units. This is more in line with the belief of Bruetsch that, because of the extreme resistance of the syphilitic exudate in the wall of the aorta, 25.0 million units may be necessary.

Nicol and Terry treated a man with gummatous hepatitis and ascites. Malignancy had been ruled out by laparotomy. They gave 10,000 units of aqueous sodium penicillin intramuscularly every three hours for four days and 20,000 units every three hours for eighteen days. Diuresis commenced within forty-eight hours and reached a maximum of 4.450 liters on the ninth day. Edema and ascites disappeared by the fourteenth day. The patient still had slight ascites some months later. This dramatic result contrasts favorably to the slow response to prolonged iodide and bismuth therapy of the past. However, the residual ascites could conceivably have resulted from too rapid resolution of the gummatous process.

Treatment of Neurosyphilis

Woltman and Kierland recommended reduced doses of penicillin at the start of treatment in general paresis, optic atrophy and gumma of the central nervous system. They also advised a single course of fever treatment in case clinical improvement is not obtained. The penicillin course should be repeated if improvement is not seen in four to six months after treatment. Ingraham et al reported on 603 patients who received penicillin alone. They believe that the maximum sustained response is reached in from one to two years earlier when penicillin is used as compared with metal chemotherapy and fever.

Curtis et al reported on 430 patients. They concluded that penicillin alone is adequate for all types of neurosyphilis except possibly severe paresis and primary optic atrophy. Curtis et al recommended 600,000 units of PAM daily or twice weekly for a total of 6.0 to 12.0 million units. Malaria therapy may be advisable if results from penicillin are unsatisfactory. Bruetsch believes that

10.0 million units has the same effect as a course of malaria. Occasional persistence of a few treponemes in the brain suggests to him that perhaps 15.0 million units would be better in general paresis.

Smith and de Morais reported autopsy findings on four patients with general paresis who had died after receiving 2.4 to 4.8 million units of penicillin. Two had improved clinically and serologically. Their brains showed less inflammation and no treponemes were found, findings similar to those following malaria. The two unimproved patients had had juvenile paresis with rapid deterioration. Their brains showed no decrease in inflammation, but no treponemes were found. Gammon et al reported autopsy findings in seven patients with neurosyphilis. One died three weeks after treatment and showed the usual signs of the disease. Evidence obtained from the other six suggested that penicillin had cleared the infection.

Treatment During Pregnancy

Goodwin and Streeter stated that syphilitic women previously treated do not need to be retreated during pregnancy, provided that (1) at least 4.0 gm. arsphenamine and concomitant bismuth have been given, or (2) 2.4 million or more units of penicillin have been given, (3) she shows no sign of active syphilitic infection, (4) serologic test is negative or only weakly positive.

Ingraham reported 98 per cent success in treating pregnant women with 2.4 million units of soluble penicillin or 4.8 million units of delayed absorption penicillin. He stated that failures were due to starting treatment too late in pregnancy or to the mother's poor response to the drug. Shaffer and Courville reported on 631 pregnant syphilitic women. They attributed the 1.1 per cent of failures to relapse or reinfection late in pregnancy in women who failed to remain under observation. Curtis et al recommend 4.8 million units. In the first two trimesters, 600,000 units are given twice weekly or 1.2 million weekly. In the third trimester, 600,000 units are given daily. If labor is imminent, 2.4 million units are given at one time, to be repeated in one week if not yet delivered. For the pregnant woman with relapsing early syphilis, 900,000 units are given weekly for four weeks. Rosahn discussed the interesting fact that syphilis in the fetus is cured by fetal tissue concentrations lower than those in the mother.

Treatment of Congenital Syphilis

Nicol stated that penicillin is more effective in early congenital syphilis than in any other phase of the disease. Results are 100 per cent satisfactory provided the child is not marasmic, in which case general medical care is most important. Ingraham stated that the younger the person, the better the results from penicillin. In early prenatal syphilis (less than two years of age), Curtis et al recommended 10,000 units per pound of body weight daily for 10 days, or 15,000 units per pound twice weekly for four weeks or 40,000 units per pound weekly for four weeks. In late prenatal syphilis (over two years of age), 600,000 units are given daily or twice weekly for a total of 6.0 million units. For treatment of interstitial keratitis, Simpson et al instilled two drops of cortisone acetate in a 1:4 dilution with normal saline in each eye hourly from 6:00 a.m. to 10:00 p.m. for ten days. In addition, 600,000 units of PAM were given daily for twelve days. Of the nine patients treated, all but one had some beneficial results.

Geriatrics

For syphilitic patients over sixty years of age, Thewlis and Gale recommended a two weeks' preparation by potassium iodide and bismuth followed by procain penicillin, 300,000 to 500,000 units daily for a total of 5.0 to 8.0 million units in eight weeks. They also suggest supportive measures, such as a well-balanced diet, vitamins B, P, and C, and liver preparations.

Public Health Control

Guthe and Reynolds stated that in five years after World War II, the lowest level of incidence of syphilis in Scandinavian countries had been practically reached, a level that required twenty to twenty-five years after World War I. Thomas and Landry and Moore believe that increased relapse and reinfection rates following penicillin as contrasted to arsenic and bismuth are more than counterbalanced by the more rapid and better public health control of the disease by penicillin.

The efficient State Board of Health Control, carried out for many years in Minnesota by Dr. Harry Irvine, and in other states, has become nationwide. According to Sklar and Schuman, for the past twelve years, the Illinois State Department of Public Health has used special contact investigation procedure with private physi-

cians to obtain contact information from patients with early syphilis or gonorrhea. For each 100 patients interviewed, 41.6 contacts were found and examined. An average of 234 new patients, including eighty-five who had primary or secondary syphilis and 127 who had gonorrhea, were found each year. Premarital and prenatal blood tests, required by most states, and pre-employment blood tests in industry have been valuable in finding infected persons.

A recent report on the syphilis rate in Chicago selectees examined during 1950 showed a decline of 51 per cent for whites and 64 per cent for Negroes as contrasted to those examined in 1940-1941.

That syphilis is by no means controlled is shown by Aufranc's statement that in 1949:

1. It infected 150,000 persons, 80,000 of whom were undiscovered.
2. It sent 6,000 persons to mental institutions.
3. Its causative organism entered the blood stream of 14,000 innocent children.
4. It killed 13,000 people.
5. An estimated 3,000,000 persons in the United States would have had positive reactions if blood tests had been given to the entire population of the United States.

However, on the opposite side of the ledger is:

1. In 1949, infant mortality from syphilis was about one-fifth the rate for 1938.
2. Syphilis mortality has been reduced 48 per cent.
3. Admission to mental institutions because of syphilis have been reduced 34 per cent.
4. The reported attack rate of syphilis has decreased consistently for the past three and one-half years.

As occurs after all wars, early syphilis was declining in frequency before the advent of penicillin, the role of which in the further decline is stated by Moore as follows: "The effect of penicillin in possible further acceleration in incidence decline cannot yet be measured. At least another decade of experience is essential."

Guy reported that, in 1946, 721 cases of primary and secondary syphilis were reported to the Pittsburgh Syphilis Control Program, in 1948 there were 493 and, for the first five months of 1950, only 29. Epstein stated that, at the Marine Hospital in San Francisco, in the years 1946 and 1947, 200 to 250 patients were seen annually with primary and secondary syphilis. For the first quarter of 1950, there were only 20. Robinson and Robinson, on the other hand, believe that the decline has been merely normal for a post-war period, and that the present incidence in Baltimore is normal.

One of the burning problems of syphilology, as emphasized by Moore, in the public health effort against the disease, is elimination, if possible, of the so far irreducible 10 per cent of persons with early syphilis who are not cured by penicillin. In the United States the tendency is to re-treat with penicillin or aureomycin, while in other countries the use of arsenicals and bismuth is recommended. Marshall believes that arsenic and bismuth give the best results, and emphasizes the value of British antilewisite (BAL) in treatment of arsenical dermatitis. Differences of opinion may be attributable to the greater experience with antibiotic therapy in this country, coupled with the fact that better control over the populace in some foreign countries insures completion of longer metal therapy courses such as could not be attained in the United States.

No drug or combination of drugs has ever been found to be 100 per cent efficient. As regards penicillin, variation in human blood level, variation in potency in batches of penicillin and varying susceptibility to the drug on the part of spirochaetes have already been briefly mentioned. Combinations of antibiotics, as reported by Romansky and others, for treatment of infection produced by antibiotic-resistant organisms have not been tried extensively in syphilotherapy. Moore stated that no infectious disease in the history of medicine has been eradicated or even controlled by the sole process of treatment of infected persons. Immunologic control may sometime be possible if abundant virulent treponemal organisms can be cultured.

For co-operative private patients who have failed to respond to penicillin therapy for early syphilis, there seems to be no good reason why the prolonged arsenic-bismuth treatment, which was efficacious in the past, could not be administered with proper precautions.

Other Antibiotics

In addition to penicillin, other antibiotics have been found to be effective in the treatment of syphilis. O'Leary et al reported beneficial effect

of aureomycin in a patient with primary and one with secondary syphilis. Clinical and serologic results were satisfactory. One year later they reported satisfactory results in treatment of two patients with late cutaneous syphilis, and the following year Kierland and O'Leary reported good results in neurosyphilis. They believe that oral therapy may have some advantages over injections. Willcox believes that aureomycin may be valuable in prophylaxis against syphilis. Thomas recommended aureomycin for patients who are allergic to penicillin or fail to respond to it.

The next antibiotic that was used in syphilotherapy was chloramphenicol (chloromycetin), as reported by Smadel et al primarily on treatment of gonorrhea. However, they gave the drug to two patients with primary syphilis. There was a definite effect, but the action was slower than that of penicillin. Hendricks et al treated four patients with early syphilis by means of terramycin. There was a definite clinical result, but the patients experienced nausea, vomiting and diarrhea. Robinson and Robinson treated patients with early syphilis by penicillin, chloramphenicol, aureomycin, both intravenously and orally, and terramycin. They maintain that patients taking a drug by mouth must be hospitalized to make sure they receive it regularly. Chloramphenicol, aureomycin and terramycin were effective, but should be studied further.

Summary

Penicillin is a safe, inexpensive, rapid and efficacious treatment for early syphilis.

Superior results of arsenic-bismuth combination are counterbalanced by the danger to life and failure of many patients to complete the long course. However, BAL has decreased the danger of arsenical poisoning.

Quick cure by penicillin clears the path for reinfection.

Penicillin treatment for late syphilis is efficacious. Damaged parenchyma cannot be replaced.

High doses of penicillin are necessary for treatment of general paresis and cardiovascular syphilis.

Short preparation by bismuth and iodides may be of assistance in visceral syphilis, neurosyphilis and even late or recurrent secondary syphilis. Reduced initial doses of penicillin may accomplish the same result.

In addition to rapid public health treatment of infectious syphilis by penicillin, better search for contacts, pre-employment, premarital and prenatal blood tests have been of assistance in the control of early and prenatal syphilis.

Prophylactic treatment of exposed persons by a single large dose of penicillin (1.2 to 2.4 million units) is recommended.

Penicillin seems to have accelerated the postwar decrease in the incidence of early syphilis.

Penicillin-arsenic-bismuth treatment for cooperative private patients might help to reduce the 10 per cent failures following rapid treatment by penicillin alone.

Aureomycin, chloramphenicol and terramycin are efficacious in the therapy of syphilis, but further study is necessary to determine their value.

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INCOME TAX INEQUALITIES

Here are some examples of the absurd inequities that have evolved in our tax structure. Today a husband, wife and two dependents pay $72 on a gross income of $3,000. Similarly circumstanced, a worker with the ability and industry to earn $6,000, twice the income, pays a tax of $666, nine and one-quarter times as much! And any wretch who had the temerity to earn three times that amount, or $9,000, pays eighteen times as much income tax, or $1,306!—B. E. Hutchinson.

TAX REVOLUTION

The Constitution provides, Article I, Section 8: The Congress shall have power to lay and collect taxes, duties, imposts, and excises, to pay the debts and provide for the common defense and general welfare of the United States; but all duties, imposts and excises shall be uniform throughout the United States.

The ratification in 1913 of the *Sixteenth Amendment* providing that "the Congress shall have power to lay and collect taxes on incomes, from whatever source derived, without apportionment among the several states, and without regard to any census or enumeration" changed fundamentally the basis and character of our government. By permitting flagrantly discriminatory taxation as between citizens it undercut the sanctity of the right of all citizens to own private property. Men now enjoy the fruits of their own labor only to the extent decreed by Congress. There is no limitation in law or in equity.

Representations were made at the time that the discrimination would be nominal. The mere mention that it might amount to as much as five per cent was considered shocking! *Only a few then were vaguely apprehensive of what has been amply demonstrated since, that the delegation to our federal government of the power so to discriminate in imposing the tax burden was an open invitation to demogoguery of which full advantage would be taken.*—B. E. Hutchinson, Annual Meeting, Chamber of Commerce of U. S. A., April 29, 1952.

Constitutional Anomalies in Recalcitrant Trichophyton Purpureum Infections

By Stephen Rothman, M.D.
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RECALCITRANT INFECTIONS of the skin and nails with the filamentous fungus trichophyton purpureum are well known to all dermatologists. Particularly common is the intractable infection of palms, soles, fingernails and toenails. This infection has a few peculiarities which are entirely unexplained. The first peculiarity is that although the localization on palms and fingernails gives plenty of opportunity for transfer from one person to the other, such transfer within the family, in the plant, in school, et cetera, has never been recorded. This indicates that possibly some individual disposition is required for the take of this infection. The second peculiarity is that the infection often remains remarkably localized, for instance, to some of the nail plates, whereas other nail plates remain unaffected even after the onychomycosis has persisted for years or decades. Even more conspicuous is the unilateral involvement of one palm for years and decades without involvement of the other palm (Table I). In the material here presented we had thirteen cases with palmar involvement, out of which six were unilateral. In five patients the right palm was involved and in only one was the left palm involved. We inquired if this man is left-handed but he is not. Still, the great prevalence of right palm involvement suggests that, in general, the greater use of right hand involving more intense sweat secretion may be one factor. Kuno pointed out that on palms and soles sweat is most abundant in those areas where mechanical stimulation, particularly pressure, is habitual.

TABLE I. UNILATERAL PALM INVOLVEMENT IN SIX OUT OF THIRTEEN CASES

Name	Sex	Age	Site	Handed
E.L.	M	24	Right palm	Right
H.O.	M	44	Left palm	Right
V.P.	F	23	Right palm	Right
W.C.	M	38	Right palm	Right
I.M.	F	61	Right palm	Right
E.S.	F	29	Right palm	Right

Also the affinity of t. purpureum to palmar skin as contrasted with t. gypseum is remarkable. All palmar mycoses I saw in thirteen years at the University of Chicago Clinics were caused by t. purpureum and none of them by t. gypseum.

In any case, it is clear that, in addition to individual susceptibility factors, also regional or local susceptibility factors must be in operation.

Individual and regional susceptibility factors have been traced in many fungus diseases, the best known example being the intertriginous moniliasis or candida albicans infections of diabetics. However, the t. purpureum infections have one more peculiarity which is unique. These fungi can be inhibited in the test tube by fungistatic agents with the same ease or easier than other filamentous fungi, but *in vivo* they are much more resistant to the same fungistatic agent than the others. Clinically entirely analogous t. gypseum infections of the soles, for instance, respond very satisfactorily to treatment with tincture of iodine, sulfur-salicylic ointments, fatty acid preparations, or to more modern compounds such as the salicylanilid-undecylenic acid combination, asterol, et cetera. With most of these preparations and in most cases clinical cure of the soles can be achieved within two weeks so that the patient is completely free of signs and symptoms if the causative agent is t. gypseum. Nothing like that can be achieved in cases of t. purpureum. The best illustration of how intractable these infections are is that the average duration in our material composing twenty cases has been around five years. The majority of our patients consulted a great number of expert dermatologists and tried practically all available fungistatic agents before they came to our clinic, usually with a most virulent infection. Nevertheless, fungi could be demonstrated microscopically and culturally in 100 per cent of the horny fragments which were taken from skin and nails in these patients.

This contradictory behavior of t. purpureum *in vitro* and *in vivo* remains to be elucidated.

I became interested in this problem five years ago when seeing a patient with unusually widespread t. purpureum infection of the neck, trunk, and extremities of two years' duration. The clinical picture was unusual. In addition to tinea circinata lesions, there were papules and eczematiform

From the Section of Dermatology, Department of Medicine, University of Chicago.

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TABLE II. GLUCOSE TOLERANCE TEST IN TWENTY PATIENTS WITH RECALCITRANT T. PURPUREUM INFECTION

Name	Sex	Age	Glucose Tolerance		BMR	Remarks
			On Oral Testing	On I.V. Testing		
H.S.	M	37	increased	increased	−11	
O.A.	M	22	borderline	normal	−19	
E.F.	F	45	increased	—	+6	
J.W.	M	40	normal	—	+12	42 mg. % 2 hour value in oral tests
E.R.	M	24	increased	normal	−9	
O.B.	M	44	normal	—	—	
M.F.	F	41	increased	lower border of normal	−4	
C.A.	M	41	increased	lower border or normal	+9	
W.C.	M	38	normal	—	−8	
C.G.	F	44	borderline	—	+13	
S.W.	M	28	borderline	—	−1	
S.B.	M	48	normal	—	−17	
V.P.	F	23	increased	—	—	
E.L.	M	24	normal	—	+4	
M.W.	M	48	slightly elevated	—	−4	
S.K.	M	28	increased	increased	0	
E.B.	M	24	borderline	—	—	
L.W.	F	19	normal	—	−7	
E.S.	F	29	increased	—	−18	
E.H.	M	55	borderline	—	—	

"Increased" oral tolerance=peak value 105 mg. % or less.
"Borderline" oral tolerance=peak value 122 mg. % or less.

crusted lesions, as described in the older literature under the name "eczema trichophyticum"; such lesions are known to occur when the patient has a high degree of trichophyton sensitivity. Furthermore, there were lichenified lesions simulating dry neurodermatitis but these lesions too, like all the others, yielded abundant amounts of fungi.

This patient was obese, pale, pasty, slow in all his reactions and sensitive to cold. All this made him suspicious of being hypothyroid. He was subjected to a detailed work-up. His basal metabolism rate proved to be normal (0) and thus the suspicion of hypothyroidism had to be abandoned. However, his oral glucose tolerance test yielded a conspicuously flat curve. To exclude the possibility that this was due to delayed gastric absorption, an intravenous tolerance test was carried out. Except the fasting value, all values were below the normal range of Lozner, Winkler, Taylor and Peters. The patient responded poorly to local antifungal treatment. On suggestion of Dr. H. Rickets, director of our Metabolism Clinic, we put the patient on a ketogenic diet (1,500 cal. with fatty acid to carbohydrate ratio of 3.5:1). The clinical impression was that the patient did much better while on this diet and continued his local treatment, but his lesions did not heal completely and fungi still could be cultured from the lesions when the patient refused to continue his diet.

This case was so intriguing that I decided to carry out the glucose tolerance test in further cases of t. purpureum infections. Up to date the oral test was carried out in twenty patients, the intravenous test in six of them (Table II). Eight out of twenty cases showed unusually increased glucose tolerance on oral testing, four were at the lower border of normal, seven were normal, and one was slightly elevated. In intravenous testing only one additional patient showed throughout abnormally low values like our first patient. In the remaining five cases the values were either on the lower border of the normal range or entirely within the normal range.

Still, the fact remained that with oral testing a little less than half of the patients showed a highly unusual type of curve.

Unfortunately in the literature of glucose tolerance tests only the upper limits of normal values are well standardized because of the great significance of these values in the discovery of incipient diabetes. Nobody has ever dealt quantitatively with abnormally flat curves; the lower limits of normal values in the glucose tolerance test are not established. From a remark of Watson, it may be concluded that one-half hour values as low as 115 mg. per cent are exceptional. I could not find any lower one-half hour values than 112 mg. per cent in the literature of glucose tolerance tests in normals. Lennox tested thirty-one normals and found one case with a peak value of only 112 mg. per cent. His next lowest peak value was 126 mg. per cent. Qualitatively it is known that flat curves occur in hypopituitarism, adrenal insufficiency and in myxedema. Such endocrine disorders have not been present in our patients. They did not have clinical signs of any of these diseases and the basal metabolism rate of all of them was within normal limits. For all practical purposes, these persons have been perfectly healthy individuals. Thus one can only assume that their increased glucose tolerance on oral testing is a constitutional peculiarity, the nature of which is not understood.

Still, the question arises as to whether this peculiarity can be linked in any way to the susceptibility towards t. purpureum and to the intractability of the infection.

Little is known about the carbohydrate metabolism of the skin proper, but it is well established that alimentary hyperglycemia causes a considerable increase in the glucose content of the skin. So-called skin glucose tolerance tests were performed by serial biopsies of normal skin before and

after ingestion of 100 gm. glucose. The one-half hour glucose values in the skin were about 100 per cent higher than the fasting values, and they remained in this high range much longer than the blood sugar values, namely, three hours and longer. It appears that if a person ingests considerable amounts of carbohydrates with three or more meals per day his skin sugar will be almost continuously considerably higher than the fasting value.

The skin sugar level is certainly influenced by the blood sugar level, and it may be assumed that a person whose blood sugar does not rise or rises only a little after ingestion of carbohydrates will have a lower average sugar content in his skin than persons with a normal degree of alimentary hyperglycemia.

Dermatophytae thrive well on media which contains both glucose and nitrogenous material. If glucose is present, they preferentially metabolize glucose, as indicated by the fact that in the presence of glucose their respiratory quotient is 1. However, they can adapt themselves to a medium free of glucose. In such glucose-free media the respiratory quotient was found to be 0.87, corresponding with a respiratory quotient which is obtained when not glucose but other substances are burned (F. M. Melton).

The first assumption in our working hypothesis is that some individuals for constitutional reasons have so little glucose on their skin surface and in their horny layer that if a fungus invades such a medium it has to adapt itself in a similar way as it does in an artificial glucose-free medium. Our second assumption is that all available fungistatic agents inhibit the thriving of fungi primarily by interfering with their carbohydrate utilization. Tentative evidence for this second assumption was presented by Grunberg et al. If this second assumption is correct we must be able to show that a strain which has grown for a while on a pure peptone medium withstands the inhibiting effect of fungistatic agents better than strains which have grown on media containing glucose. This is actually the case. Table III shows an experiment in which a fungistatic agent, pelargonic acid, a straight-chain saturated fatty acid containing nine carbon atoms, was added in graded concentration to the media. In one series a pure peptone medium was inoculated with a strain which was carried for six months on peptone, and in the other series a glucose-peptone medium was inoculated with a strain which was carried for five months on a glucose-peptone medium. In this experiment the peptone-bred strains proved to be four times more resistant than the strain bred on glucose-peptone. A second experiment had a similar result.

TABLE III. FUNGISTATIC THRESHOLD CONCENTRATION FOR PEPTONE-BRED AND GLUCOSE-BRED STRAINS

Pelargonic Acid Concentration	1	2
0	++	++
1:200,000	++	−
1:100,000	+	−
1:50,000	−	−
1:25,000	−	−
1:12,500	−	−

1=peptone-bred strain inoculated on peptone.
2=glucose-peptone-bred strain inoculated on glucose-peptone

Many more experiments are being planned and have to be performed before the working hypothesis here presented can be regarded as valid. In the meanwhile we may ask whether all these findings and speculations may have any practical application towards a more effective therapy. I already mentioned the attempt to influence the increased glucose tolerance by ketogenic diet. In the first case it seemed to help but the treatment was too short. In the second case a patient, a forty-one-year-old housewife, was kept on a ketogenic diet for six weeks (40 gm. carbohydrates, 160 gm. fat, 2,000 cal.). This patient did not improve on this diet, and she remained mycologically positive. Again on Dr. Ricketts' advice this patient was given, in addition to the local anti-fungal treatment, thyroid tablets, 1 gr. three times daily in an attempt to raise her alimentary glycemia. Clinically, she started to improve right after this treatment, and in one month her palms completely cleared up. Not trusting the situation, I have continued this treatment up to date, for a total of nine months without any side effect. However, her glucose tolerance test did not change much, and worse than that, her nails did not clear up. Her palms are perfectly clear.

In the case of a forty-six-year-old man with a bad t. purpureum infection of the soles and feet the thyroid medication also seemed to help considerably. After six weeks this patient disappeared from further observation.

In a few other cases thyroid therapy had to be discontinued because of poor tolerance, and thus so far I have only one case in which this therapy

(Continued on Page 856)

Hypospadias

By A. I. Dodson, M.D.,
and
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HYPOSPADIAS is among the most frequent congenital deformities and is extremely disturbing both to parents and child. In recent years, pediatricians and obstetricians, realizing the advancements that have been made in correcting these conditions, are prompt to apprise the parents of the deformity. Consequently, we are frequently visited by anxious parents with small children, seeking advice about the nature of the condition and the possibilities of correction. Fortunately, in most instances a normal or almost normal condition can be expected following properly applied plastic procedures.

Hypospadias occurs once in about every 300 births and may vary from the simplest type of deformity, in which the meatus is situated just in front of the frenum with practically no downward curvature of the penis, to a condition so severe that it may be difficult to determine immediately the sex of the child. It is natural, therefore, that the parents are greatly concerned and that if the condition is not corrected, the child in later life may have difficulties in adjusting himself to society.

Before beginning the treatment, it is well to discuss with the parents the operative procedures involved and the results expected. They should be advised that the excision of scar tissue will liberate the hypospadiac opening and cause it to be situated further posteriorly. They should be acquainted also with the fact that several operations may be necessary before a complete cure is obtained. In this way much dissatisfaction may be avoided. When the downward deformity has been completely corrected, the child will develop normally and plastic procedure for the formation of an anterior urethra can be taken care of at a later date. When possible, all plastic procedures should be completed by the time the child is six years old or before he starts to school. Children are much more apt to behave normally and will not so frequently develop personality problems when they are not handicapped by deformities or disturbances that make them in any way different from other children.

There is some difference of opinion as to the optimum age for undertaking plastic correction. It seems preferable to begin the operative procedures early. This, of course, depends somewhat upon the growth and the health of the child, but in most instances the first operation should be done by the time the child is two years of age. In most cases there is a downward curvature of the penis, which usually varies with the extent of the hypospadias. The type in which the hypospadiac opening is situated at or behind the penoscrotal junction is accompanied by a much more severe deformity than one in which the opening is situated further forward.

The first step in treatment consists of dissecting out the bands of scar tissue which bind the penis downward. The operation is begun by making a transverse incision in the skin on the under surface of the penis a short distance beyond the hypospadiac opening. Buck's fascia is divided and all constricting bands of scar tissue are dissected away from beneath the hypospadiac opening to the base of the glans penis. These bands of fibrous tissue are situated mostly between and along the ventrolateral margins of the corpora cavernosa. The dissection should extend back beneath the terminal portion of the urethra for a short distance. In advanced degrees of hypospadias, it is better to make two transverse incisions, one just anterior to the hypospadiac opening and the other posterior to the base of the glans penis. When the dissection has been completed, all bleeding is carefully controlled and the fascia and the skin are closed in the opposite direction of the incision. If the skin appears to constrict the penis, short longitudinal incisions may be made on the dorsal surface and sutured in the opposite direction, thereby relaxing the skin. This aids in healing and has a tendency to shift skin from the dorsal to the ventral surface of the penis for future need in constructing the urethra.

Occasionally, the fibrosis seems to involve the adjacent skin to the extent that when the penis has been straightened there is not sufficient skin to cover the defect. In such cases, the prepuce may be transferred to the ventral surface of the penis as has been suggested by Edmunds, Blair and Nesbit. In the operation described by Nesbit, the prepuce is retracted and an incision is made

From the Urological Service of St. Elizabeth's Hospital, Richmond, Virginia. Presented at the eighty-sixth Annual Session of the Michigan State Medical Society at Grand Rapids, September 26, 1951.

around the penis about one-half inch posterior to the corona, the skin is then retracted backward and dissected from the shaft sufficiently to expose and remove all constricting bands from the ventral surface. An incision is made through the redundant prepuce near its base and the glans penis is pulled through this incision. In this way the redundant portion of the prepuce is transferred to the ventral surface of the penis. The margins of the incision through which the glans has been pulled are sutured to the wound posterior to the corona and the free margin of the prepuce is sutured to the margin of the skin incision below. In this way an abundance of skin is available for the formation of the urethra at a later operation. If possible, it is better to leave the prepuce undisturbed. It is frequently useful in constructing a portion or all of the urethra.

When the straightening operation has been completed, it is well to suture the glans penis to the skin of the lower abdomen so that the penis will be held straight while healing is in progress. A small catheter may then be inserted into the hypospadiac opening and fixed in place to drain the bladder for the first few days. A light pressure bandage completes the procedure.

Before the new urethra is constructed, the urine must be diverted, preferably by a perineal urethrostomy. In a child, the urethra is situated very close to the skin, and this is an easy procedure. A simple method is to insert a small catheter into the bladder through the hypospadiac opening. The catheter is coiled into the bladder until only 4 to 6 inches protrude. A small stiff probe is then inserted into the lumen of the catheter and the point made to press against the perineum; a short incision is made over this area, exposing the catheter. The catheter is grasped, the probe removed, and the distal end of the catheter withdrawn. The catheter is adjusted so that only a couple of inches remain in the bladder. A suture of heavy silk or silkworm gut, placed around the urethra just anterior to the urethrostomy wound and tied just tightly enough to occlude but not injure the urethra, will prevent urine from escaping by the catheter into the newly constructed anterior urethra.

In cases of severe deformity where several operative procedures are contemplated, it has been found advantageous to form a semi-permanent perineal opening. Here an incision about one-half inch long is made into the urethra and the mucous membrane of the urethra is sutured to the margins of the skin. The child then voids through the perineum until the operations have been completed. After this an incision is made to liberate the urethral mucous membrane and the perineal urethra is reconstructed. This operation has some advantages in that it obviates the necessity of wearing a catheter and sometimes of making repeated urethrostomy openings.

In cases of perineal hypospadias, the hypospadiac opening serves for drainage while the penile portion of the urethra is constructed. When the anterior urethra is completely healed, the perineal defect may be closed over a small catheter which is left in the bladder for drainage. Considerable tissue can be closed over the repair and fistulas are not troublesome in this area.

Almost everyone interested in plastic surgery has devised an operation, or a modification of one, for the correction of hypospadias. The appendix, the ureter, the saphenous vein, and tubes constructed from the mucous membrane of the bladder and split grafts from the skin have been utilized. As a rule, these free transplants are not as satisfactory as pedicle grafts. Transplanted tissue often sloughs or is absorbed, and at best a constricted tube results which must be repeatedly dilated to maintain an open channel. The least complicated operations are more apt to be successful. The principles involved in pedicle grafts are embodied in the operation described by Thiersch, Bucknall and Ombredanne. These operations, modified according to the problem at hand, are likely to be successful. No one method can be applied in all cases. The technique of these operations is familiar or can be obtained from the original sources. The newest addition to the list of operation procedures for correction of hypospadias is that of Dennis Brown. This technique seems good, but further cases must be accumulated before it can be properly evaluated.

The senior author prefers the Thiersch method of constructing the urethra whenever it can be applied. In this operation the urethra is constructed from the skin of the penis with the roof of the urethra left attached along the entire surface. By this method there is no doubt that the canal will develop with the development of the penis. A broad base assures adequate blood supply and the line of sutures for constructing the urethra and the sutures for closing the skin flap over the urethra are not opposite each other, and post-

operative fistulas are relatively infrequent. If there is not enough skin left after constructing the urethra to close the defect without tension on the sutures, the prepuce may be used to cover the defect. If the prepuce has been removed, the operation may be completed by using Cecil's modification of the Bucknall operation or by using a skin flap from the scrotum as suggested by Blair.

The Bucknall operation is usually a successful method of constructing the urethra. There is the assurance of an adequate blood supply, and postoperative fistulas are rare. It has the disadvantage, however, that a portion of the urethra is formed from scrotal skin. This creates a possible hazard from the growth of hairs into the urethra. Cases have been reported in which calculi formed on these hairs and troublesome infection and fistulas formed years following the correction of the hypospadias. This disadvantage may be overcome by Cecil's modification in which the urethra is formed from the skin of the penis by dissecting up longitudinal flaps to form a tube just as is done in the method of Thiersch. A longitudinal incision is then made in the scrotum and the newly formed urethra is buried in the scrotum by suturing the margins of the scrotal incision to the margins of the wound on the ventral surface of the penis. After several weeks the penis is dissected from the scrotum and the operation completed as in the original Bucknall operation. In both the Thiersch and the Bucknall operations the newly formed urethra terminates in the region of the frenum. This gives satisfactory functional results, but falls somewhat short of the perfection desired by most patients and particularly by the parents of young children.

The most satisfactory method of carrying the urethra to the end of the penis is the use of a pedicle graft as recommended by D. M. Davis. This tube is constructed from the dorsal skin of the penis. Incisions begin at the margin of the prepuce and may extend backward almost to the base of the penis, depending upon the length of the tube graft needed. They should be from one-half to three quarters of an inch apart, depending upon the age of the child. The intervening skin is dissected up from both margins and a tube is formed over a catheter by suturing the margins of the graft together. The sutures should be of very fine plain catgut and should be placed in such a manner as to turn the margins of the skin inward. A transverse incision is then made at the margin of the prepuce and the tube separated from the dorsal surface of the penis. Care should be taken to preserve the blood supply of this tube. A liberal stab wound is made through the glans penis. The incision should be made about at the normal location for the urethral meatus. Frequently, a dimple in the anterior portion of the glans indicates the proper area. The stab wound is carried back through the glans, emerging well behind the frenal area. In patients with a hypospadiac opening situated midway the penis or a little further forward, the tube graft may be made sufficiently long to be anastomosed directly with the hypospadiac urethra. When the tube is intended to extend the urethra from the distal end of a Thiersch or Bucknall graft it need only extend back behind the frenum. The end of this tube is then anastomosed with the newly formed urethra or with the hypospadiac urethra.

In most cases better results will be obtained by suturing the tube in place and permitting complete healing to occur before the anastomosis is done. In older children and in adults, it is frequently possible to combine the straightening operation with the formation of the channel through the glans penis by this tube graft. This not only simplifies the final construction of the urethra but also aids in holding the penis straight while healing.

The Ombredanne operation is the most unsatisfactory of all pedicle graft methods of constructing the urethra. It has two advantages which have made it fairly popular. In the first place, the execution of the operation is not very difficult, fistulas are rare, and a completed urethra can usually be expected. In the second place, diversion of the urine is not necessary. The principal disadvantages of the Ombredanne operation are: First, it gives an extremely poor cosmetic result; there is very little similarity between the average Ombredanne pouch and a normal urethra. Second, if the meatus is situated near the penoscrotal area, a portion of the urethra must be formed by scrotal skin; consequently, there are the disadvantages of hairs growing into the urethra. In mild degrees of hypospadias with the meatus situated at the frenal area with very little penile deformity, the Ombredanne operation can be applied with very good results. Here, the entire urethral portion is formed of skin from the ventral surface of the penis and the flap does not have to be so wide. Consequently, a reasonably normal

urethra can be obtained and the meatus can be advanced almost to the tip of the penis. Diversion of the urine with a small catheter for two or three days is of value. If the frenal hypospadias is accompanied by pronounced deformity of the penis, the operation is done in two stages, using a pedicle tube graft to construct the urethra.

In the construction of the urethra, many types of suture material have been recommended, including silver wire, stainless steel, horse hair, silk and catgut. In actual experience, the material used is of little consequence; the results are largely dependent upon the care with which the sutures are placed. On the whole, better results are obtained with the use of catgut. For the construction of the urethra, very fine plain catgut is quite satisfactory, preferably 000 in size. Sutures must be placed so that the skin edges will be turned into the urethra. A more even tension can usually be secured by using interrupted sutures. The slightest defect in the suture line may be the cause of a fistula. Fine chromic catgut or silk are satisfactory for the superficial sutures. In small children, chromic catgut is more satisfactory because of the discomfort caused by the removal of nonabsorbable sutures.

No plastic procedure requires more careful postoperative attention than the operation for hypospadias. When the operation is completed, the catheter should be carefully inspected to determine that it is in the proper position for free drainage. The dressing should be applied with moderate pressure. A soft sea-sponge covered with a few layers of gauze and held in place by strips of adhesive provides even, elastic pressure. A fairly thick coating of sulfonamide ointment applied over the wound is helpful. This prevents the gauze from sticking. When the child is returned to his bed, he should be watched closely for several days. The slightest evidence of poor bladder drainage as indicated by discomfort or leakage around the catheter requires immediate attention. Contamination of the wound with urine discharging through the newly formed channel is one of the most frequent causes of wound dissolution. At the end of a week the catheter should be changed, as deposits of salts from the urine gradually occlude the catheter. Drainage should be continued until the wound is entirely healed or until it is evident that the operation is unsuccessful. When the patient has passed puberty, small doses of stilbestrol are helpful. The first dressing is changed about forty-eight hours following operation, provided there is no indication, such as unusual pain or excessive bleeding, to require that it be changed sooner. When there has been subcutaneous bleeding, the blood can be evacuated and edematous areas can be punctured with a pointed knife, thereby reducing tension. Subsequent dressings are applied without pressure. A minimum of two weeks is required for healing. In a reasonable number of these patients slight dissolution of the wound occurs, usually consisting of a minute fistula, and occasionally fairly large portions of the urethral wall will break down. When such evidence of failure is noted, it is useless to attempt to correct the condition immediately. It is best to discontinue treatment and permit the patient to return home, to be readmitted for further surgical correction after a period of six months.

When a large area has broken down, the most satisfactory method of repair is to liberate flap and reconstruct this portion of the urethra. The denuded area is then buried in the scrotum in the same manner that the urethra is buried in Cecil's modification of the Bucknall operation. After a period of three or four months the scrotum can be dissected away and the skin closed. When there are small fistulas, the method suggested by D. M. Davis is satisfactory. An incision is made around the margin of the fistulous opening, and the fistulous tract is dissected free from the overlying skin. A straight needle threaded with silk is passed through the urethral meatus, eye first, and made to emerge through the fistulous opening. One end of the thread is clamped and left emerging through the urethral meatus; with the needle a purse string suture is taken around the margins of the fistulous opening. The needle is then inserted, eye first, and carried out through the urethral meatus; both ends of the thread are then pulled upon, thereby inverting the fistulous tract. The subcutaneous tissues and skin are closed, and a very small urethral catheter is passed through the urethra and fixed in place for drainage. The sutures which emerge from the urethra may be tied around the catheter under moderate tension, or they may be sutured to the glans penis. After a few days the sutures will cut out, and by that time healing is usually complete.

A summary of cases operated upon by the senior author during the years 1935 through 1949 is as follows:

Total number of patients	75
Total number of operations	182
Total hospital days	1625

Type of procedure:

Freeing and lengthening	63
Thiersch	24
Dorsal tube (Davis)	34
Scrotal flap	4
Other flaps	15
Ombredanne	6
Perineal urethrostomy	56
Fistula repair	34

Degree of hypospadias:

Glandular	5
At or near coronal sulcus	36
Mid-penile shaft	8
Just beyond penoscrotal junction	4
Penoscrotal	16
Perineal	5
Unable to determine from record	1

Complications:

Fistula—immediately postoperative:		
Penile	7	single
	2	multiple (2-3)
—after healing		
Penile	24	single
	4	multiple (3-3-2-2-)
Perineal	4	
Wound breakdown	3	
Stricture	2	
Pneumonia	1	
Epididymitis	1	
Pyelonephritis	1	

Lower urinary tract sepsis occurred so frequently as to be considered almost a concomitant of the operative procedure. In recent years, with the use of sulfa and the antibiotics the incidence and severity of infection have been markedly reduced.

Other anomalies noted in this group were:

Pseudohermaphrodism	2
Gynecomastia	2
Hypolydigism	1
Bilateral undescended testis	3
Single undescended testis	2
Speech impediment	1
Crossed eyes	1
Urethra imperforate at birth	1
Nevus of forehead	1

In conclusion, it is well to mention that most operations for the correction of hypospadias fail because the principles underlying plastic surgery are neglected. Adequate blood supply is absolutely necessary for good results. A broad pedicle should be left for the nourishment of the flaps which should be dissected just far enough to be approximated accurately without tension. In outlining flaps and grafts, it is important to remember that the skin of the penis or scrotum shrinks considerably when it is dissected free. Efforts to construct and cover the urethra with inadequate skin flaps result in excessive tension on the sutures. This interferes with the blood supply along the suture line and retards healing. Absolute hemostasis is also of greatest importance; even the most minute bleeding point should be controlled. Blood clots and infection, usually resulting from urine leakage and soiling, are the most frequent causes of wound breakdown.

CONSTITUTIONAL ANOMALIES IN RECALCITRANT TRICHOPHYTON PURPUREUM INFECTIONS

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could be given a fair trial. Although one certainly cannot draw conclusions from our findings up to date, the impression in three cases has been that thyroid administration may favorably influence the course of recalcitrant t. purpureum infections.

Summary

1. In eight out of twenty cases of intractable t. purpureum infections an unusually increased glucose tolerance was found on oral testing. The values on intravenous testing were abnormally low only in two cases.

2. A working hypothesis is presented, postulating that if the glucose content of the skin surface and horny layer is low, the fungi adapt themselves to metabolizing substances other than glucose and thereby become more resistant to fungistatic agents which primarily inhibit carbohydrate utilization.

3. Administration of thyroid seems to influence the course of the infection favorably.

An early cancer of the breast is usually a local cancer and thereby a curable cancer, if properly managed.

Emotional Factors in a University Setting

By Benjamin B. Stamell, M.D.
Detroit, Michigan

WHAT ARE the emotional problems facing the student when he comes to a university? What are the social and emotional adjustments he must make before he advances to a greater maturity?

With seventeen or eighteen years of life experience, the student enrolls in the university. What these experiences have done toward making him a well-integrated personality, how willingly and how eagerly he has entered upon the last period of academic training are factors of great importance in his final preparation of meeting life as an adult.

In addition to the usual social and academic stresses facing the student today is the impact of social unrest and the fluidity of sovereignties and national governments, which accords a feeling of insecurity to all peoples. The strains and dislocations that accompany war and world travail are reflected in uncertainties in the behavior of the young people who most certainly bear the brunt of the cataclysm. It therefore becomes a greater problem for their developing personalities to accommodate and adjust to an unstable environment.

It is not the purpose of this paper to enter into a discussion of the tensions manifested by a world at war, but to consider the elements of the milieu that the post-adolescent and young adult must face when he enters a university. However, notice must be taken of the fact that the environment of the college student is no longer a comfortable and secure four-year period of gradual adjustment.

Usually, entrance into a university catches the student in transition from adolescence to adulthood at a time when he is experimenting with many attitudes, feelings and convictions. Physical growth has been sporadic and unequal. Mental growth is inconsistent and unpredictable. The student is generally unaware of his capacities. Before he is fully conscious of any one aspect of himself as dependable and understandable, he finds himself caught in dozens of other relationships, in none of which does he feel any real security.

The student comes from an outside world in which out of his own frustrations and emotional needs he has built up many symptoms. As he learns to understand himself and others sufficiently well, he is called upon to make further adjustments upon the college campus. The great concern of the faculty is that the student mature emotionally to the fullest extent and profit by his four years of university training. Learning is undoubtedly a feeling process. The student, affected by his emotional conflicts, cannot learn unless he has settled the problems that are troubling him personally, thus leaving him free to take in material from his textbooks and instructors.

The physical separation from home life, like the psychological weaning from the family, is of extreme importance to the student on most campuses. Where at one time his dissatisfactions with his family were many, his sentimental attachments are still numerous and strong. Even when the family is scorned for its conservatism or its lower economic or social standards or its narrow ethical principles, it may still be sought as a safe haven from the too insistent competition of campus life. It is not difficult to find on any campus the student that is struggling with a family at once too critical and, at the same time, too sympathetic. Also, quite as provoking and also more harmful is the dissatisfied parent who is aloof and disapproving, and sometimes even actively antagonistic.

At an urban university, the student who lives at home during his college years is more frequently faced with this particular dilemma. He will lack the freedom which students attending an out-of-town school enjoy so carelessly, and for him the conflict between the older and the younger generation, between his family and the campus standards, are all the more obvious and inescapable. The young person invariably looks forward to garnering more and exciting new experiences, and his parents look back in the light of their own painfully acquired experience, and a conflict ensues. The student will be preoccupied with his struggle for independence, especially in minor details of his life. His wrong steps, his unsuccessful experiments are observed continuously by his parents. Every thought and action must be endlessly explained and defended.

Behavior symptoms may then become evident. Unexpressed or expressed anxieties, and aggressions

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may occur. The student may be haunted by his fear of failure, and he may find it difficult to face the inadequacies that lie deep within himself, or that he dare not face frankly or express. Hostility may become apparent in his attitudes toward his family, schoolmates, and the general community. He may fear becoming openly hostile and have recourse to physical complaints and symptoms that have no organic basis but that gain for him, if only momentarily, protection, freedom from responsibility, and emotional satisfaction from his family.

Every university is a meeting place for many cultural elements. Students come from all walks of life, all levels of intelligence, and from widely scattered geographical areas. New and different religious and political beliefs are encountered for the first time. Manners, morals, and social attitudes that have always been taken for granted are challenged, sometimes pleasantly and gently, and sometimes with stinging shock. To some the wider horizon is awesome and stimulating; to others it is fearful and foreboding.

Social drives during college years are extremely important, for social life plays a significant role in the development of the individual in his formative years. For every student the establishment of his place and his general acceptability within home and campus groups must somehow be accomplished. The poise which the young adult counts as of such great importance is founded on social approval in childhood and subsequently through experience and practice of social skills. This need for acceptance and approval must be met to satisfy the budding personality.

As in the family, there is a mental and emotional climate in the university, and personalities will remain whole and healthy as long as a situation remains fairly favorable. When the environment becomes uncongenial or too demanding, conflicts develop. On the college campus especially, the sensitive individual meets for the first time the considerable stresses and strains of adult life.

Most college students desire an easy give-and-take relationship with their fellows. The socially insecure, however, manifest their agonies in many ways. The student who acknowledges his need for social activities may not be able to accept the opportunities when they are given him. The individual who is conspicuous by loud behavior at a campus hangout may be bravely attempting to conceal his non-acceptance in a desired group. Withdrawals from school may occasionally be the result of a failure to receive a bid from a sorority or fraternity. The ability to make friends may also make the difference as to whether or not a student stays in school.

The establishment of satisfactory heterosexual relations is of prime importance. This quite obviously does not always run a smooth course. The adolescent and the post-adolescent phases are times of crushes and over-dependency. Many college students have not totally emerged from this period. Adjustment to the opposite sex is difficult and arduous for quite a number of them. This is true for both the married and the unmarried. When marriage has a solid foundation in the case of students, its sobering and stabilizing influences are often noted in the students' performance. But if a marriage is unhappy, it can either be the cause or the result of a personality problem.

How, then, can these young people be helped in the university mental hygiene clinic? What are the symptoms that suggest the need for referral to a guidance counselor?

It is essential that genuine sympathy and understanding in emotional terms be an attitude of the counselor. The student quite obviously must be met at his own particular level of development. It should be recognized that the mores of his generation, his moral codes, his speech habits, his life values, and his social handicaps, and his aspirations are a necessary part of his personality. A comprehension of all elements of the personality makeup of the student is important in determining a possible solution to his problems.

To become aware of the difficulties and the needs of a student requires observation from more than one angle and on more than one occasion. It is easy for an instructor in a university to think of his students in terms of grades or in terms of a certain tractability in the classroom. However, the internal problems which the student faces are situations of which the instructor may be entirely oblivious.

In determining the need for special attention, it cannot be too strongly emphasized that no one symptom can be taken as an inevitable indication of maladjustment. More information, in order to ascertain whether or not a symptom is a definite characteristic of that particular individual, should be obtained. Thus, a single observation of a slightly elevated temperature does not warrant a diagnosis of illness. An individual may normally maintain a slightly higher body temperature than

the average; and if there are no signs of physical illness, it would be unwise to become unduly concerned. It is the symptom complex, not the isolated symptom, that should be considered. A knowledge of the background, history, and culture patterns of the student is then necessary.

When flagrant emotional illness asserts itself, a moderately intelligent person with no particular training may quickly become aware of the condition. However, it requires more training and acumen to detect these illnesses in their incipiency, and at a time when preventive measures can be instituted. More than that, it is assumed that it is desirable, if possible, to facilitate a better adjustment rather than letting the student sweat it out by himself.

In judging the need for special attention, some recognition must be taken of the individual's appearance, performance, and relationships with other students, as well as what he says himself. Signs of tension may be manifested by restlessness, irritability and impatience, and occasionally a drive to work beyond capacity or conversely to throw in the sponge and get away from it all by bolting classes and by sporadic attendance. The "eager beavers," the perfectionists, are fertile soil for investigation because of their rigid standards as well as the students who do poorly in their work. The serious, over-meticulous, exact individual may be headed for an emotional breakdown more quickly than the lively, nonchalant individual who takes his classwork with a grain of humor.

Indecision, inefficiency and inability to concentrate are common complaints and require further investigation in order to determine their significance. If indecision extends to all routines of living, it can be assumed that a profound emotional situation exists. It should be noted that the domineering, chronically aggressive person has such a high nuisance value that help is sought for him more quickly than for the reticent, socially inert person, whose difficulty renders him inconspicuous. However, it may be that the withdrawn person is more in need of assistance and is less able to procure it for himself.

Daydreaming and other signs of withdrawal may mean only temporary preoccupation; but when normal activity is interrupted for any length of time, then it is an unhealthy sign. Sudden incongruous and unaccountable changes in behavior like cutting classes, declining grades, and shifts in programs may be indications of disturbance. Inappropriate giggling and laughter as well as frequent sighing and bored expressions may be transitory but in conjunction with other symptoms may be part of a more serious state. An apathetic or indifferent attitude may portend a morbid state of mind or it may be a cover-up for great anxiety.

Peculiar mannerisms, jerking movements, and muscular spasms are as often manifestations of long-standing maladjustments as they are of neurological disorders. Cheating, lying, stealing, and violations of the law are not infrequent behavior disorders, and are indications that a careful study of the individual is required. Behavior, it may be readily apparent, is the resultant of many forces, both external and internal. Variation in mood is expected of all individuals and quite often parallels physiological states. Some persons recognize and have learned to accept periods of let-down and decreased efficiency, while others are alarmed unduly at the variation. When the extremes are so great as to alter behavior and to prevent the individual from acceptable performance for appreciable lengths of time, the change can be said to be significant. Mood often can be inferred from facial expression, manner of speech, and statements of inadequacy or worthlessness. Mood swings that are not explainable or represent departures from the usual pattern, as well as absence of emotional response are indications that the student needs treatment. Mood that is inappropriate to thought processes and to the situation may be a sign of serious mental illness and suggests need for further study.

That emotional difficulties can be translated into physical complaints has long been recognized by the medical profession. Lately this has been reemphasized, and the lay public has become increasingly aware of this factor. The concern over physical sensation and ailments varies with the individual and in the same individual at different times. Student health services usually experience a marked upsurge in dispensary calls at examination time. It is recognized, of course, that other hygienic factors add to the total load which the student carries at this time. Physical distress is an accompaniment of practically all forms of mental illness, and many symptoms have a basis in demonstrable physiological changes.

The problem of therapy for students is undeniably complex. The correction or prevention of personality distortions that express themselves in

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Differentiation of Dyspnea Caused by Cardiac Disease from Dyspnea Associated with Pulmonary Emphysema

By Richard V. Ebert, M.D.
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THE PROBLEM which I am to discuss here is the diagnosis of the middle-aged or elderly patient with dyspnea. Shortness of breath is a common symptom and is usually attributed to failure of the heart. It must be remembered that dyspnea is primarily a pulmonary symptom and is produced by diseases which interfere with normal ventilation of the lungs.

Pulmonary emphysema is a common cause of dyspnea in the older age group. It is often diagnosed incorrectly as heart disease. There are several reasons for this. In the first place the presenting symptoms are similar. Dyspnea is the chief complaint in both diseases. The physical findings in pulmonary emphysema may be obscure, leading the physician to a diagnosis of heart disease by a process of exclusion. Finally, the patients with pulmonary emphysema may develop right heart enlargement as a result of pulmonary hypertension, and exhibit the signs of right heart failure, namely, distended neck veins, hepatomegaly and edema.

An accurate differentiation of pulmonary emphysema from primary heart disease can usually be made by careful attention to certain details of the history and physical examination. Contrary to what one might suppose, the nature of the dyspnea is of little aid in differentiating cardiac from pulmonary dyspnea. Paroxysmal dyspnea and nocturnal dyspnea are common in both disease states. Patients with emphysema often breathe most comfortably in the sitting position as do patients with cardiac failure. The duration of the dyspnea is of some importance. Patients with emphysema will often develop exertional dyspnea gradually over a period of years, while patients with heart disease usually have a more abrupt onset of this symptom. Cough is an almost universal symptom in patients with emphysema and is usually of long duration, often preceding the onset of dyspnea. In heart failure cough is usually not a conspicuous symptom.

Examination is of greater aid in diagnosis than is history. Visible cyanosis may or may not be present in either disease. Intense cyanosis occurs more commonly in pulmonary emphysema than in primary heart disease. For this reason patients with pulmonary emphysema and cor pulmonale have been called black cardiacs. Most patients with pulmonary emphysema will exhibit a barrel chest. Unfortunately this configuration of the chest is not specific for emphysema. Many elderly persons will have an increased anterior posterior diameter of the chest and a rounded kyphosis of the thoracic spine and yet exhibit relatively normal pulmonary function. For this reason this sign must be interpreted with some caution. The same is true of hyperresonance of the chest and obliteration of cardiac dullness. Of more importance is the marked limitation of motion of the chest on use of the accessory muscles of respiration in patients with emphysema.

Of greatest importance in the physical examination is the detection of cardiac enlargement. Patients with heart failure as a cause of dyspnea will almost always present evidence of cardiac enlargement. Patients with emphysema will not show evidence of cardiac enlargement on physical examination even though there is right heart enlargement present in the roentgenogram of the chest. Enlargement of the heart is best detected by palpation of the apex impulse. The presence of significant murmurs, gallop rhythm, or auricular fibrillation should lead one to suspect that dyspnea is on a cardiac basis.

Roentgenographic and fluoroscopic examination of the chest may be of greater value. The characteristic finding in pulmonary emphysema is low flat diaphragms which move poorly in fluoroscopy. The heart is usually vertical in type and not enlarged. If cardiac enlargement is present, it is primarily of the right ventricular type. At times bullae can be visualized in the roentgenogram of the chest. In dyspnea of cardiac origin the heart is almost invariably enlarged and the enlargement is usually of the left ventricular type. In mitral disease the enlargement is of the right ventricular type and the roentgenographic picture may be similar to that seen in pulmonary emphysema with cor pulmonale.

The electrocardiogram in pulmonary emphysema is normal or may show evidence of right

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ventricular hypertrophy or positional change. The circulation time from arm to tongue is usually normal in patients with pulmonary emphysema and prolonged in patients with dyspnea on the basis of heart failure.

The differentiation of cardiac failure from pulmonary emphysema can be most reliably made by studies of the total lung volume and its subdivisions. In pulmonary emphysema the vital capacity is reduced and the residual air is markedly increased. The total lung volume is normal. In heart failure the vital capacity is reduced as is the total lung volume. The residual air is normal. While the measurement of residual air and total lung volume requires special techniques, a great deal of information can be obtained by the measurement of vital capacity. The vital capacity in emphysema is usually reduced to a greater extent than in heart failure. More important, the expiration of air is very slow, while in heart failure the air can be expelled rapidly. The determination of the vital capacity can be done in the office or at the bedside with a simple portable device.

A final point in differentiation is the carbon dioxide content of the blood. In pulmonary emphysema there is impaired ventilation of the alveoli and the carbon dioxide tension of the blood rises. The bicarbonate of the blood increases to compensate and maintain a normal P_h. In heart failure, on the other hand, the excretion of carbon dioxide is normal.

The importance of the differentiation of the dyspnea of heart failure from the dyspnea of pulmonary emphysema lies in the treatment of the patient. Morphine is a most useful drug in controlling the paroxysms of dyspnea in congestive heart failure. It is a lethal drug in pulmonary emphysema. This is because by depressing respiration it accentuates the anoxia and carbon dioxide retention which are present. Oxygen therapy may correct the anoxia, but the patient may die from accumulation of carbon dioxide and respiratory acidosis. The use of antibiotics to control bronchial and pulmonary infection may greatly aid patients with emphysema. Bronchodilators may also offer relief of symptoms. On the other hand, digitalis is of no value unless right heart failure is present.

FEDERAL LEGISLATION

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or amended proposals will need special Health and Welfare Committee approval.

* * *

AEC to Charge 20 per cent of Production Costs for Isotopes Used in Cancer.—Effective July 1, the Atomic Energy Commission will charge 20 per cent of production costs for radioisotopes for use in the study, diagnosis or treatment of cancer. Since 1948 when distribution of isotopes started, AEC has charged full production, handling and shipping costs for isotopes to be used in *other medical research or treatment,* but has waived production costs on those to be used in *cancer.* Explaining the changed policy, AEC said:

"The field has developed so rapidly that certain clinical applications of radioisotopes now have become a matter of routine, and research workers have become fully aware of the usefulness of these atomic tools in cancer research . . . The stimulus of completely free distribution no longer is necessary to encourage the use of radioisotopes in the field of cancer."

For use on cancer, the price schedule will be fifteen cents per millicure for radioiodine 131, twenty-two cents for radiophosphorus 32, five cents for radiogold 198, twenty cents for radiocarbon 14.

* * *

Senate Subcommittee Considers Restrictions on International Treaties.—A Senate Judiciary subcommittee currently is holding public hearings on S.J. Res. 130, designed to prohibit international agreements which interfere with constitutional rights of U. S. citizens. The resolution was introduced by Chairman O'Conor (D., Md.) of the subcommittee and fifty-four other Senators, including Senator Bricker (R., Ohio), who testified before the subcommittee. Senator Bricker, pointing out that the legislation is directed primarily at the Covenant on Human Rights being drafted by the UN's Human Rights Commission, noted that among other things that covenant undertakes to enact legislation which will "assure the right of all to medical service and medical attention in the event of sickness." Once approved by the Senate, treaties become the law of the land.

GAINS IN LIVING STANDARDS

Millions of Americans have made remarkable gains in living standards during the past ten years according to a study made by Dr. Simon Kuznets of the University of Pennsylvania. There is a redistribution of the national income. The very poor have been reduced in numbers by two-thirds. In 1939 three out of every four families had incomes less than $2,000. In 1949 one out of three were in the same group. The well-to-do and the rich have become more numerous. In 1939 one family in fifty had an income over $5,000, and one in 100 earned over $10,000. These rates as of 1949 were one in six and one in twenty.

Neurodermatitis (Atopic Eczema)

Concept and Functional Aspects

By Stephen Rothman, M.D.
Chicago, Illinois

IN DISCUSSING neurodermatitis, a disease entity of unknown etiology and of a poorly understood pathomechanism, I believe that it may be useful to start out with a historical analysis of the two synonyms by which this condition is most frequently designated: atopic eczema and neurodermatitis.

The term atopic eczema was coined by A. F. Coca in 1925. His conception has been that this disease is a special form of allergic hypersensitiveness, not having a single cause-single effect mechanism as is the case in eczematous contact-type dermatitis, but being based on an inherited constitution with multiple dermal sensitivities and multiple sensitivities of the mucous membranes; therefore, association of atopic eczema with asthma and hay fever is common in the individual and in his ascendents. It has been to the credit of Coca that he clearly stated that patients of this group have a particular constitution, which is inherited. However, he and his followers did not succeed in proving that the cutaneous manifestations of this constitution are allergic in nature. There is no proof that the multiple dermal sensitivities, demonstrable by scratch and intradermal tests or by the presence of antibodies, have any relation to the skin disease itself. A positive skin test becomes etiologically significant for a dermatosis only if contact with or administration of the incriminated substances provoke specific skin lesions, if after the elimination of these substances the eruption clears up promptly, and if such experiments can be repeated at any time and under all circumstances with the same unequivocal result. This is not the case with atopic dermatitis. On the contrary, all clinical dermatologists know a great number of cases in which the patient goes on for years avoiding incriminated foods or contacts without any effect on the course of his skin disease.

One can imagine an allergic disease with a multitude of ubiquitous or almost ubiquitous allergens such as components of dust, or, among food stuffs, proteins in general, which never can be completely eliminated. However, such an assumption in the case of atopic dermatitis is purely hypothetical. At present, the only observation which might support this hypothesis is that change in environment often brings about complete remission. However, others use the same argument to prove that atopic eczema is a functional disease because change of environment brings about changes of job, of bosses, of neighbors and, what seems particularly important, in personal problems, it often brings about separation from the family. You see how different the interpretation of the same observation can be. Obviously, one will have to study the effects of environmental changes more closely, under more precisely set experimental conditions, before one will be able to draw valid conclusions. So far, observations have been made in a rather haphazard way and often with a preconceived opinion. The complex "environmental change" never has been taken apart into single elements and studied by varying these elements. We have "impressions" only. My impression, for instance, is that change of environment is most effective if the patient moves to a sunny, warm, dry climate.

There is a particular difficulty to correlate dermal sensitivities to the clinical picture of atopic eczema. Atopic eczema is a primarily epidermal disease, whereas the multiple sensitivities are dermal, demonstrable by scratch and intradermal tests and not by patch tests. It is a notorious fact that atopic patients become sensitized to epidermal allergens with greater difficulty than normal persons. Becker finds that epidermal sensitivities never occur in atopic eczema. Atopic eczema may be an allergic disease but the evidence for it is still lacking.

The name "neurodermite" was first used by L. Brocq and L. Jacquet in 1891. Originally, the name meant that itching is the primary phenomenon which precedes visible cutaneous changes. The authors assumed that there must be a "paresthesia," an abnormal sensation due to an abnormal sensory impulse, and, therefore, neurodermatitis is of nervous origin. It was not specified by these authors whether they meant an organic nerve disease or a disturbance in the psychic sphere. At about the same time, however, another French author, H. Leloir, quite clearly separated these

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two possible mechanisms. He said that there are, firstly, "reflex dermatoneuroses due to a simple and transitory excitation of nervous centers secondary to peripheral nervous irritation" and, secondly, "dermatoneuroses caused by moral shock." It is perhaps worthwhile to mention that "moral shock" as an etiologic factor was mentioned as early as 1855 by Canuet, a pupil of Cazenave.

The neurogenic theory of neurodermatitis was further developed by C. Kreibich, who published his famous work on angioneurotic inflammation in 1909. His theory is based on the observation that there are exaggerated vasomotor responses to any kind of local stimulation in neurodermatitis. He carried his "angioneurotic" theory of exaggerated vasodilator response to sensory stimuli so far as to claim that sensory impulses arising in an irritated lesion may be projected by long reflex processes to symmetrical or other distant areas where inflammatory lesions will arise by nervous impulses alone without intervention of any external stimulation. Kreibich ignored the results of physiological experimentation which indicates that permanent inflammatory lesions cannot be produced by autonomic nervous impulses. However, it was Kreibich's merit to point out the participation of friction and scratching in the development of lesions and the abnormality of the response to such mechanical stimuli in neurodermatitis.

In its most modern form the theory of nervous origin of neurodermatitis was originated in this country by Stokes and developed thoroughly and in great detail by S. W. Becker. They have described the emotional instability of the patients suffering from neurodermatitis, their unusual tenseness, and the two main personality types, the overactive or overambitious and the worrying type. These authors have the great merit of having shown that the emotional tension, as well as the itching and eruptions of these patients, are greatly benefited by administration of sedatives, by carefully dosed rest periods and by a simple (I almost would say primitive) psychotherapy—giving the patient insight into his tenseness and advising him how to get out of it ("don't give a damn" program of Stokes).

The work of Stokes and of Becker brought about a clinically highly significant progress in the rational management of the disease. Nonetheless, the modern "psychosomatic" concepts of neurodermatitis (including the psychoanalytic approach) did not further elucidate the etiology and pathomechanism of the disease. The labeling of neurodermatitis as a functional disease does not give an answer to the important question: through what mode of action do emotional factors create the eruption? We know that the course of the disease can be influenced by modifying the psychic attitude. This indicates that psychic factors play a role, primary or secondary or tertiary, in the course of the disease, but it does not mean that the disease originates in the psyche as do functional bowel distress or cardiac neurosis, in which exaggerated autonomic impulses originating in the cortex perfectly explain all signs and symptoms.

Such functional neuroses are well known to occur also in cutaneous pathology, the best examples being functional hyperhidrosis, functional vasoneurosis and in a somewhat different way the quite unique picture of cholinergic urticaria, in which normal antidromic vasodilator impulses lead to the appearance of fleeting inflammatory eruptions because the skin is hypersensitive to acetylcholine, the otherwise normal tissue product of this impulse. However, as indicated above, hitherto it has not been demonstrated that psychic impulses in themselves are capable to produce stable inflammatory lesions as we see them in neurodermatitis.

A primary faulty sensation of itching, of course, may be purely psychogenic, and the scratching or rubbing following this sensation can provoke inflammatory lesions. By repeated itching-scratching spells, the relatively mild and unstable scratch reactions may be aggravated and become permanent. The lesion may enlarge in size and become more and more severe in the degree of inflammation and degree of epidermal injury. This is the concept of scratch eczema or frictional eczema of Kreibich, and there is much to say in favor of this conception.

Firstly, there is the old contention that lesions of neurodermatitis start out with itching sensation without visible changes, and this is confirmed by free admission of many of our patients. They sometimes express this experience by saying that they are able to predict where the next new lesion will appear. Secondly, we know that neurodermatitis lesions itch and are scratched or rubbed beyond proportion to their clinical appearance. Thirdly, itching, as any other cutaneous sensation, may arise in the cerebral cortex either without any event in the periphery as a purely "functional"

symptom or in response to sub-threshold peripheral stimuli because of hyperexcitability of the cortex. In normal individuals, everyday stimuli to the skin, such as slight friction, pressure, release of pressure, or temperature changes, evoke the so-called minimal pruritus which does not enter or hardly enters the consciousness and is taken care of with a few rubbing movements due to subcortical reflexes or remains entirely without response. Apparently, sensations of the same intensity evoke violent scratching in neurodermatitis patients. This may be called "conditioning to itching and scratching" and could be very well a consequence of the emotional make-up of the patient if we admit that such make-up is already evident in early infancy, because this conditioning starts with the infantile eczema.

This concept would imply that all lesions of neurodermatitis are purely factitial, results of rubbing and scratching, and this cannot be true for all lesions—not, for instance, for the nummular lesions of exudative neurodermatitis ("nummular eczema") because the circular shape and sharp limitation of these lesions is incompatible with the assumption that they are scratch or rub effects.

Even if we disregard nummular eczema as a quite particular manifestation, possibly not belonging to neurodermatitis, and if we consider the diffuse lesions only, and claim that they are effects of rubbing and scratching, we still cannot regard neurodermatitis as being of purely functional origin as we do regard neurotic excoriations or hysterical self-induced lesions. Somatic elements come into the picture with the abnormal reactions to mechanical injury. In exudative neurodermatitis there are exaggerated vasodilator response and increased vulnerability of the epidermis; they lead first to the état ponctueux (status punctosus) of Devergie and then to oozing and crusting in response to relatively mild traumatization. In dry neurodermatitis lichenification develops; this is an abnormal tissue reaction to chronic rubbing which cannot be provoked experimentally in normal persons. The best clinical example to illustrate this point is pruritus ani. About one-half of the pruritus ani patients have no atopic history; they had no infantile eczema, no dermatitis, no asthma, no hay fever—neither themselves nor their ascendants. They readily admit having rubbed their anus for years, but they do not develop lichenification. When a neurodermatitis patient starts to complain of pruritus ani, he develops severe lichenification within a few weeks.

Exaggerated tendency to exudative reactions and lichenification tremendously facilitates the development and permanence of the itching-scratching cycle, because both states—lichenification more intensely—decrease the itching threshold, i.e., increase itching hyperexcitability to external stimuli.

On the other hand, these somatic abnormalities are again greatly accentuated by psychic influences. By the emotions of distress, self-pity, uneasiness and apprehension, arteriolar hyperemia is induced into inflammatory lesions via antidromic vasodilatation. This hyperemia also decreases the itching threshold and increases itching susceptibility. Thus the itching-scratching cycle is indeed a psychosomatic affair.

Recapitulating, the most important features of the disease we can list are emotional instability and increased conditioning to itching and scratching, on the psychic side—abnormal tissue reactions to mechanical stimulation, multiple cutaneous and mucous membrane sensitivities, on the somatic side. If we add that these features are familial and that in many cases they become manifest in early infancy, it seems that the common denominator of all these psychic and somatic features is a particular inherited constitution. I am aware that this concept is atavistic, and falls back on the old prurigo diathesique of Besnier, but nevertheless, it is the only interpretation which harmonizes with all the known facts. It implies that the disease has no etiology in the sense that infection, metabolic disturbances, allergic conditions or functional diseases have, but it rather can be compared to genetically induced abnormalities in both the psychic and somatic spheres.

If it is true that neurodermatitis is not an etiologic entity but a constitutional anomaly, the best we can hope for in its management is its improvement by symptomatic treatment along both the psychotherapeutic and the dermatotherapeutic lines.

If it is true that neurodermatitis patients are not made but born, the basic concept of psychoanalysis on neuroses cannot be applied to their case. Their anomaly does not develop from repression of early adverse experiences or from psychic traumata of any kind. On the contrary, it does not make any

(Continued on Page 877)

Observations of the Efficacy of Chloramphenicol (Chloromycetin) and ACTH in the Treatment of Typhoid Fever in Children

A Report of Two Cases

By Irving F. Burton, M.D., and
Mary McDermott, M.D.

Detroit, Michigan

OF THE chemotherapeutic and antibiotic agents available for the treatment of typhoid fever, chloramphenicol (Chloromycetin®) has been reported the most effective. Following the original report by Woodward in 1948, a series of papers[6,9] were published which in most instances have been enthusiastic concerning the use of chloramphenicol in the treatment of typhoid fever in adults. More recently, relapses following such therapy have been reported as well as its relative ineffectiveness in eradicating typhoid bacilli in carriers.[8]

Selingman and Wasserman[4] report that although chloramphenicol exerts a marked inhibitory effect on the growth of salmonella organisms *in vitro*, the drug, even in large amounts, is incapable of controlling salmonella infections in mice.

Ross[3] reported poor results in the treatment of salmonella enteritis, other than typhoid, in infants. After prolonged treatment with chloramphenicol the stools of seven of nine patients which were negative for salmonella during the period of treatment became positive shortly after stopping the drug and the organisms recovered were highly sensitive to chloramphenicol again.

An editorial in the *New England Journal of Medicine*[1] suggests that the organisms are either inaccessible to the antibiotic or in some way they are protected from its action.

Recently Greengard[2] reported seven cases of typhoid fever in children treated with large doses of chloramphenicol, .070 gm. to .140 gm. per kg. every twenty-four hours. It was felt that improvement in five cases was due solely to the treatment, while two cases improved coincidental with the beginning of therapy.

From the Pediatric Division of Harper Hospital, Detroit, Michigan.

During the fall of 1951 we treated two cases of typhoid fever in children, one with chloramphenicol and one with chloramphenicol plus ACTH. Because of the relatively few cases reported in children and the dramatic course of the disease in the instance where ACTH was used, it is believed our observations may be of interest to others.

Case 1.—E.R.S., a seven-year-old white boy, was admitted to the Harper Hospital Pediatric service on August 24, 1951, with the complaint of cough, fever, diarrhea, abdominal cramps, sore throat and headache. The onset began abruptly two weeks prior to admission with fever and coughing. He was seen one week later by his physician and a diagnosis of pneumonia made. He received an initial dose of 400,000 units of aqueous procaine penicillin and oral chloramphenicol, 50 mg./kg. per day. He seemed much worse in the following week and was seen by one of us and hospitalization advised.

The past history was irrelevant except that he had been swimming in the local public pools and in the Detroit River during the summer. Similar illness was not found in the family or his companions. Physical examination revealed an acutely ill child with moderate dehydration. The liver and spleen werc palpable 3 cm. below the costal margin. The abdomen was slightly distended and there was exquisite tenderness in the right upper quadrant. A few fine râles were heard bilaterally throughout the chest with occasional wheezing. The pharynx was slightly injected.

The clinical course, laboratory studies and treatment are outlined graphically in Figure 1. Although a tentative diagnosis of typhoid fever was made, a positive diagnosis was not made until the fifth hospital day, when the agglutinations became positive, and the stool culture was reported as positive on the eighth day for S. typhosa.

The child received supportive treatment, and chloramphenicol, 50 mg./kg. body weight, was given in divided daily doses. An x-ray of his chest on admission was essentially normal. A flat plate of the abdomen showed moderate distention of both small and large bowel with a slightly enlarged spleen. Our chief concern was with his distention and exquisite pain in the upper right quadrant. This persisted until the twentieth hospital day. He was seen by Dr. Clifford Benson of the Surgery Department, who felt that the distention was that of adynamic ileus and therefore recommended a conservative program. It is interesting that the child had an almost persistent leukocytosis throughout. He was discharged on the twenty-sixth hospital day. Follow-up stool cultures were all negative.

Case 2.—S.A., a five-year-old white boy, was first seen by one of us in consultation in another hospital. This child had visited an epidemic typhoid area in Sicily one month previously. He had received no typhoid immunizations. Three days prior to admission he complained of a sore throat and had a temperature ranging up to 103° F. He was given daily injections of 400,000 units of aqueous procaine penicillin at home, but as he seemed worse, he

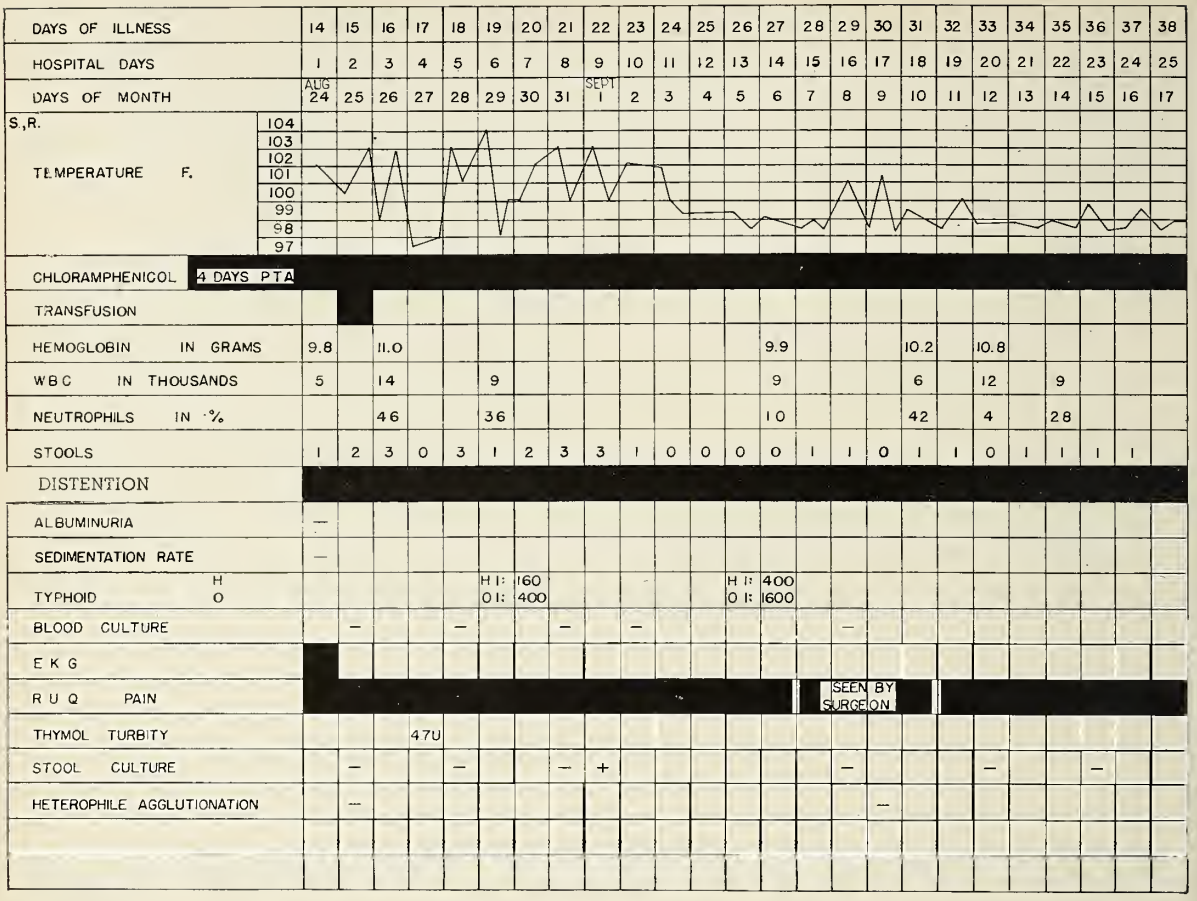


Fig. 1.

was admitted to the first hospital. Physical examination revealed an acutely ill, nearly moribund child with severe dehydration, acaphoid abdomen, marked sordes and nuchal rigidity. Temperature was 106° F. and required considerable nursing to keep it from rising higher. Liver and spleen were only slightly enlarged. The pulse was rapid. A lumbar puncture showed a normal spinal fluid. Agglutinations for typhoid were positive, 1:1280 for the H and O antigen. The initial blood culture was reported as positive for S. typhosa on the fourth hospital day. He was given supportive treatment and started on chloramphenicol, 50 mg./kg. body weight in divided doses. When the diagnosis was confirmed on the third hospital day, transfer to Harper Hospital was advised.

His condition became so critical that on the second day at Harper Hospital he was given ACTH intramuscularly, 20 mg. every twelve hours for four doses and then 10 mg. every twelve hours for the next three days. His temperature dropped rapidly and he became responsive within forty-eight hours. Three days later, he was totally afebrile. The clinical progress and laboratory data are shown graphically in Figure 2. Abdominal distention and discomfort disappeared on the ninth hospital day. On the seventh hospital day, a shower of rose spots appeared and remained for three days before fading. A small area of alopecia of the scalp was noted on the tenth day. An electrocardiogram taken on the tenth day showed myocardial damage but no conduction defects. This child also showed a moderate leukocytosis persistently. His course thereafter was uneventful and he was discharged on the twenty-first hospital day. Three weeks after discharge, a stool culture was reported as positive for S. typhosa. Another two weeks' course of chloramphenicol was given and subsequent stool cultures for three months have been negative. Agglutinations for typhoid taken on the mother and the uncle of this boy, who were on the same trip with him, were negative.

Comment

In each case, a positive stool culture and in one case a positive blood culture was obtained on admission—the first case after one week and the second case after three days of chloramphenicol treatment, on the basis of 50 mg./kg. body weight per twenty-four hours.

Many of the complications described in typhoid fever developed while they were under chloramphenicol treatment. The first case had a moderately severe bronchitis and persistent ab-

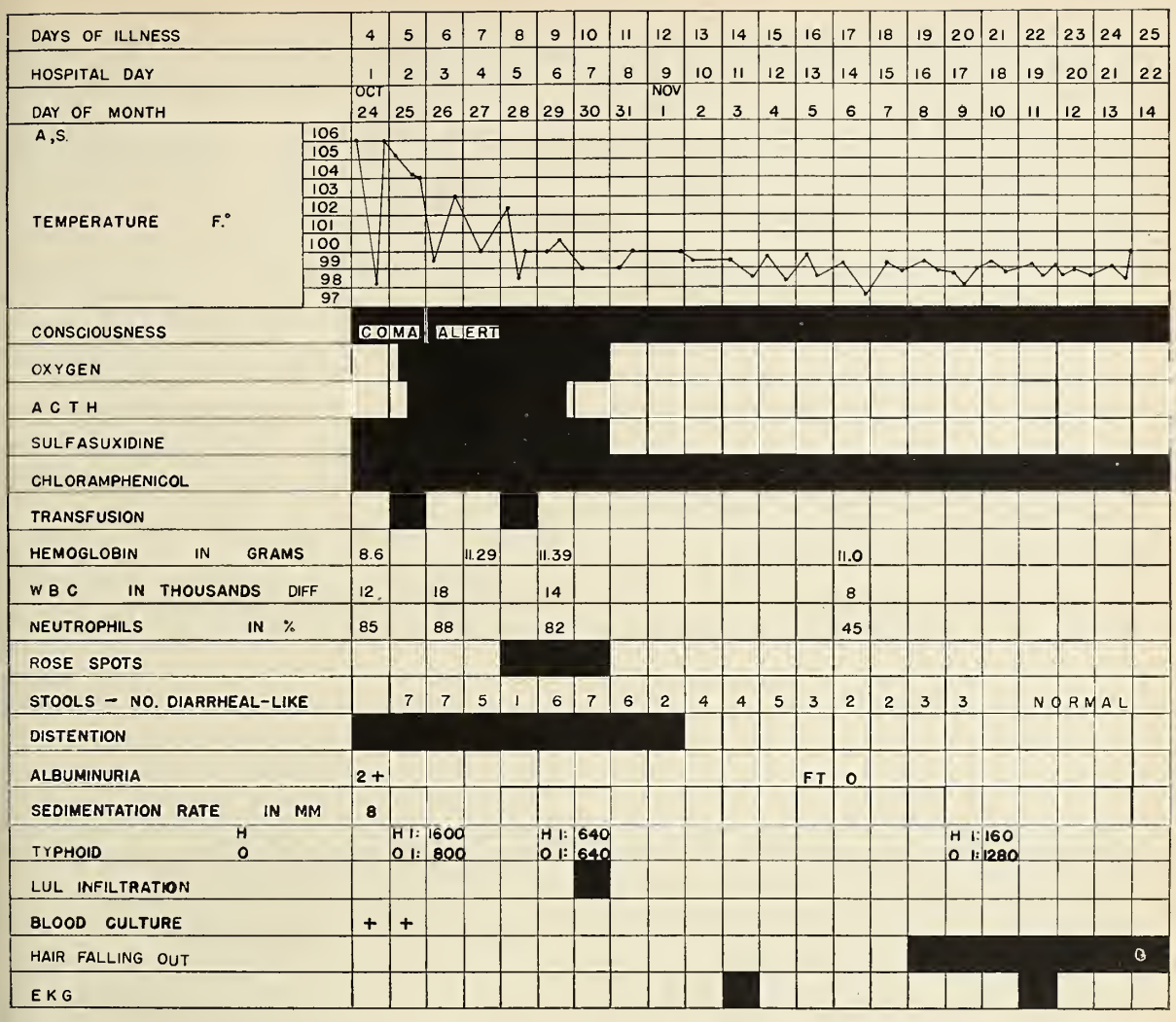


Fig. 2.

dominal pain and tenderness especially in the right upper quadrant. A positive stool culture was found after twenty-two days of illness. The second case had symptoms of a moderately severe upper respiratory infection, meningismus, anemia, myocarditis, rose spots, alopecia, delirium and coma. A positive stool culture was found three weeks after discharge.

We do not feel that the course of this disease in the two children was significantly altered by the use of chloramphenicol in the dosage or the mode of administration that was used. Neither the duration nor the severity of the disease seemed to be much different from cases we have seen in children prior to the use of chloramphenicol. These results are similar to the ones described by Selingman and Wasserman in their experiments with mice and by Ross in infants with Salmonella infection.

The organism in the second case was very sensitive to chloramphenicol *in vitro* as tested in our laboratories and at the laboratories of Parke, Davis & Company. The difference between its action on a child and an adult was inadvertently demonstrated by an unfortunate laboratory accident. A laboratory technician from the referring hospital (Case 2) developed typhoid fever two weeks after handling the contaminated urine. On the same dosage of chloramphenicol on a per pound basis, she recovered very rapidly with little ill effects.

The use of cortisone in conjunction with chloramphenicol in the treatment of typhoid had been reported.[5,7] The results have been favorable. ACTH was administered in the second case because

he was moribund shortly after admission. He showed an immediate and dramatic response. This hormone was administered on an empirical basis, but we feel that there may be come rationale for its use. It may very well be that ACTH and cortisone produce the physiologic response in the patient which augments the effectiveness of the drug.

Summary

Two proved cases of typhoid fever in boys of seven and five years, respectively, are presented.

Chloramphenicol in the dose of 50 mg./kg. body weight per twenty-four hours is relatively ineffective in children as compared to adults.

ACTH administration in the one moribund child proved effective as adjunct therapy.

Acknowledgment

The authors gratefully acknowledge the generous assistance of Dr. Edgar Martmer, chief of the Division of Pediatrics, Harper Hospital, Detroit.
Harper Hospital.

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EMOTIONAL FACTORS IN A UNIVERSITY SETTING

(Continued from Page 859)

an uneconomical use of emotional energy is not simple. The basic guiding principle of treatment is the need of the individual and how that need can most successfully be met, rather than the establishment of any special category to which the student's needs must conform. Successful therapy requires skill and sensitivity on the part of the therapist, who must be capable of comprehending the emotional values of the student. An evaluation of both the positive and negative psychological factors facing the student must be accomplished before attempts are made to interpret his problem.

Summary

The student who first matriculates in a university represents an accumulation of seventeen or eighteen years of experience. Stresses and strains from which he had hitherto been protected are brought to bear on him. His reactions to these stresses are largely determined by many previous events. The campus requires a reorientation and a reassessment of values. Some students become confused and require assistance from the mental hygiene clinic. Emotional help can be obtained with the guidance and sympathy of the faculty and medical staff.

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OLD AGE AND SURVIVORS' INSURANCE

A drop in public spending for relief to the needy aged has resulted from the amended Social Security Act of 1950, according to Arthur J. Altmeyer, Commissioner of Social Security. By July, 1951, there were more persons on the Old Age and Survivors' Insurance rolls than were receiving old age relief. The report reveals that there has been a shift of some of the load from public aid to the public insurance system. As of July 1, 1951, there were 112 aged persons drawing old age insurance benefits for every 100 on old age relief. The federal share of public assistance has been cut by about $7 million a month.

The Use of Anti-Hemophilic Globulin in Obstetrics and Gynecology

By F. W. Tamblyn, M.D.
Lansing, Michigan

VAGINAL BLEEDING in certain obstetric and gynecologic conditions is often a troublesome and dangerous manifestation. Recently, anti-hemophilic globulin has been used in some of these problems with satisfactory results—occasionally dramatic. While discussing the problem with physicians associated with the Michigan State Department of Health, the use of this product was suggested, this being a by-product of whole blood.

The following are a few case reports which we believe have enough significance to warrant further use of the above-named product.

Case 1.—Mrs. L., aged thirty-five, had a rapidly growing carcinoma of the cervix, originating in the cervical canal, while the external os looked normal. Radium was inserted and the vagina packed as usual. The patient hemorrhaged profusely on return to her room, and the radium was removed. The patient was packed, using gel-foam, but bleeding continued. She was given three 20 cc. doses of anti-hemophilic globulin in twenty-four hours, and bleeding promptly stopped after the first dose. During her intermittent stay in the hospital until death on October 28, 1950, or six months later, she received this medication on six different occasions. Bleeding was promptly controlled each time. Once at night, she told the interne to give her the "stuff" in the vein, and that would stop her bleeding.

Case 2.—Mrs. K. B., aged forty-five, had been bleeding almost daily for one year. She was admitted to the hospital on August 24, 1951, because of a severe vaginal hemorrhage. On August 25 she was given 1,000 cc. of blood and was packed, using gel-foam. There was bleeding through pack. On August 26 I saw her for the first time. She was given two 20 cc. doses of anti-hemophilic globulin in eight hours. The bleeding stopped. On August 28 radium was inserted, after a frozen section revealed carcinoma of the cervix, and she was given three 20 cc. doses of globulin in twelve hours. On August 29 there was no bleeding. The radium was removed on August 30, with no bleeding. She was discharged on August 31 to deep therapy laboratory.

Case 3.—Mrs. F. F. had been treated since May 12, 1951, for carcinoma of the cervix, with radium and x-ray. She entered the hospital on November 10, 1951, because of pain in the left lower quadrant and partial intestinal obstruction. She bled vaginally on December 7. She was given three doses of 20 cc. anti-hemophilic globulin, and the bleeding promptly stopped after the first dose. No packing was used.

Case 4.—Mrs. E. M. was a nurse, aged twenty-six, gravida 3, para 1. The estimated date of delivery was October 5, 1951. She was given thyroid and stilbestrol during pregnancy. On July 4, 1951, there was vaginal bleeding of 500 cc. She entered the hospital that day, and after the usual bed rest and transfusions, the bleeding gradually subsided in five days. She was discharged on July 11. On September 4 she bled 500 cc., passed several large clots, and was admitted at 12:00 noon, with a diagnosis of partial abruptio. At 12:20 p.m., 20 cc. of anti-hemophilic globulin was given. At 1:30 p.m., the bleeding was subsiding, and it stopped by 2:00 p.m. The globulin was repeated in the evening and on the morning of September 5. She was discharged on September 7. The patient asked, "Why didn't you give me this the first time?" She was delivered of a normal infant on September 30, 1951.

Case 5.—A patient at term entered hospital with severe vaginal bleeding. She was almost completely dilated with a breech presentation. There were no fetal heart tones. The diagnosis was abruptio placenta. The membranes were ruptured and the baby delivered. The placenta was delivered and then 500 cc. of old blood clots came from the uterus. She continued to bleed. The uterus was packed and gel-foam used. Still she continued to bleed. Sub-total hysterectomy was done, and the cervix was closed tightly with figure-of-eight chromic sutures. She continued to bleed vaginally and was packed with gel-foam and gauze pack. The bleeding continued. She was given 20 cc. of anti-hemophilic globulin, and in five minutes the bleeding stopped. All the while the patient had been receiving whole blood, for a total of seven pints.

Case 6.—Mrs. McK. was aged twenty-one, gravida 4, para 3. Her first two pregnancies were normal; her third pregnancy was a stillborn in 1950, supposedly of toxic separation of the placenta. The present pregnancy was uneventful and the estimated date of confinement was November 15, 1951. On morning of November 17 the patient began to bleed and was admitted to the hospital, with an estimated loss of 200 to 300 cc. of blood. She was having occasional abdominal cramps, but no definite uterine contractions were noted. Her general condition was good; blood pressure 112/68; fetal heart satisfactory. She was still bleeding moderately on admission to hospital at 11:20 a.m. At 12:15 p.m. the patient was given 20 cc. of anti-hemophilic globulin, and at 12:45 p.m. the bleeding stopped. At 2:30 p.m. on November 18 the membranes were ruptured artificially and at 6:37 p.m. she was delivered of a normal infant with no difficulty.

Case 7.—Mrs. A. F., aged twenty-two, had a fairly difficult low forceps delivery after long labor. There was moderate bleeding post-partum, with extension of the

episiotomy along the vault. She was discharged after five days. She returned to the hospital on the seventh day post-partum, with severe bleeding, not from the cervix, but there was severe oozing from the episiotomy wound in the vagina. She was given 20 cc. of anti-hemophilic globulin. The bleeding promptly stopped. She received a transfusion the next day and was discharged in two days with no further bleeding.

Case 8.—Mrs. W., aged forty-three, had moderate uterine bleeding for ten days and severe bleeding for twenty-four hours. Dilatation and curettage were done, but the bleeding continued. The uterus was fibrotic and there was probably one small fibroid in the uterine cavity, felt by the curette. After the dilatation and curettage she was bleeding quite heavily. She was given 20 cc. of anti-hemophilic globulin, and the bleeding promptly stopped. She was discharged forty-eight hours later with no further bleeding.

Case 9.—Mrs. R., gravida 3, had an uneventful prenatal course until she was estimated to be about five months pregnant. Suddenly she began to have painless bleeding. The patient was admitted to the hospital and given sedatives and 10 mg. of stilbestrol three times daily for two days. The bleeding subsided somewhat, but she was still losing some blood and a few blood clots. She was given one unit of anti-hemophilic globulin, and the bleeding promptly stopped. She was discharged in forty-eight hours.

Schneider[2] reports three cases of abruptio placenta, treated by cesarean section. In all three cases the fibrinogen level of the plasma was very low. These levels were taken several hours after the onset of the symptoms. The first patient was also a pre-eclamptic and her level was 0.11 gm. per cent. The second patient had 0.09 gm. per cent, and in the third the level was too low to be read. Normal values for pregnant women at term range from 0.3 to 0.7 gm. per cent, and for pre-eclamptic patients the values range from 0.3 to 0.9 gm. per cent.

In his three cases, fibrinogen levels were back to normal within three days after the abruption. His analysis of the cases indicated that the patients must have had normal fibrinogen levels before the acute onset of the abruptio. All of them developed an acute fibrinopenia, and all rapidly began to form fibrinogen again, since in all of them, fibrinogen was soon restored beyond the level attributable to transfusion. Schneider theorizes that the abruption frees the thromboplastin from the decidual tissue. Thromboplastin then enters the maternal circulation and causes a widely disseminated intravascular deposition of fibrin, thus producing fibrinopenia. The utilization of fibrinogen in this process may deplete this substance so severely that it may become insufficient for hemostasis.

J. Frederick Johnson, Walter H. Seegers, and R. G. Braden[1] have studied the plasma Ac-globulin and fibrinogen levels in two cases of abruptio placenta.

In the first case, one hour after fetal heart was no longer heard, the Ac-globulin was less than ¼ unit per milliliter as compared with normal plasma Ac-globulin of 13 to 17 units. The prothrombin concentration was 40 per cent of normal, and the fibrinogen content was less than 10 per cent of normal. The patient had a stillbirth and was given 500 cc. of blood. Seventeen hours after delivery, the Ac-globulin was only 3 to 5 units per milliliter, but the fibrinogen content had been restored to a greater extent, as had the plasma prothrombin. The Ac-globulin concentration reached normal values two to three days after delivery, thus indicating that this clotting factor is restored slowly.

In giving anti-hemophilic globulin intravenously, we are adding to the blood three factors: fibrinogen, Ac or accelerator globulin, and the anti-hemophilic factor. One vial of the powdered globulin, containing 200 mg. of fibrinogen, is mixed with 20 cc. of distilled water (for convenience in administration), and it is injected quite rapidly. There have been no undesirable reactions noted so far. In one case, 18 units of the globulin were given without any complications.

We are satisfied that anti-hemophilic globulin is a worthwhile product in certain kinds of bleeding. We believe that further studies, both clinical and laboratory, should be carried out in an attempt to still further evaluate this product.

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Why does Government cost more? Here's a clue:

The Declaration of Independence contains 300 words: The Ten Commandments contain 297 words; The Lord's Prayer contains fifty-six words; The two Commandments that comprise the whole law of God contain twenty-three words.

But despite the examples of simplicity and brevity set by these masterpieces of wisdom and literature, the OPS order setting the price of cabbage contains 26,911 words.

Why Michigan's Basic Science Law Should Be Repealed

By Franklin L. Troost, M.D.

Holt, Michigan

BEFORE OPENING this discussion, the writer will give his sources of information for the facts presented in this paper. They are the United States Census Bureau; the Directories of the American Medical Association; the State Board Numbers of the American Medical Association; the Federation Bulletins published by the Federation of State Medical Boards of the United States; Special Bulletin 370 on Distribution of Doctors of Medicine and Osteopaths in Michigan Communities, written by Dr. John F. Thaden of Michigan State College; Michigan Department of Health Office Law Enforcement Reports, and the basic science laws of the eighteen states and the District of Columbia which have such laws. The laws of all of these states have been carefully studied and material from them will be used in this paper. The State of Nevada passed a basic science law in 1951, but there are no figures yet available on its application; therefore Nevada will not be included.

My interest in Michigan's basic science law came about through my term of service for nearly five years, from February, 1947, to November, 1951, as a member of the Michigan State Board of Registration in Medicine. This term brought to me the appalling results of our basic science law in depriving Michigan people of badly needed medical doctors. Further it has crippled all of our large teaching hospitals because interns and residents cannot be secured in sufficient numbers. No one disputes the fact that our state is desperately short of medical care; there is a difference of opinion as to how to correct the situation. An attempt will be made to keep statistics at a minimum; it will, however, be necessary to use a certain amount of them. Let me emphasize that this article is written at my own behest and that the Michigan State Board of Registration in Medicine has nothing to do with it. The board has never taken any action on the basic science law.

EDITOR'S NOTE: The Council, at its January 25 and 26 session, authorized publication of a paper by Dr. Troost and a reply by Dr. Spalding, for general information prior to the Annual Session in September.

Historical

Connecticut was the first state to pass a basic science law. This happened in 1925. In the same decade Arkansas, District of Columbia, Minnesota, Nebraska, Washington and Wisconsin followed suit. In the 1930's, Arizona, Colorado, Florida, Iowa, Michigan, Oklahoma, Oregon and South Dakota passed similar laws. In the 1940's New Mexico, Rhode Island, Tennessee and Texas joined in. In 1951 Nevada also approved like legislation. The avowed purpose as set forth in some of these laws was to protect the health or safety of the citizens of the state and to improve the standard of the *healing arts*. None of them mentions improving the standard of *medical practice*. One can see that the high tide of basic science laws was reached in the 1930's. Since then the enthusiasm for them has waned. In spite of their high-sounding avowed purposes and sanctimonious preambles, these laws were designed to exclude those of other schools of practice, namely, osteopaths and chiropractors. This is a serious statement, but in a matter of this kind, we must be candid. Has this happened in Michigan? We shall see.

Interstate Medical Reciprocity

The following is taken from a paper delivered in 1950 by Jacob L. Lochner, M.D., secretary of the New York State Board of Medical Examiners and president of the Federation of State Medical Boards of the United States:

"The evident original purpose of basic science laws as a prerequisite for licensure in all of the healing arts was to exclude from licensure inadequately trained practitioners. There appears to be considerable doubt as to whether they have or are accomplishing their purpose. Statistics would indicate that the number of cultists examined in 1946 comprise only 3.5 per cent of the total number of 3,333 candidates examined that year. In order to control this 3.5 per cent of applicants for licensure plus 6 per cent of osteopathic candidates, the remaining 90 per cent (all graduates of approved medical schools and many with additional postgraduate training) are required to submit to the basic science board examination. All but four of the basic science boards apparently have the discretionary power to endorse basic science examinations given in other states but apparently many of them are not willing to exercise this power. Therefore, the basic

science boards offer one of the most important obstacles to more widespread interstate endorsement."

Dr. Roy Harrison addressed the annual meeting of the American Association of Basic Science Boards in February, 1948, as follows:

"With the present setup, I am very fearful that such a thing as reciprocity by all states is a very long way off. Louisiana could easily put in a basic science board as a subsidiary to our board but I cannot see any reason for it, and if we would put one in, it would be in a form of subterfuge purely to meet certain technicalities of other states so that our applicants could get repicrocity. I would admit that that may be one way out and several of the states may have to resort to such a plan, but I certainly do not think that it is necessary."

Dr. Harrison was also perturbed at the situation a physician finds himself in who has met all the requirements of the law and who is eligible for reciprocity but cannot get it without taking the basic science examination.

In 1950 Michigan has accomplished interstate medical reciprocity with every state in the Union, except for Florida, which has no reciprocity with any state in either medicine or basic science. No other state in the country has as widespread medical reciprocity as Michigan. In 1951, Massachusetts removed Michigan from the list of states with which it reciprocates. Its reason was that Massachusetts physicians, to practice in Michigan, must first pass our basic science examination, while Michigan physicians, going to Massachusetts, would not be faced with this ordeal. Can we blame Massachusetts? Certainly not. There have been mutterings from other states on this line and our fine interstate reciprocal medical reciprocity is in danger of collapse. Do you doctors want that to occur?

Some twenty-five or more years ago, Dr. F. A. Coller, head of the Department of Surgery at Ann Arbor, and Dr. Cyrus Sturgis, head of the Department of Medicine, came to Michigan from Massacrusetts. If men of that calibre were to come to the University of Michigan or to Wayne University today to accept the chair in some department of our medical schools they would be required to take the basic science examination if they graduated after 1941. Could we expect to get such men into Michigan if they were required to face this examination? The answer, I believe, is very obvious.

Basic Science Reciprocity

There are those who say that we should retain our basic science law because our own basic science licentiates would lose their basic science reciprocity if they moved to other states having basic science laws. Actually Michigan has basic science reciprocity with just three states: Arkansas, Minnesota and Nebraska. In any other basic science state, our doctors would be required to take the basic science examination. Therefore, this argument does not hold much weight.

At the present moment (February, 1952), the Michigan State Medical Society is sponsoring a bill in the legislature of the State of Michigan to amend the basic science law. One provision is to remove the subjects of hygiene and public health from our basic science law. The object is to open up more possible interstate reciprocity in basic science with other basic science states. At present only Michigan and Texas include public health in the basic science subjects, but most of the states require hygiene. The states that do not require hygiene are Colorado, District of Columbia, Florida, New Mexico, Rhode Island, South Dakota, Tennessee and Wisconsin. If we eliminate hygiene, it is very likely that we will lose the three states—Arkansas, Minnesota and Nebraska—with whom we have reciprocity, as they all require hygiene. In their place, we might effect reciprocity with only Colorado, District of Columbia, Rhode Island, South Dakota, Tennessee and Wisconsin. The states of Florida and New Mexico reciprocate in basic science with no other state; this is also true of the states of Connecticut and Washington. At present, Rhode Island reciprocates in basic science only with the Massachusetts Board of Registration in Medicine. Thus, if our law is amended as submitted, we shall have potential reciprocity in basic science with only five or six states, most of them being small states. This writer believes the proposed amendment to be very bad from that standpoint. It will make our reciprocity in basic science smaller rather than larger.

Other Schools of Practice and Our Basic Science Law

The most frequent question asked concerning repeal of our basic science law is: "Would not repeal open the gates to those of other schools of practice?" The gates are wide open now. In 1940 there were 435 osteopaths registered in Mich-

igan; in 1950 this has increased to 907, an increase of over 100 per cent in ten years, *during which time the basic science law was in effect.* Chiropractors registered in Michigan increased from 492 in 1940 to 747 in 1950, an increase of 50 per cent. There are some 11,000 osteopaths in the country. On a population basis, we should have about 4 per cent of them. Actually we have between 8 and 9 per cent, and all this has come about with our basic science law in full effect. Does our law keep them out? Most definitely not. People will ask "How do those of other schools get into the state, then?" A few come in by examination, most of them by reciprocity in basic science with Minnesota, Nebraska and Arkansas—chiefly Minnesota. In 1949, Michigan issued 126 basic science certificates by reciprocity; only 38 of these to medical doctors, the rest being to osteopaths, chiropractors and unclassified. It must be granted that if our law were repealed we would probably have more than ever of the other schools for a short while. Soon, however, our state would secure enough medical doctors and the situation would take care of itself. Many people are cared for by non-medical men because there is no medical care available. This writer has enough confidence and pride in the medical profession to believe that most of the people would come back to us if there were enough of us to serve them.

States without basic science laws are not overloaded with those of other schools. Illinois has 12,795 medical doctors and less than 500 osteopaths. Ohio has 9,883 medical doctors and less than 500 osteopaths. Neither state has a basic science law. When there is enough medical care available, the other types of practitioners fade away to large extent.

Who Favors Repeal of Our Basic Science Law?

Repeal of our law is favored by many of the leading medical educators of this state. These men, in their contact with students and interns, have learned that many of our own graduates and those from other states are not interested in practicing in Michigan because in addition to a state board examination they must face the basic science examination. Among those in favor of repeal are Dr. A. C. Furstenberg, dean of the Medical School of the University of Michigan; Dr. Gordon Scott, dean of Wayne University School of Medicine; Dr. F. A. Coller, professor of surgery at the University of Michigan; Dr. Paul Barker and Dr. H. M. Pollard, both of professorial rank in the Department of Medicine at Ann Arbor; Dr. Clarence Owen, pathologist at Grace Hospital, Detroit, and Dr. Frank Weiser, who has charge of intern and resident training at Grace Hospital. These men have learned in their teaching duties that we cannot interest enough young doctors to take residencies in our great teaching hospitals, as our laws require that residents be licensed, and licensure depends on a basic science certificate before they can be examined or licensed by the State Board of Registration in Medicine.

Both Dr. Furstenberg and Dr. Scott have volunteered to appear before our House of Delegates next fall to plead for repeal of the basic science law.

Some years ago the doctors of Washtenaw county introduced a resolution in the House of Delegates of our State Society to repeal the basic science law. In 1950 and 1951, Ingham County Medical Society instructed its delegates to introduce a similar resolution. The reference committees to which these resolutions were referred in both 1950 and 1951 brought in a favorable report recommending that the law be repealed. The chairman of the 1950 committee was Dr. Frank Weiser, mentioned above; the chairman of the 1951 committee was Dr. Arch Walls of Detroit, recently president of Wayne County Medical Society and a man who holds high office in the American Academy of General Practice. In fact, the Legislative Committee of the State Society in 1950 adopted a resolution recommending repeal of the law, the committee favoring repeal by a vote of 11 to 2. Could you think of a more impressive group than these men mentioned above?

In 1950 the question was put aside by the House of Delegates for another year's study. In 1951 repeal was defeated in the House of Delegates by a narrow margin. Many of those voting against the motion, or who did not vote, told this writer that they wanted to talk it over with their constituents back home before voting for repeal. When the doctors of the state realize what this law has done in depriving our people of medical care, it will be repealed.

Who Favors Retention of Our Basic Science Law?

Many who favor retention are those who do not know the facts as to what has happened to our physician supply since the advent of basic science. It is hoped this article will bring to them

the facts. Others are those who twenty years ago began to sponsor this law and do not like to see their efforts of two decades ago put aside. Basic science laws were the vogue of the 1920 and 1930 eras. Let us be up to date; let us realize that in the present decade there is keen competition for medical doctors and we must do all we can to get our share so that the people of Michigan can be served. Some will say that no state has ever repealed its basic science law. This is true. Michigan State Medical Society is proud of its "Michigan Firsts" in medicine. Let us be the first to rid our state of such legislation and watch the other states follow along.

Some say that it is a good law but that it has been poorly administered. What is good about it? Has it kept out those of other schools of practice? It has not. Has it kept out medical doctors? Very definitely yes. If our law were the most perfect one in the country and if it were administered to perfection, it still would not help us, as the medical students and doctors *would still have to take the examination, and they will not do it in sufficient numbers.*

I have asked proponents of this law to give me one single, solitary, valid reason to keep it. The only reason I can find is that those who fostered it do not care to admit it was a mistake and did not turn out well. Could they not swallow their pride if it would give the people of the state enough doctors to take care of them? If that is the reason, then I say we have failed in our trust—we have failed in our duty to serve the sick to the best of ability, and all because we will not correct a mistake that we made. Can we afford to keep the basic science law with people clamoring (and correctly) that they cannot get doctors. Of course we cannot; we should do all we can to encourage qualified medical doctors to come into Michigan instead of doing all we can to keep them out.

I do not agree with the oriental philosophy of saving face. My philosophy is to save the health and lives of our citizens by making medical care available to them.

The Michigan State Medical Society is sponsoring another amendment to the basic science law. This reads: "That this act (the basic science law) shall not be construed as applying to interns and residents who are training in Michigan hospitals." A companion bill would also exempt interns and residents from being required to obtain a Michigan license. It is admitted that these would solve, to large extent, the problem of the hospitals not having sufficient residents. They always had a plethora of residents before we had basic science. However, it would not give us more practicing doctors, but rather less. These men, judging by past experiences, would put off taking their examinations until they had finished their training. Then they would be ten years away from their bacteriology, chemistry and other subjects and would not take the basic science examination, or, if they did, most of them would fail. Many are licensed in other states before coming to Michigan, or are National Board diplomates, thus giving them plenty of places to locate without further examinations and we would lose them.

Results of Basic Science Examinations in Michigan

The following figures are taken from the *Journal of the AMA* for the last five years in their state board numbers. In 1946, 1947, 1948, 1949 and 1950 a total of 1,979 medical doctors and medical students took the Michigan basic science examinations. Of the 1,979, 452 failed. This is a failure rate of 23 per cent. In other words, the basic science law cost us directly 452 physicians through failure. The national average of failure of medical doctors and medical students on basic science is about 12 per cent. Michigan's failure rate is thus almost double the national average.

It is not only those who fail who concern us. There are many well-trained medical doctors, general practitioners and specialists alike (many of whom have passed the boards in their specialities) who would like to move into Michigan. But we have a most effective road block in their way: the basic science law. If this law were repealed, they could come in through interstate reciprocity from almost any state in the country. How many there are of these is of course impossible to say. The best estimate is that we lose more this way (through their refusal to take the basic science exams) than we do through direct failure.

Just today this writer talked with four interns at the E. W. Sparrow Hospital in Lansing. All of these men are National Board diplomates, and all came from other states. All can be licensed in their own states upon completing their internships. All want to stay in Michigan and practice in small communities. None of them is going to practice in

Michigan as they do not have the time to spend preparing for the basic science examination. This is an example of why we have such a paucity of doctors of medicine.

Let no one think that basic science is popular throughout the country. While nineteen states and the District of Columbia have such laws, many of them are very small states. In 1950 there were 201,277 medical doctors in the country. Only 50,787 of them were located in the basic science states. In other words, when a young doctor wants to locate, there are three places out of four that he can go to without bothering with a basic science examination. No wonder they pass us by.

Michigan's Need of Physicians

The following article was copied from the December, 1951, issue of the *Bulletin of the Wayne County Academy of General Practice:*

"The President's Message in the *Muskegon County Medical Society Bulletin* was very interesting. That county has eighty-two M.D.'s for a population of 112,000 people, but of that total he figures there are only about thirty physicians who are either willing or capable of giving general medical care to the population. In other words there is one general practitioner to 3,733 persons.

When only three out of eight physicians can and will make house calls and attend the average family's emergencies, it is a strained situation. The English panel system limits a physician panel to a top of 4,000 people so each of these thirty in Muskegon must be traveling at high speed and doing a production type of medicine of necessity.

Is it any wonder the so-called cults are doing a thriving business and in many places are replacing the M.D.'s?"

How does this article strike you?

The following statements are taken from Dr. Thaden's article mentioned at the beginning of this paper.

"There is a total of 6,937 physicians in Michigan (1950). This is a ratio of 919 persons per physician. For the United States the ratio is 749 persons per physician."

"From 1910 to 1950, the number of physicians in Michigan increased from 4,100 to 6,937, an increase of 69 per cent, while total population increased 126 per cent."

"From 1910 to 1950, the number of persons per physician increased from 685 to 919."

"Between 1930 and 1950, the number of persons per physician increased from 1,292 to 1,728 in the twenty-two entirely rural counties and from 857 to 903 in the sixty-one counties with both rural and urban populations."

"One-fourth of the communities surveyed are adequately supplied with physicians and three-fourths are not."

Medical Schools in State, 1940-1949, Graduated Less Than Half of State's Requirements

"It seems that the demands for physicians in Michigan have consistently exceeded the supply of medical doctors who have been graduated from the medical schools located in Michigan. The number of persons who were graduated from the University of Michigan Medical School during the decade 1940-1949 totaled 1,189. The corresponding figure for the College of Medicine of Wayne University was 711, a combined total of 1,900, which is a considerable number. Nevertheless, this figure is slightly less than one-half as many persons as were licensed to practice medicine in Michigan by the State Board of Registration in Medicine during that same period—a total of 3,815. One logical deduction is apparent: that the number of graduates from Michigan's two medical schools during the past decade was insufficient to replace the doctors who retired, became inactive, died, or moved to other states and at the same time was inadequate to keep pace with the state's rapidly growing population."

Doctors of Medicine Licensed to Practice in Michigan, 1940-1949, Are Predominantly Natives of Other States and Graduates of Medical Schools Outside of Michigan

"Most of the graduates of medical schools in Michigan, soon after completing one year of internship, apply to the Michigan State Board of Registration in Medicine for approval to practice medicine within the state. As previously mentioned, a tabulation of those approved during the decade 1940-1949 shows that a majority were born in other states (or countries) and are graduates of medical schools outside Michigan. Less than one-third (31 per cent) of the 3,815 medical doctors who were approved were born in Michigan. Less than one-half (44 per cent) were graduated from either of Michigan's two medical schools. In only two years (1943 and 1944) were as many as one-half of those approved to practice medicine in Michigan graduates of the state's own schools of medicine."

It is to be remembered that our 6,937 physicians includes all of those in the state. This includes interns, retired doctors, those in public health work, state hospitals and others. Actually only 5,343 doctors were engaged in private practice in 1950. Just 5,343 men to render medical care to all of the 6,300,000 people of Michigan! In 1940, there was one doctor for every 752 people in the country and one for every 749 in 1950. This stayed practically stationary. In Michigan the number increased from one to every 826 people in 1940 to one to every 919 in 1950. Every year our shortage gets worse. At present we have 20

per cent less doctors than the nation as a whole. Of the doctors in the state, about one half were graduated in our medical schools. We must import the rest of them. The increase in the size of classes in our medical schools will increase our total graduates from seventy-five to ninety per year, nowhere near enough. Reciprocity will not help. As many doctors leave the state by reciprocity each year as come in. In time, this will be more unfavorable as only those who graduated by 1941 can come in by reciprocity without taking basic science examinations.

In the last decade, Michigan's population increased 1,115,660 people, the total number in the state now being 6,371,766. During this same period, the number of physicians in the country increased 26,114. Michigan's increase of physicians numbered only 575. That is only one new medical doctor to about 2,000 new citizens in our state. If we take the national average of one doctor to every 749 people, our physician increase should have been 1,489. Our total population increase in the last ten years was exceeded only by California, Texas and New York. We gained more people than did the states of Ohio, Pennsylvania and Illinois. The census bureau estimates that the population of the country increased by 2,500,000 people in 1951. At one doctor per 749 people (the national average), 3,338 more doctors were needed in the country in 1951 than in 1950 just to take care of this increase of population. This is more than half the number that the medical schools graduated. There will continue to be keen competition for medical doctors. Does it not seem sensible that we revise our thinking to meet present needs and make it possible for Michigan to get its share of doctors by elimination of the deterrent influence, the basic science law?

On a population basis, we should have 8,400 doctors, so at present we are short 1,500 doctors of medicine. We are a progressive, growing state, gaining population at the rate of 110,000 people per year. Doctors would be glad to come to Michigan but will not or cannot because of our basic science law.

In 1950 there were 6,002 new young doctors who took a license for the first time. Of these, only 186 came to Michigan. Ohio, with a population only 25 per cent greater than that of Michigan, secured 348 of these young doctors, almost double of those we secured. New York State, with a population double ours, obtained 701, almost four times as many as we did.

Where are we going to secure the 1,500 doctors that we are now lacking? Where will the replacements come from for the 150 to 200 Michigan doctors who die or retire each year? Where will the 143 (one for every 749 people) doctors come from to serve the annual population increase of 110,000 a year? If we could secure 500 medical replacements a year for a period of ten years, we would finally get up to national physician-population ratio. Of this 500 needed we secured only 186 in 1950. The answer as to where the needed doctors are coming from is that *they are not coming*—not coming until we become realistic and repeal the basic science law.

What to Do

Many doctors ask what they can do to get the basic science law repealed. If this article has convinced them that it should be done, they can ask their fellow practitioners to read it carefully. Then they can bring the matter up in their county medical society meetings and have their delegates instructed to vote for repeal in the House of Delegates in 1952. There are those who will say that it will be difficult to get it through the Legislature. This I do not believe. Everyone admires a man or a group who has made a mistake and is willing to admit it and try to rectify it.

For a period of thirteen or fourteen years this country tried prohibition. It turned out to be a failure and was discarded. The basic science law has been a dismal failure in its fifteen years of existence. Cannot we be honest enough to admit we made a mistake and take the necessary steps to correct it? I think we can.

Let us not temporize with this problem. Amendments to the basic science law cannot solve the problem. Either we have a basic science law or we do not. Let us meet this head on with courage and with faith. Let us repeal the basic science law in its entirety; let us be neither apostles of appeasement nor disciples of despair.

MSMS

You Can't Be a Good Citizen Unless You VOTE
You Can't Vote Unless You REGISTER!

Reply to Article by Dr. Franklin L. Troost on Repeal of Basic Science Law

By Edward D. Spalding, M.D.

Detroit, Michigan

There appears in this issue of The Journal of the Michigan Medical Society a 4,700 word article by Dr. Franklin L. Troost calling loudly for the repeal of the basic science law of this state. When a resolution from Ingham County to this effect was reported on favorably by a reference committee, the 1950 House of Delegates, instead of passing the resolution, referred the question to a special study committee. This study committee after some months of careful consideration unanimously reported that they considered the law fundamentally to be a good one, but that certain modifications in it should be made. The primary difficulties, they claimed, were not in the basic science law itself, but in its administration on the one hand, and in the medical practice act on the other. *(All this is not mentioned in Dr. Troost's article.)*

The 1951 House of Delegates, on receiving the report of the study committee, and after quite prolonged debate, voted *not* to work for the repeal of the basic science act by the very substantial majority of 71 to 23 (and not the "narrow margin" claimed by Dr. Troost). Instead appropriate efforts were made to effect modifications in the basic science law along the lines suggested by the study committee, and also in its companion bill, the medical practice act. These were successful, and this April the Legislature passed, and the governor signed, the amended basic science act, which has six changes, the most important of which are: (1) elimination of examinations in "hygiene and public health" (to be in conformity with a number of other states); (2) not requiring re-examinations in those subjects previously passed; (3) not construing the act to apply to interns and residents in training in Michigan hospitals; (4) requiring the Board of Examiners to file with the Secretary of State each January a list of all those certified during the preceding year.

The modification of these two acts does away with the basic difficulties previously encountered and leaves the law, with the proper restrictions, to operate as was the intent when originally passed.

The arguments of the essayist about the keen competition among the states for young doctors and that "we must do all we can to get our share" make sorry reading. What we need, and *want*, is young men of ability, not just numbers. Are we to believe that the present generation of young medical men is intellectually so feeble that an examination in the basic sciences represents a formidable obstacle? If so, the country is indeed in bad shape.

A proper modification of a fundamentally good law has been achieved. It should now be permitted to function; and let us hear no more of this casting off of all restrictions, just because in its application some adjustments were found to be necessary.

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NEURODERMATITIS

(Continued from Page 864)

difference whether the patient is sheltered and well balanced or exposed to evil experiences. His peculiar innate personality, his restlessness, his conditioning to itching and scratching, and his abnormal reaction to frictional trauma are stigmata and not acquired properties.

The disease has characteristic but no specific features. The lack of allergenic specificity is best expressed with the very word "atopic." Lack of specific psychologic features has been pointed out by Becker, and the same conclusion can be drawn from the careful analyses of Klauder and of Lynch.

Summary

All known features of neurodermatitis can be interpreted as being due to an inherited constitutional anomaly involving both the psychic and somatic spheres. The main characteristics of this anomaly are emotional instability, pathologically increased conditioning to itching and scratching, abnormal tissue reactions in response to scratching, which in turn lead to itching hyperexcitability, facilitating the creation of itching-scratching cycles. Emotionaly induced vasodilatation may further aggravate the vicious cycle.

MSMS

Desmoid tumors may develop in any of the striated muscles or their aponeuroses.

* * *

Generally speaking, desmoid tumors are not malignant and, while prone to local recurrence, do not metastasize.

Editorial

MICHIGAN STATE MEDICAL SOCIETY ANNUAL SESSION
SHERATON-CADILLAC HOTEL—DETROIT
September 24-25-26, 1952

"We hold these truths to be self-evident; that all men are created equal; that they are endowed by their Creator with certain inalienable rights; that among these are life, liberty, and the pursuit of happiness. That to secure these rights, governments are instituted among men deriving their just powers from the consent of the governed."—DECLARATION OF INDEPENDENCE, July 4, 1776.

DEVIOUS METHOD

THE *Saturday Evening Post* of May 10, 1912, published an advertisement, "Hell's Canyon?" The local Electric Light and Power Company, on the Idaho-Oregon border, wished to build a dam and hydroelectric plant on the Snake River, to cost about $357,000,000. Quote: "But the job is held up. For there are those who want the Federal Government to take over electricity—as well as medicine and other businesses and services. They insist that the government develop the power even though it takes longer and costs many millions more."

This advertisement speaks volumes. It points out a roundabout method of giving the politicians control. When bureaucrats get a foothold in electricity, they have demonstrated their abilities to expand and extend their powers and influences. The Tennessee Valley Authority grew out of a flood control project. No one except the Social Planners expected such growth.

On May 19, 1952, another devious method of infiltration was defeated. The Congress was considering a supposedly inoccuous bill to increase the benefits to old-age retired persons, and certain others, about five dollars a month. No one expected opposition. The bill was prepared in secrecy, approved by the Ways and Means Committee, bypassed the Rules Committee, and was called up under suspension of the rules, with twenty minutes of debate on each side and no amendments possible. Federal Security officials had inserted "sleepers" in the bill (hidden, unless one had at hand the basic law which was being changed by words and phrases) so there would be granted increased power to the FSA Administrator to set up a new social security program and name the persons to make the prescribed examinations.

The Congress was faced with the necessity of passing this Socialized Medicine entering wedge or denying the old-age retired persons a paltry five dollars a month. The measure did not carry. That was not a vote against the old-age benefits, but against Socialized Medicine. Promptly President Truman blasted the American Medical Association as having "waved the big stick" and forced the Congress to do its bidding. He accused the American Medical Association of defeating the benefits due to retired persons.

Again government administrators sought to extend Socialized living by devious methods, by subterfuge and misrepresentation. The bill purported to be a benefit for the old people on inadequate retirement allowances, but actually offered a meagre amount of help. It would, however, have extended the F. S. Administrator's grip on the health needs of the nation.

We have mentioned repeatedly that frontal attack in the field of Socialized Medicine is not being pushed, but bites are attempted here and there. Insidious and devious ways are used to further the grasp of the bureaucrats already in the government and to establish new leads. The objective seems to be to use medicine, if they can, or electricity, education, business—any group available—affording professional planners a permanent place in the government and an opportunity to do what they do so poorly in contrast with the natural excellent and wise leaders in medicine, business or industry.

INCOME TAXES

WE HAVE BEEN informed that the Internal Revenue agents are in certain sections now in the process of going over and searchingly investigating the books of all doctors who have gross incomes of $25,000. That limit includes a great percentage of actively practicing physicians.

The inspectors are interested in automobile ex-

penses, and in case of persons who chiefly practice in hospitals then will allow only enough transportation to get from one hospital to another. Costs of getting to the doctor's place of business are not included and have been more or less taboo for some time.

Claims for deduction of entertainment expenses are being scrutinized very carefully. The account must be in the form of checks or receipts showing the time and place of entertainment, the persons present and evidence that those persons have actually referred patients to the doctor. Otherwise the entertainment is claimed to have been a personal expense. For instance, the department is loathe to admit the legitimacy of a specialist entertaining his professional friends.

The department claims that this form of entertainment is actually advertising, and points to the American Medical Association Code of Ethics as prohibiting all forms of publicity which might be construed as advertising.

Why should the medical profession be selected for this special type of attention? It is not the first time we have been suspect. We have one important suggestion for all members who claim deductions in income tax reports. Have every item written down, covered with receipts or checks if possible.

MEDICAL ETHICS AND ADOPTION

THIS STATEMENT is intended to provoke discussion regarding the correct ethical position of the medical profession toward non-relative adoptions. It is not directed at the evil of the black market in babies, against which Michigan has adequate law. It is concerned with those cases in which doctors advise interested would-be parents of the availability of a particular newly-born or about-to-be-born baby, the adopting parents carrying on from there in accordance with the Adoption Law.

The Michigan law provides that first the couple must file a petition to adopt the particular child. Then after proper study of the home by court personnel and after an order severing maternal rights and making the child a ward of the court, the judge may authorize placement of the child in the adoptive home. Thus legally the judge has complete power to decide what is best for the child, but in practice judges can hardly refuse petitions of prominent families of excellent reputation when the petitions are endorsed by highly respected members of the medical profession. The question, therefore, is whether doctors should refuse to divulge information about babies which may be available for adoption, referring all inquiries to the social agencies licensed or authorized by law to make placements.

The doctors who continue to believe that the furnishing of the information about babies to would-be parents is a proper part of medical practice usually believe in their own ability to "pick" would-be parents, despite the fact that few general practitioners or obstetricians know their patients in the intimate personal manner of the practitioner of two generations ago. The picking is even more subjective when non-patient personal acquaintances of the doctor importune him, since he is subject to the common problem of everyone in being impersonal in evaluating friends. The doctor usually also supports his action by believing he is doing a favor to the mother whose hospital bill has to be paid or to the adopting parents who "need" a child, for personal emotional reasons. But the doctor frequently does the adopting parents a dis-favor. Judges usually insist that this type of adoption petition be granted at once, without a waiting period after placement of the child, since otherwise if the unmarried mother disappears, no one will be responsible for the child if the adopting parents change their minds because of disappointment in the baby as it develops; nor does he do a favor to the mother who, after the stress of pregnancy is over, may, too late, reconsider her decision to place the child. Nor does he have time to make a study of the background of the child to determine if he is likely to fit the new home, an assurance to which the natural mother of the child is entitled.

Much more serious, though, is the fact that the baby's rights are overlooked in doing supposed favors to old or new parents. The baby is the patient when the question is placement—not the parents. Have the best possible parents in the community been selected for this particular child? It is impossible for the doctor to answer "yes" to the question in most cases. Yet proper treatment of the patient requires such an answer. No competent doctor has the time to prepare carefully social histories on 100 or more prospective parents from whom he can pick a couple.

Has the time come to write into our ethical code a prohibition on child placing activity?—Prepared by Child Welfare Committee.

Welcome to Detroit!

Michigan's outstanding medical event of the year —the Michigan State Medical Society Annual Session—will once again attract hundreds of medical practitioners to Detroit this September.

The 87th Annual Session offers three information-packed days to the doctors of medicine who will attend from Michigan and the surrounding states in the midwest. The twenty-four authoritative medical teachers from throughout the United States will discuss the latest advances in the swiftly moving science of medicine, September 24-25-26, 1952, at the Sheraton-Cadillac Hotel, Detroit.

Besides the excellent scientific program, this year's Annual Session also will feature social programs of interest to the visiting doctors and their wives. These social affairs include Officers' Night on Wednesday, September 24, at which time a nationally famous personality will present the annual Biddle Lecture. The following night, Thursday, September 25, the Michigan State Medical Society will be hosts to all registrants and their guests at the State Society Night.

An innovation has been added to the scientific program this year. There will be no luncheon meetings. Instead, a daily Discussion Conference will be held from 12:00 noon to 1:00 p.m. At this daily Discussion Conference all of the day's scientific speakers will appear and participate. These daily meetings offer the visiting practitioners an excellent chance to preview and review the day's scientific events. The twenty-four scientific speakers, all outstanding specialists in their particular fields, include the following:

Gaylord W. Anderson, M.D., Minneapolis, Minn.; Claude S. Beck, M.D., Cleveland, Ohio; John J. Bonica, M.D., Tacoma, Wash.; Spencer Braden, M.D., Cleveland, Ohio; George Crile, Jr., M.D., Cleveland, Ohio; Ormond S. Culp, M.D., Rochester, Minn.; Daniel C. Darrow, M.D., New Haven, Conn.; Edwin J. DeCosta, M.D., Chicago, Ill.; Garfield G. Duncan, M.D., Philadelphia, Pa.; Carl W. Eberbach, M.D., Milwaukee, Wis.; Dwight E. Harken, M.D., Boston, Mass.; Peter C. Kronfeld, M.D., Chicago, Ill:; Milton I. Levine, M.D., New York, N. Y.; Roland P. MacKay, M.D., Chicago, Ill.; Samuel F. Marshall, M.D., Boston, Mass.; Earl R. Miller, M.D., San Francisco, Calif.; Emil Novak, M.D., Baltimore, Md.; Duncan E. Reid, M.D., Boston, Mass.; David A. Rytand, M.D., San Francisco 15, Calif.; Ben H. Senturia, M.D., St. Louis 5, Mo.; Evan W. Thomas, M.D., Albany 7, N. Y.; Philip Thorek, M.D., Chicago, Ill.; Leonard F. Weber, M.D., Chcago, Ill.; Claude E. Welch, M.D., Boston, Mass.

While the doctors of medicine are attending the Annual Session in the Sheraton-Cadillac Hotel their wives and their medical assistants will be holding annual conventions concurrently. The Woman's Auxiliary to the Michigan State Medical Society will meet at the Fort Shelby Hotel, Detroit, September 24-25-26, 1952. The Michigan State Medical Assistants Society will hold its Third Annual Convention on Wednesday and Thursday, September 24 and 25, 1952, at the Tuller Hotel in Detroit.

The technical exhibits will be a highlight of the 87th Annual Convention as in the past. A total of ninety-nine technical exhibitors will display the latest in medical supplies and medical equipment.

All doctors of medicine are cordially invited to take part in this outstanding medical event of the year in Michigan. The 87th Annual Session is a stimulating and beneficial experience for every medical practitioner. It is also a time to renew old acquaintances.

You, as a practicing doctor of medicine, will not want to miss this outstanding event.

Michigan State Medical Society

The 87th Annual Session

SHERATON-CADILLAC HOTEL, DETROIT, MICHIGAN

September 24-25-26, 1952

ANNUAL SESSION INFORMATION

DIRECTORY

Headquarters—Sheraton-Cadillac Hotel, Detroit

Registration—Fifth Floor, Sheraton-Cadillac Hotel

Assemblies—Grand Ballroom (Fourth Floor), Sheraton-Cadillac Hotel

Exhibits—Fourth Floor, Sheraton-Cadillac Hotel

Press Room—Suite 500, Fifth Floor, Sheraton-Cadillac Hotel

Woman's Auxiliary Headquarters—Fort Shelby Hotel, Detroit

Michigan State Medical Assistants Society Headquarters —Tuller Hotel, Detroit

* * *

- REGISTER—Fifth Floor, Sheraton-Cadillac Hotel—as soon as you arrive.
 Hours: Tuesday, September 23—1:00 p.m. to 5:00 p.m.
 Wednesday, September 24—7:30 a.m. to 5:00 p.m.
 Thursday, September 25—8:30 a.m. to 5:00 p.m.
 Friday, September 26—8:30 a.m. to 3:30 p.m.

* * *

- NO REGISTRATION FEE FOR MEMBERS OF MSMS AND OTHER STATE MEDICAL ASSOCIATIONS, AMA, AND CANADIAN MEDICAL ASSOCIATION.
 Admission will be by badge only to all Scientific Assemblies, Section Meetings, Discussion Conferences and the Exhibition. Please present your MSMS or other State Medical Association, AMA, or CMA Membership Card to expedite registration.

* * *

- GUESTS—Members of any state medical association, AMA, or CMA members from any province of Canada, and physicians of the Army, Navy and U. S. Public Health Service are invited to attend, as guests. No registration fee. Please present credentials at the Registration Desk.
 Bona fide doctors of medicine serving as residents, interns, or who are associate or probationary members of Michigan county medical societies, if vouched for by an MSMS Councilor or the president or secretary of the county medical society in whose jurisdiction they practice, will be registered as guests. Please present credentials at the Registration Desk.

- MICHIGAN DOCTORS OF MEDICINE, in practice but who are not members of MSMS, if listed in the American Medical Directory, may register as guests upon payment of $25.00. This amount will be credited to them as dues in the Michigan State Medical Society FOR THE BALANCE OF 1952 ONLY, provided they subsequently are accepted as members by the County Medical Society in whose jurisdiction they practice.

* * *

- DOCTOR, register Tuesday! Registration of physicians will be held Tuesday afternoon from 1:00 to 5:00 p.m.—as well as on Wednesday, Thursday, Friday, during the 1952 MSMS Annual Session. The Tuesday afternoon registration hours are arranged so that physicians may avoid waiting in line Wednesday morning before the opening Assembly.
 We recommend to Detroit physicians—and those who arrive in Detroit on Tuesday—that they register Tuesday, September 23, from 1:00 to 5:00 p.m., Fifth Floor, Sheraton-Cadillac Hotel.

* * *

- REGISTER AT EVERY BOOTH—There is something of interest or education in the large exhibit of technical displays. Stop and show your appreciation of the exhibitors' support in helping to make successful the 1952 MSMS Convention.

* * *

- TELEPHONE SERVICE—Special lines to handle local and long distance telephone service for registrants at the MSMS meeting will be installed on the Fourth Floor, near Grand Ballroom, Sheraton-Cadillac Hotel. Call WOodward 1-8000.

WEDNESDAY, THURSDAY, FRIDAY

The Exhibit Section of the MSMS Annual Session is as important, interesting and desirable to most doctors of medicine as the papers that are presented in the meeting room.

At the 1952 MSMS Annual Session in Detroit, this Section will feature ninety-nine technical displays.

Doctor, visit the technical exhibit (fourth floor, Sheraton-Cadillac Hotel) to see and hear about something NEW.

- **CHECK ROOM**—Fourth Floor, Sheraton-Cadillac Hotel, near meeting room.

* * *

- **GUEST ESSAYISTS** are very respectfully requested not to change time of their lecture with another speaker without the approval of the Assembly. This request is made in order to avoid confusion and disappointment on the part of some members of the audience.

* * *

- **PUBLIC MEETING**—The evening Assembly of Wednesday, September 24—Officers Night—will be open to the public. Invite your patients and other lay friends to this entertaining meeting, to be held in the Grand Ballroom of the Sheraton-Cadillac Hotel at 8:30 p.m. Program on page 888.

* * *

- **CABARET-STYLE DANCE AND ENTERTAINMENT**, with the compliments of the Michigan State Medical Society, will be held in the Grand Ballroom, Sheraton-Cadillac Hotel, Thursday evening, September 25, at 10:30 p.m. All who register, and their ladies, will receive a card of admission and are cordially invited to attend.

* * *

- **TRANSPORTATION**—The C & O Streamliners afford a convenient means of transportation to the MSMS Annual Session in Detroit for hundreds of physicians in the central and western parts of the State. Order reservations well in advance.

* * *

- **PARKING**—Do not park on Detroit's streets. Inside parking, at a convenient distance from the Sheraton-Cadillac Hotel, is available at the Book Tower Garage, 333 State, the DAC Garage, 1754 Randolph, and the Grand Circus Garage, 1776 Randolph.

* * *

- **THE ANNUAL COMMITTEE ORGANIZATION** luncheon, a meeting of the MSMS committee chairmen appointed by President-Elect R. J. Hubbell, M.D., Kalamazoo, to serve during the year 1952-53, will be held on Thursday, September 25, at 12:15 p.m. in the Founders' Room.

SECTION MEETINGS—on Wednesday-Thursday-Friday, September 24-25-26, immediately following adjournment of the daily Assembly.

WEDNESDAY, SEPTEMBER 24, 5:00 to 6:00 p.m.: The following Sections will meet: Dermatology-Syphilology; Pediatrics; Urology; Gynecology-Obstetrics; Ophthalmology.

THURSDAY, SEPTEMBER 24, 5:00 to 6:00 p.m.: The following Sections will meet: Anesthesia; Surgery; Otolaryngology: Public Health and Preventive Medicine; Gastroenterology and Proctology.

FRIDAY, SEPTEMBER 25, 4:30 to 5:30 p.m.: The following Sections will meet: Radiology; Medicine; General Practice; Nervous and Mental Diseases.

For programs and meeting places, see pages 887, 891 and 893.

THREE DISCUSSION CONFERENCES

These quiz periods will be held Wednesday-Thursday-Friday, September 24-25-26, Grand Ballroom, Sheraton-Cadillac Hotel, 12:00 to 1:00 p.m. with all the guest speakers of the day on the platform.

An opportunity to ask questions concerning the presentations of the guest essayists, or to discuss one of your interesting cases with them, will be provided.

- **POSTGRADUATE CREDITS** are given to every MSMS member who attends the Annual Session.

* * *

- **TECHNICAL EXHIBITS**—Ninety-nine (99) Technical Exhibits will open daily at 8:30 a.m. and close at 5:30 p.m., except on Friday when the break-up is at 3:30 p.m. Frequent intermissions to view the exhibits have been arranged before, during, and after the Assemblies.

* * *

INFORMATION OF PRACTICAL VALUE IN DAILY PRACTICE will be found at the Michigan State Medical Society Annual Session. All subjects on the MSMS Annual Session Program are applicable to clinical medicine. They stress diagnosis and treatment, usable in everyday practice.

- **THE MSMS HOUSE OF DELEGATES** convenes Monday, September 22, at 10:00 a.m., Book-Casino, Sheraton-Cadillac Hotel; it will hold three meetings on Monday, September 22, at 10:00 a.m., 2:15 p.m., and at 8:00 p.m.; also two meetings on Tuesday, September 23, at 10:00 a.m. and at 8:00 p.m.

PRE-REGISTRATION OF DELEGATES WILL BE HELD SUNDAY, SEPTEMBER 21, FROM 8:00 TO 10:00 P.M. PLEASE REGISTER IN ADVANCE AND SPARE YOURSELF STANDING IN LINE MONDAY MORNING.

* * *

- **ARCH WALLS, M.D.**, Detroit, is General Chairman of Arrangements for the 1952 MSMS Annual Session in Detroit.

PAPERS WILL BEGIN AND END ON TIME

Believing there is nothing which makes a scientific meeting more attractive than by-the-clock promptness and regularity, all meetings will open exactly on time, all speakers will be required to begin their papers exactly on time and to close exactly on time in accordance with the schedule in the program. All who attend the meeting, therefore, are requested to assist in attaining this end by noting the schedule carefully and being in attendance accordingly. Any member who arrives five minutes late to hear any particular paper will miss exactly five minutes of that paper!

MEETINGS OF SPECIAL SOCIETIES, ALUMNI AND AUXILIARY GROUPS

Wednesday, September 24, 1952

1. **The Michigan Branch of the Academy of Pediatrics** will have a dinner and business meeting on Wednesday, September 24, 6:30 p.m., in the English Room, Sheraton-Cadillac Hotel.

2. **The MSMS Section on Ophthalmology** and the **Detroit Ophthalmological Society** will meet for dinner on Wednesday, September 24, 7:00 p.m., in the Pan American Room, Sheraton-Cadillac Hotel.

3. **The Detroit Branch of American Urological Society** will meet on Wednesday, September 24, as follows: reception beginning at 6:30 p.m. in suite assigned to William Bromme, M.D., Detroit, followed by dinner in suite 500 at 7:30 p.m., Sheraton-Cadillac Hotel.

4. **"Upper Peninsula Day"** on Wednesday, September 24, 1952, Sheraton-Cadillac Hotel, Detroit. This will be a get-together with cocktails and dinner in Parlors G-H-I of the Sheraton-Cadillac Hotel at 6:00 p.m.—no speeches.

Thursday, September 25, 1952

5. **Michigan Allergy Society** will meet on Thursday, September 25, for cocktails at 6:30 p.m., dinner at 7:15 p.m. followed by a meeting at 8:30 p.m. in Parlors G-H-I of the Sheraton-Cadillac Hotel, Detroit. Samuel M. Feinberg, M.D., Chicago, Professor of Medicine and Chairman of Allergy Clinic, Northwestern Medical School, will be the speaker.

6. **The Wayne University Alumni Association will** hold an alumni banquet on Thursday, September 25 in the English Room of the Sheraton-Cadillac Hotel at 6:30 p.m. Alumni, their wives and guests are cordially invited. Tickets will be available at the registration desk. Dean Gordon Scott will give a report for the Medical School to the alumni. The banquet program will be dismissed in time for alumni to attend State Society Night in the Grand Ballroom of the Sheraton-Cadillac Hotel.

 An alumni headquarters will be maintained at the Sheraton-Cadillac hotel during the Annual Session.

7. **The Michigan Regional Committee on Trauman of the American College of Surgeons** will meet on Thursday, September 25, for luncheon, 12:00 noon, Pan American Room, Sheraton-Cadillac Hotel. A meeting will follow the luncheon.

8. **The Michigan Chapter of the American College of Chest Physicians** will hold a dinner on Thursday, September 25, 7:00 p.m., in the Pan American Room, Sheraton-Cadillac Hotel.

9. **The Michigan Pathological Society** will hold a meeting on Thursday, September 25, from 2:00 to 4:30 p.m. in the Michigan Room, Statler Hotel, and a dinner and meeting starting at 6:30 p.m. in the Michigan Room. Elson B. Helwig, M.D., of the Armed Forces Institute will moderate a slide seminar covering some interesting dermatologic lesions.

10. **The Michigan Academy of General Practice Board of Directors** will hold a dinner and meeting on Thursday, September 25, 6:00 p.m. in Parlor F, Sheraton-Cadillac Hotel.

11. **The Michigan Chapter, Arthritis and Rheumatism Foundation** will hold a joint meeting with the Michigan Rheumatism Society on Thursday, September 25, 7:00 p.m. (dinner and meeting) in the Founders' Room, Sheraton-Cadillac Hotel.

Friday, September 26, 1952

12. **The Michigan Society of Neurology and Psychiatry** will meet on Friday, September 26, beginning with reception at 5:30 p.m. and dinner at 7:00 p.m. in the Pan American Room, Sheraton-Cadillac Hotel. A business meeting will follow the dinner.

 All those who attend the Nervous and Mental Diseases Section meeting are invited for cocktails at 5:30 p.m. in the Pan American Room as guests of the Michigan Society of Neurology and Psychiatry. The dinner and business meeting are limited to members only.

Women's Organizations

13. **The Michigan State Medical Assistants Society** will meet September 24-25, 1952, Tuller Hotel Detroit.

Wednesday, September 24

A.M.

9:00 Registration at Tuller Hotel
View Exhibits at Sheraton-Cadillac Hotel

9:30 MSMAS Executive Committee Board Meeting

10:30 "Psychological Aspects of Plastic Surgery"
CLAIRE L. STRAITH, M.D., D.D.S., F.A.C.S.
(Lecture and movie followed by question period)

11:30-M. View Exhibits, Sheraton-Cadillac Hotel

P.M.

12:30 Leaving by Bus *from Tuller Hotel* for:
Parke, Davis & Co., trip through Chloromycetin Plant and Research Laboratory
Return to Tuller Hotel for:

6:00 Cocktail Party and Dinner—Entertainment sponsored by Parke, Davis & Co.

Thursday, September 25

A.M.

9:00 Registration at Tuller Hotel
View Exhibits at Sheraton-Cadillac Hotel

10:00 "Surgical Treatment of Deafness"
ARTHUR E. HAMMOND, M.D.
(Illustrated with motion pictures)

11:30-M. "Lecture and Demonstration of the Maico Trainear"
This equipment is designed for the teaching of the hard of hearing children, particularly those of pre-school age

P.M.

12:30 PRESIDENT'S LUNCHEON-BANQUET
Speaker—MR. HUGH W. BRENNEMAN, Public Relations Counsel of Michigan State Medical Society—"Formula for Freedom"

2:00 Annual Business Meeting and Election of Officers (Non-Members welcome)
Followed by
Social Hour to meet your new officers and greet old friends
"Afterglow"—Courtesy—Drug Industries, U. S. Vitamin Corp., J. F. Hartz Company
Non-members welcome to all activities. Registration fee for non-members, $2.00.

14. **The Women's Auxiliary to the Michigan State Medical Society** will meet as follows:
September 22, 23, 24, 25, 1952
Headquarters, Fort Shelby Hotel, Detroit, Michigan
(Registration from Monday noon through Thursday noon)

MONDAY—September 22

P.M.
6:30 Finance Committee Dinner meeting

TUESDAY—September 23

A.M.
11:00 Busses leave Hotels Fort Shelby and Sheraton-Cadillac for Luncheon at Dearborn Inn, followed by trip through Greenfield Village.

P.M.
6:30 Organization Dinner. Mrs. Walter Stinson and retiring and incoming District Directors.
6:30 Past Presidents' and Secretaries' Dinner

WEDNESDAY—September 24

A.M.
10:00 Annual Session opens with Pre-Convention Board Meeting.
MRS. ROBERT S. BREAKEY, President, presiding
(All Officers, Directors, State Committee Chairmen, 1951-52 and 1952-53 County Presidents and Delegates are expected to attend ALL GENERAL SESSIONS)

P.M.
12:30 Luncheon
1:45 Résumé General Session and Annual Meeting
4:00 Business adjourned until 9:00 A.M., Thursday
5:30 Cocktail party
6:15 Annual Banquet (Dress optional). Husbands are cordially invited. Official representatives of MSMS will be our guests.
Speaker: MRS. RALPH EUSDEN, President Woman's Auxiliary to AMA.
8:30. MSMS Officers' Night. Biddle Lecture, Sheraton-Cadillac Hotel

THURSDAY—September 25

A.M.
9:00 Résumé General Session, including unfinished business of Annual Meeting, Election and Installation of officers, and Post-Convention Board Meeting with Mrs. William Mackersie presiding.

P.M.
12:45 Annual Luncheon, honoring Past Presidents Speaker to be announced.
3:30 Adjournment
10:30 State Socicty Night. Dance and Floor Show. Sheraton-Cadillac Hotel.

NATIONAL TAX FREEDOM HOLIDAY

The first dollar you could call your own, out of all the money you have earned this year, was in your pay of May 19. Up to that day the average American had been working to pay this year's taxes—local, state and Federal.

Never before have Americans had to work so long to pay their taxes. Out of each hour worked, twenty-three minutes pay is taken by the Government in direct and hidden imposts.

Observance of this first day of the year on which a man can call his earnings his own, a day to be celebrated as "National Tax Freedom Holiday," is advocated by Dallas L. Hostetler, executive director of the Florida State Retailers Association.

Last year even Congress recognized the occasion by adopting a resolution providing that it "be symbolized as a day of relief throughout the land, with such demonstrations as may seem appropriate, including a prayer for deliverance."

Last year, local, state, and Federal taxes took thirty-two cents out of each dollar the average American earned. This year the over-all tax load takes thirty-eight cents. Mussolini took 40 per cent of his people's income. Hitler took 50 per cent. Stalin is taking 70 per cent.

In 1920, Americans began working for themselves on February 26 for the first time that year. By 1940 the date had advanced to March 27. In 1951 the tax freedom holiday was observed on April 28. This year it is pushed up to May 19.

"Whither 1953?"

* * *

The incomes below $2000 in 1939 should be compared with an income of about $4000 in 1949 after allowance is made for the depreciation of the dollar and taxes that the Government has taken.

A family which had a $5000 income in 1939 was probably better off than they would be today with $10,000 when one considers the much larger proportion paid out in taxes today.

* * *

HOTEL RESERVATIONS

MICHIGAN STATE MEDICAL SOCIETY

87th Annual Session

Detroit, September 22 to 26, 1952

The reservation blank below is for your convenience in making your hotel reservations in Detroit. Please send your application to Robert M. Buckley, Sheraton-Cadillac Hotel, Detroit, Michigan. Mailing your application now will be of material assistance in securing hotel accommodations.

As very few singles are available, registrants are requested to co-operate with the Committee on Hotels by sharing a room with another registrant, when convenient.

.....

Committee on Hotels,
Michigan State Medical Society
c/o Sheraton-Cadillac Hotel,
Detroit, Michigan

Attention: Robert M. Buckley

Please make hotel reservation (s) as indicated below:

.....Single Room(s)

.....Double Room(s) for.....persons

.....Twin-Bedded Room(s) for.....persons

Arriving September.....hour A.M. P.M.

Leaving September.....hour A.M. P.M.

Hotel of First Choice:.....

Second Choice:.....

Names and addresses of all applicants including person making reservation:

Name	Address	City	State
.....			
.....			
.....			
.....			
.....			

Date Signature.....

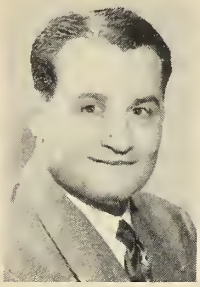
Address City.....



G. W. Anderson, M.D.



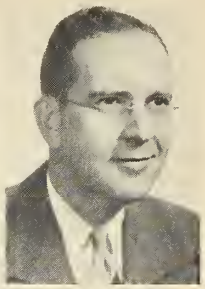
C. S. Beck, M.D.



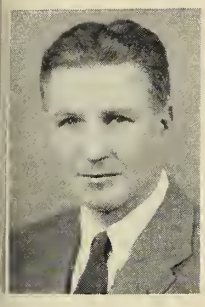
J. J. Bonica, M.D.



Spencer Braden, M.D.



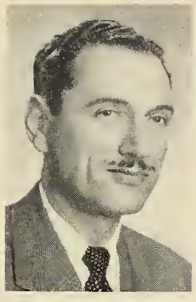
O. S. Culp, M.D.



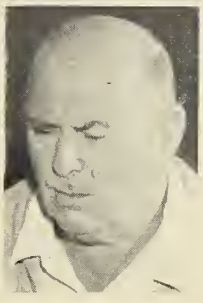
George Crile, M.D.



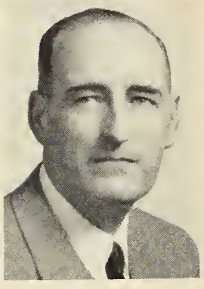
D. C. Darrow, M.D.



E. J. De Costa, M.D.



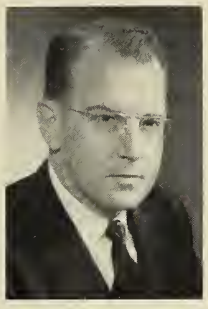
Paul de Kruif, Ph.D.



G. G. Duncan, M.D.



C. W. Eberbach, M.D.



D. E. Harken, M.D.



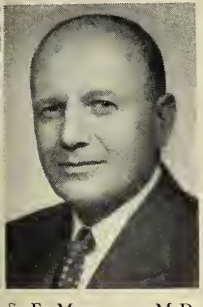
P. C. Kronfeld, M.D.



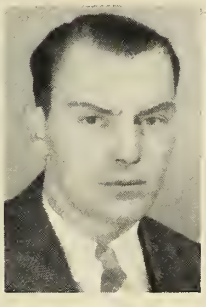
M. I. Levine, M.D.



R. P. Mackay, M.D.



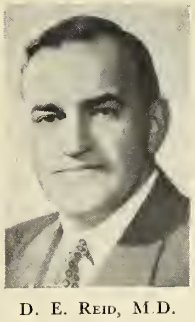
S. F. Marshall, M.D.



E. R. Miller, M.D.



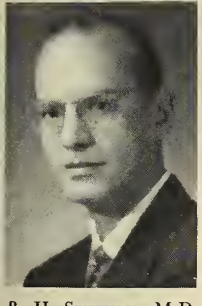
Emil Novak, M.D.



D. E. Reid, M.D.



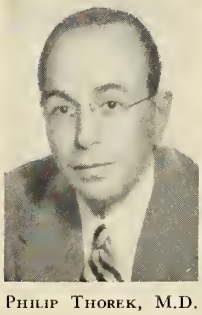
D. A. Rytand, M.D.



B. H. Senturia, M.D.



E. W. Thomas, M.D.



Philip Thorek, M.D.



L. F. Weber, M.D.



C. E. Welch, M.D.

Michigan State Medical Society

The 87th Annual Session

PROGRAM OF ASSEMBLIES AND SECTIONS

WEDNESDAY MORNING
September 24, 1952
First Assembly

Grand Ballroom, Sheraton-Cadillac Hotel, Detroit

Chairman: W. D. Barrett, M.D., Detroit
Secretary: D. R. Boyd, M.D., Muskegon

A.M.

9:00 "Operation for Coronary Artery Disease"

Claude S. Beck, M.D., Cleveland, Ohio
Professor of Cardiovascular Surgery, Western Reserve University, Cleveland, Ohio; Associate Surgeon, University Hospitals; Consultant, Crile Veterans Hospital; Visiting Neurosurgeon, Cleveland City Hospital.

The operation is done in two stages. The first stage consists of placing a vein graft between the coronary sinus and the aorta. The coronary sinus is the vein which drains the blood from the heart muscle of the left ventricle. This vein graft establishes an arteriovenous fistula. Three weeks later the fistula is reduced by ligating the coronary sinus where it empties into the right auricle. This builds up a pressure in the venous system of the left ventricle.

This operation protects the heart against coronary artery occlusion. This protection has been well proved by experimental work. It reduces the death rate after an artery has been occluded. It also reduces the amount of destruction in the heart muscle. The mechanism for the benefit has been studied. The operation actually sends blood in a retrograde direction through the capillary bed and it also brings about the development of intercoronary arterial channels.

Sixty-two patients with severe coronary disease have been operated upon. The operation on patients has been shown to be beneficial. Some of the patients received excellent results.

9:30 "The Overtreatment of Heart Disease"

David A. Rytand, M.D., San Francisco, California
Associate Professor of Medicine, Stanford University School of Medicine.

As diagnostic methods increase in number and sensitivity, heart disease is discovered more frequently. Some of this "disease" is nothing but harmless variation from our inadequate conceptions of what is normal. Overtreatment has its roots in overdiagnosis. Accepting an accurate diagnosis of heart disease in a hypothetical patient, one may well remember that the usual aim of treatment is that of such symptomatic management as may prolong useful and comfortable existence. Therapy should be less of a burden than is the disturbance against which it is directed. Unfortunately, however, recent advances in therapeutic agents and concepts have provided increasing numbers of patients whose main complaints are directed justifiably against their treatments rather than against their original disabilities.

It is, of course, the thoughtful physician's responsibility on the one hand to be aware of the potential application of new therapeutic methods to certain of his patients with hypertension, myocardial infarction, angina pectoris, etc., while on the other to avoid excessive or premature enthusiasm in their use. Overtreatment perhaps reaches its peak in ordinary, chronic congestive heart failure. All too often, such patients find themselves on intolerable diets, flat in bed and restricted to use of a bedpan although constipated by inactivity and resins, depleted by diuretics (which are given more often as their effectiveness declines) or by mechanical removal of tissue fluids, receiving anticoagulants for thromboembolism accompanying too-rapid hemoconcentration from mineral and water losses, and intoxicated by long-acting glycosides of digitalis (administered in increasing dosage as tachycardias of toxicity occur). At least some "refractory cardiacs" are best managed by stopping everything but common sense.

10:00 INTERMISSION TO VIEW EXHIBITS

11:00 "The Impact of Psychoanalytic Knowledge on the Medical and Surgical Care of Children and Adolescents"

Milton I. Levine, M.D., New York, New York
Associate Attending Pediatrician, New York Hospital, N. Y. C.; Assistant Professor of Pediatrics, Cornell University Medical College; Consulting Pediatrician, N. Y. C. Department of Health.

Within the past twenty years a great deal of knowledge concerning the developmental needs of children has been accumulated through psychoanalytic observations. This knowledge enters into and affects almost all situations in the medical and surgical care of children. Already certain changes have been made in the approach to infant feeding, in our handling of hospitalization, in our attitude toward masturbation. But there are many situations in the general handling of the child by the physician, in the methods used in diagnosis as well as treatment, in the surgical approach—preoperative as well as postoperative, and in the handling of adolescents where recognition of the emotional needs of the child is invaluable. The use of this accumulated psychoanalytic knowledge differentiates the modern physician from the physician of yesterday.

The paper includes a discussion of such topics as the causes and treatment of constipation, enuresis and feeding problems, indications for hospitalization, the manner of hospitalization, the management of adolescent medical problems, the optional time for elective operative procedures, and the preoperative and postoperative care of the child, all viewed in the light of this new knowledge.

11:30 "Contact Dermatitis"

Leonard F. Weber, M.D., Chicago
Clinical Professor of Dermatology, University of Illinois College of Medicine.

Contact dermatitis is a disease caused by the local action of irritant substances. Synonyms for contact dermatitis are dermatitis venenata and at times occupational dermatitis. This disease is one of the common diseases of the skin seen in general practice.

The search for and removal of possible cutaneous irritants is of most importance to the patient if his suffering is to be relieved within a reasonable period.

The first sign of inflammation in the skin is redness, and this is followed by vesiculation, oozing, crusting and swelling. Widespread toxic eruptions of eczematoid type may follow as a result of absorption of toxic substances from the original sites of dermatitis. Chronic cases due to prolonged contact with a low sensitizer cause thickening, lichenification and fissures. Secondary infection may be superimposed on the acute and chronic types.

Dermatitis venenata occurs usually on the exposed parts, that is the hands, face and neck. The primary site of involvement often is a clue to the causal irritant. If the cause is obvious and is removed at once, the course of the disease is self-limited. If the offending irritant is again contacted a recurrence will follow.

12:00 END OF FIRST ASSEMBLY

WEDNESDAY NOON

(No Luncheons)

September 24, 1952

12:00 to 1:00 p.m.

DISCUSSION CONFERENCE

Grand Ballroom, Sheraton-Cadillac Hotel

Leader: L. J. Hirschman, M.D., Traverse City
Participants: Claude S. Beck, M.D., Cleveland, Ohio; Spencer Braden, M.D., Cleveland, Ohio; Ormond S. Culp, M.D., Rochester, Minnesota; Peter C. Kronfeld, M.D., Chicago, Illinois; Milton I. Levine, M.D., New York, New York; David A. Rytand, M.D., San Francisco, California; and Leonard F. Weber, M.D., Chicago, Illinois.

WEDNESDAY AFTERNOON

September 24, 1952

Second Assembly

Grand Ballroom, Sheraton-Cadillac Hotel, Detroit

Chairman: B. M. Harris, M.D., Ypsilanti
Secretary: J. G. Molner, M.D., Detroit

P.M.

2:00 "Palpable Masses in the Flank"

Ormond S. Culp, M.D., Rochester, Minnesota
Consultant in Urology, Mayo Clinic; Associate Professor of Urology, Mayo Foundation, University of Minnesota.

A discussion of lesions which present themselves as tumors in the upper abdomen, with or without urinary symptoms. To be illustrated by typical cases, with special emphasis on clues which should expedite preoperative diagnosis by the general practitioner.

2:30 "Bleeding in the Last Trimester of Pregnancy"

Duncan E. Reid, M.D., Boston, Massachusetts
Wm. Lambert Richardson Professor of Obstetrics, Harvard Medical School; Chief of Staff, Boston Lying-In Hospital.

In recent years the policies governing the management of obstetrical bleeding in the las trimester have become fairly well standardized. Exceptions are evident, however, and the controversies which revolve about them are of more than academic interest. With respect to placenta previa, considerable wave of enthusiasm has been expressed for a non-intervention form of treatment. The merits and dangers of such a policy deserve careful evaluation. It is generally accepted that the method of treatment to be employed in placenta previa is dependent upon the degree of placenta which is involved in the previa. However, a lack of uniformity in classification lends confusion to the degree of previa present and prevents a careful analysis of results obtained by the various methods of treatment.

Regarding premature separation, an attempt will be made to correlate the clinical findings with the degree of placental detachment. The two more serious complications, namely, anuria and hemorrhagic diathesis will be elaborated upon. A summation of the obstetrical management of these various complications will be outlined and a policy propounded for the treatment of the various forms of premature separation.

3:00 INTERMISSION TO VIEW EXHIBITS

4:00 "The Acutely Inflamed Eye"

Peter C. Kronfeld, M.D., Chicago, Illinois
Professor of Ophthalmology, University of Illinois

4:30 "Subarachnoid Hemorrhage with Special Emphasis on Its Management"

Spencer Braden, M.D., Cleveland, Ohio
Visiting Neurosurgeon St. Luke's Hospital, St. Vincent's Charity Hospital and Huron Road Hospital; Consulting Neurosurgeon U.S.P.H.S. Hospital, Lutheran Hospital and Deaconess Hospital.

5:00 END OF SECOND ASSEMBLY

——Program of Sections——

WEDNESDAY

September 24, 1952

5:00 to 6:00 P.M.

SECTION ON DERMATOLOGY AND SYPHILOLOGY

Parlors G-H-I, Sheraton-Cadillac Hotel, Detroit

Chairman: J. R. Delaney, M.D., Detroit
Secretary: C. J. Courville, M.D., Detroit

"Cutaneous Cancer in Industry"

Leonard F. Weber, M.D., Chicago, Illinois

Are occupational cancers uncommon in the United States? Are they increasing because our industry is becoming more diverse? Even when there is known exposure to industrial carcinogens with the appearance of cutaneous cancer later there is considerable difficulty in establishing a causal relationship of this hazard to cancer. Much reliance is placed upon a complete and adequate history to confirm our opinion that cancer may arise out of the occupation. Assume that the history is inadequate or incorrect., then what other criteria do we have which are helpful? None of the known industrial carcinogens cause a type of cutaneous cancer that is readily recognized as a definite histologic structure. For instance, basal cell epithelioma caused by irradiation has the same clinical and histologic appearance as a basal cell epithelioma occurring in a pitch and tar worker.

Of what importance is sex and age in occupational cancers of the skin? Is the occurrence or development of several cancers frequent in occupational malignancy? What part does single or repeated trauma play in the cause of cancer? Occupational and industrial cancer is a medical problem that has many interesting phases. One important part of occupational cancers is that the laws pertaining to some of these cases have limitations as to the time of filing compensation claims.

SECTION ON PEDIATRICS

English Room, Sheraton-Cadillac Hotel, Detroit

Chairman: H. L. French, M.D., Lansing
Secretary: P. S. Bradshaw, M.D., Muskegon

"Newer Concepts Concerning Tuberculosis During Childhood"

Milton I. Levine, M.D., New York, New York

The use of streptomycin, PAS, promizale and more recently isonicotinic acid hydrazide has greatly changed our approach to the problem of tuberculosis in children. Should children with uncomplicated primary tuberculosis receive drug therapy or should it be withheld for use in case of hemotogenous spread or the development of a progressive primary process? What are the most recent developments in the treatment of tuberculosis meningitis? Is the use of tuberculin, streptokinase and streptodornase advisable in tuberculosis meningitis?

Other subjects to be discussed are the contagiousness of primary tuberculosis and the question as to whether bedrest or hospitalization is indicated. These problems assume considerable importance for many hospitals refuse cases of primary tuberculosis since they feel that isolation with all the accompanying precautionary measures must be instituted. Furthermore, the question arises as to whether children with active primary lesions may attend school and mingle freely with non-infected children. Some of the more recent thoughts concerning the use of BCG as a phophylaxis against tuberculosis will also be discussed.

SECTION ON UROLOGY

Founders Room, Sheraton-Cadillac Hotel, Detroit

Chairman: R. A. Burhans, M.D., Lansing
Secretary: William Bromme, M.D., Detroit

"Urologic Enigmas"

Ormond S. Culp, M.D., Rochester, Minnesota

A presentation of "problem cases" which have required unconventional therapeutic measures or have been characterized by bizarre complications.

SECTION ON GYNECOLOGY AND OBSTETRICS

Grand Ballroom, Sheraton-Cadillac Hotel, Detroit

Chairman: L. C. Bosch, M.D., Grand Rapids
Secretary: J. P. Ottaway, M.D., Detroit

"Heart Disease in Pregnancy"

Duncan E. Reid, M.D., Boston, Massachusetts

While advances have been made in the care of the pregnant cardiac patient, opinion still differs as to which patients with heart disease have the right to accept the risk of pregnancy. The competence of the cardiac patient to withstand pregnancy is dependent upon factors other than her ability to perform satisfactorily her daily activities. These additional data which are required in classifying cardiac patients into "favorable" and "unfavorable" groups with respect to their anticipated response to pregnancy will be discussed.

Moreover, during recent years, the introduction of chemotherapy and antibiotic drugs and the expanding indications for cardiac surgery have created new and interesting problems regarding heart disease in pregnancy. These therapeutic aids have enabled some patients with heart disease to embark on a pregnancy which several years ago would have been regarded as folly. More specifically these include patients with marked pulmonary hypertension resulting from severe mitral stenosis and those forms of congenital heart disease which are amenable to cardiac surgery. These and other major complications will be considered, while the causes of death in cardiac patients will be analyzed and recommendations made as to ways and means of further reducing the maternal mortality.

SECTION ON OPHTHALMOLOGY

Chairman: L. E. McCullough, M.D., Detroit
Secretary: L. L. Loder, M.D., Muskegon

The MSMS Section on Ophthalmology will meet jointly with the Detroit Ophthalmology Society for dinner at 7:00 p.m. in *Pan American Room,* Sheraton-Cadillac Hotel.

"Tonography"

Peter C. Kronfeld, M.D., Chicago, Illinois

WEDNESDAY EVENING
September 24, 1952

GENERAL (PUBLIC) MEETING

Grand Ballroom, Sheraton-Cadillac Hotel, Detroit

President: Otto O. Beck, M.D., Birmingham
Secretary: L. Fernald Foster, M.D., Bay City

P.M.

8:30 OFFICERS' NIGHT—PUBLIC MEETING

1. Call to order, announcements and reports of the House of Delegates by L. Fernald Foster, M.D.
2. Introduction of President Otto O. Beck, M.D., followed by President's Annual Address.
3. Induction of members into the MSMS "Fifty-Year Club" by President Otto O. Beck, M.D.
4. Presentation of Scrolls.
5. Introduction of President Elect R. J. Hubbell, M.D., Kalamazoo, and induction of Dr. Hubbell into office of President of the Michigan State Medical Society by the Retiring President.
 Response of Dr. Hubbell.
6. Introduction of the new President Elect and other newly elected Officers and of the Chairman of The Council, William Bromme, M.D., Detroit.
7. Presentation of scroll and Past President's Key to Retiring President Dr. Beck by the Chairman of The Council, Dr. Bromme.

9:15 8. The Andrew P. Biddle Lecture.
Paul de Kruif, Ph.D., Holland, Michigan
(30 minutes)



Andrew P. Biddle, M.D.
(Deceased August 2, 1944)
Patron of Postgraduate Medical Education

9. Presentation of Biddle Lecture Scroll.

10:00 10. Adjournment.

THURSDAY MORNING

September 25, 1952

Third Assembly

Grand Ballroom, Sheraton-Cadillac Hotel, Detroit

Chairman: A. H. Miller, M.D., Gladstone

Secretary: R. L. Fitts, M.D., Grand Rapids.

A.M.

9:00 "Pelvic Endometriosis"

Emil Novak, M.D., Baltimore, Maryland

Assistant Professor Emeritus, Johns Hopkins Medical School; Gynecologist-in-Chief, Bon Secours and St. Agnes Hospitals.

Historical review of subject, and a discussion of chief viewpoints as the etiology of endometriosis, the present trend being that mechanism of its origin is not always the same. Pathologic picture shows many variations in degree, especially in ovary, most common site of endometriosis, though many other possible sites are also discussed. Ectopic endometrium often of immature type, responsive to estrogen but not to progesterone. A brief comment on possible origin of certain ovarian carcinomas from endometriosis of ovary.

Clinical symptoms vary widely in character and degree, and may be absent in some cases. Between cases of only academic and scientific interest and those with severe and at times disabling nature all gradations are encountered. Diagnosis should, with rare exceptions, be based on palpatory findings rather than clinical symptoms, though not infrequently it is presumptive rather than precise. The bearing of endometriosis on fertility is considered a relatively high degree of relative infertility being generally accepted.

The management of endometriosis does not always include surgery, though frequently it does. The scope of operation must be adapted to the extent of the disease, the age of the patient, and the importance or unimportance of further reproductiveness. The increasingly conservative trend in the surgical treatment of endometriosis in the younger group of patients is fully justified by reported results in relief of symptoms and in high incidence of later pregnancy. When dysmenorrhea has been a prominent symptom presacral neurectomy may be advantageously combined with conservative operations. When disease is very extensive, with perhaps serious involvement of bowel, radical operation, with complete removal of ovarian tissue, is fully justified and desirable.

9:30 "The Adenoid Problem"

Ben H. Senturia, M.D., St. Louis, Missouri

Assistant Professor of Clinical Otolaryngology, Washington University Medical School.

0.00 INTERMISSION TO VIEW EXHIBITS

1:00 "Management of Pain of Malignancy"

John J. Bonica, M.D., Tacoma, Washington

Director, Department Anesthesia, Tacoma General Hospital; Director, Department of Anesthesia, Pierce County Hospital; Senior Consultant in Anesthesiology, Madigan Army Hospital; Senior Consultant in Anesthesiology, Veterans Administration Hospital.

The management of pain associated with inoperable cancer is a difficult clinical problem which should interest every physician. This pain, which in the terminal stages of the disease, is often so intense and persistent as to cause a physiologic and psychologic deterioration. deserves an intelligent appraisal and perhaps equally vital, a systematic plan for relief which will conserve the patients's physical, mental, and moral resources and his social usefulness insofar as possible.

At the present time the management of this problem resolves itself in about four months of approach. The first approach is removal of the cause by palliative operation, radiation therapy, the administration of endocrine substances, castration and other methods which decrease or completely remove the tumor. Unfortunately, these methods all too often are either not feasible or ineffective and, therefore, pain must be controlled by decreasing or preventing its perception and/or by modifying the reaction to it. The value of opiates and other narcotic analgesics in the management of cancer pain is generally appreciated and, therefore, needs no elaboration. It should be pointed out, however, that not infrequently these drugs are misused and even when they are properly administered, they produce certain undesirable effects which aggravate the inanition and cachexia of the patient. Neurosurgical operations designed to interrupt the pain pathways such as rhizotomy, sympathetectomy, chordotomy, and medullary tractotomy or operations designed to modify the reaction to the pain, such as prefrontal lobotomy, when skillfully carried out produce excellent results. However, these procedures impose the risk of major surgical operations and often cannot be tolerated by these patients. Moreover, not infrequently they are accompanied by serious complications.

Another approach to the problem is to chemically interrupt pain pathways by means of nerve blocks. While this method has limitations, it does offer certain advantages which may not be had with any other form of treatment. Effective nerve blocks not only afford relief from pain but may enable the sufferer to receive more intensive radiation therapy and other medical treatment, which otherwise could not be tolerated. Properly executed blocks do not add to the patient's discomfort nor are they often followed by serious untoward reactions such as a severe depression of function inherent to massive narcotic therapy or the mutilation sometimes produced by neurosurgical operations.

In order to obtain optimal results with nerve blocks, the mechanism producing the pain and the pathways over which it is carried must be thoroughly understood and the best agents and technics of producing prolonged interruption must be carefully considered. For pain of the face, mouth, tongue, throat, and neck, alcoholic injections of the trigeminal, glossopharyngeal and/or the upper cervical spinal nerves are usually very effective. Pain below the neck can be effectively controlled for weeks and months with subarachnoid alcohol blocks or injections of peripheral nerves. Since in many of these cases the sympathetic nervous system is involved in the pain mechansims, sympathetic nerve blocks are necessary to completely alleviate the pain. It is necessary for the physician to be always cognizant of the possible complications which can occur with these procedures and special efforts should be made to prevent them. When they do occur they should be properly treated.

The essayist will discuss cancer pain of various regions of the body, the mechanisms producing it and the analgesic agents and technics which produce optimal results. The advantages, disadvantages and complications of each procedure will he stressed.

11:30 "What Is the Scope of Public Health"

Gaylord W. Anderson, M.D., Minneapolis, Minnesota

Mayo Professor and Director, School of Public Health, University of Minnesota; President, American Public Health Association.

The fundamental legal mandate given to health departments is that they shall concern themselves "with the interests of health and life among the people." The evolution of public health is a fulfillment of this mandate. Problems have changed from those of environmental sanitation to communicable disease control, then to child health and now to adult health. Throughout its evolution there has been no change in the fundamental concepts of public health but merely in the types of problems against which the people are taking action through their health agencies.

12:00 END OF THIRD ASSEMBLY

THURSDAY NOON

(No Luncheons)

September 25, 1952

12:00 to 1:00 p.m.

DISCUSSION CONFERENCE

Grand Ballroom, Sheraton-Cadillac Hotel

Leader: Charles S. Stevenson, M.D., Detroit

Participants: Gaylord W. Anderson, M.D., Minneapolis, Minnesota; John J. Bonica, M.D., Tacoma, Washington; George Crile, Jr., M.D., Cleveland, Ohio; Edwin J. DeCosta, M.D., Chicago, Illinois; Carl W. Eberbach, Milwaukee, Wisconsin; Samuel F. Marshall, M.D., Boston, Massachusetts; Emil Novak, M.D., Baltimore, Maryland; and Ben H. Senturia, M.D., St. Louis, Missouri.

THURSDAY AFTERNOON

September 25, 1952

Fourth Assembly

Grand Ballroom, Sheraton-Cadillac Hotel, Detroit

Chairman: W. S. Jones, M.D., Menominee
Secretary: P. S. Bradshaw, M.D., Muskegon

P.M.

2:00 "Tumors of the Stomach"

Samuel F. Marshall, M.D., Boston, Massachusetts
Department of Surgery, The Lahey Clinic.

The early recognition of tumors of the stomach is of paramount importance because approximately 95 per cent of gastric tumors are carcinomas and because the five-year survival rate following operation for carcinoma of the stomach is lower than for any form of malignant disease.

The other tumors of the stomach, which comprise about 1.5 per cent of all such tumors, are the benign tumors, such as adenomatous polyps, fibromas, leiomyomas, neuromas, and so forth. They are of great significance, however, because the adenomatous polyps apparently have a tendency to degenerate into malignant tumors and should be treated as potential malignant lesions. Another group of tumors consists of the sarcomas, the most common of which arise from the smooth muscle and from lymphoid tissue; this group of tumors comprise about 3.0 per cent of gastric neoplasms. Although sarcomas arising from lymphoid tissue are similar to carcinomas, the survival rate is somewhat higher. If sarcomas are recognized early, the opportunity for cure is greater than for carcinoma of the stomach.

In reviewing approximately 1600 or 1700 cases of carcinoma of the stomach, one of the most striking features is the lateness with which the diagnosis is made in most of these cases. Unfortunately, a large percentage of these patients are treatted for months, without roentgenologic examination and without the question of carcinoma of the stomach being raised and thus valuable time is lost before these patients are brought to surgery. Another feature is the tendency of carcinoma of the stomach not only to spread into the lymph nodes but also to show evidence of vascular invasion, diffuse lymphatic spread, and extension to the duodenum. Thus, the decision as to the extent of the resection of the stomach cannot be based entirely upon the gross appearance of the tumor because the tumor may extend beyond the point of transection. This extension can be determined only by study of numerous frozen sections of the duodenal wall or of the gastric wall at the point where the duodenum or the stomach is divided. Because of the difficulty in determining the extent of the tumor, it has been proposed that a more radical operative procedure should be carried out, and there is a growing tendency to utilize total gastrectomy for earlier cases of cancer of the stomach. Over the last three years the mortality has been approximately 5 per cent for partial gastrectomy and 8 to 9 per cent for total gastrectomy. Thus, total gastrectomy is a reasonable procedure to employ in properly selected cases of carcinoma of the stomach.

At this clinic, the five-year survival rate following partial gastrectomy has been approximately 27 per cent, whereas the five-year survival rate following total gastrectomy has been 12.5 per cent. It must be remembered, however, that total gastrectomy heretofore has been employed only for advanced cases of carcinoma of the stomach and the five-year survival rate is limited because this procedure has been used only in this type of case. Whether a higher curability rate will be obtained when a radical procedure is employed can be determined only after careful follow-up studies of the results of total gastrectomy have been made.

One of the most important features in the early diagnosis of gastric neoplasm is the awareness on the part of the physician of the frequency of occurrence of this serious condition after the age of 45 particularly in men. The mere suspicion of a possible gastric neoplasm makes it imperative to carry out accurate diagnostic studies so that these cases are discovered at an early stage of the disease and better results will follow partial gastrectomy or even total gastrectomy.

2:30 "The Treatment of Chronic Ulcerative Colitis"

Geoerge Crile, Jr., M.D., Cleveland, Ohio
Department of Surgery, Cleveland Clinic.

Indications for subtotal colectomy with simultaneous ileostomy in chronic ulcerative colitis are:

1. In patients with long continued activity of the ulcerative process or with pseudopolypoid change, the colon should be removed to prevent the development of cancer. In such cases the risk of colectomy is much less than that of cancer.
2. In patients with systemic manifestations of the disease such as arthritis or pyoderma gangrenosum, the colon should be removed promptly before irreversible damage is done or before the patient's general condition becomes so poor that life is endangered.
3. In acute toxic ulcerative colitis the colon should be removed as soon as possible because the risk of the disease is high and colectomy is the most effective means of preventing its fatal complications. In any case of acute toxic ulcerative colitis in which the colon is distended perforation is impending and a fatal termination is apt to ensue if an emergency colectomy is not performed.
4. Although medical treatment and a trial on steroid therapy may have its place in the treatment of many of the mild or chronic manifestations of the disease, acute toxic ulcerative colitis with distention of the colon is a surgical emergency and should be treated by immediate colectomy.

3:00 INTERMISSION TO VIEW EXHIBITS

4:00 "Cortisone and Pregnancy"

Edwin J. DeCosta, M.D., Chicago, Illinois
Assistant Professor of Obstetrics and Gynecology, Northwestern University Medical School; Associate Attending Gynecologist and Obstetrician, Michael Reese Hospital.

Since the introduction of cortisone (11 dehydro 17 hydroxy corticosterone) in 1949 for the treatment of rheumatoid arthritis, hope has never waned that the "miracle drug" would "cure" just about everything. This miracle drug is actually a hormone. It is one of several hormones which have been isolated from the adrenal cortex. These steroids differ quantitatively from each other in their physiological effects[1]. Cortisone predominantly affects carbohydrate and protein metabolism. In addition it profoundly affects mesenchymal tissue and appears to modify the response of the host to stress. Since pregnancy is associated with tremendous metabolic changes, it is reasonable to speculate that the adrenal hormones may be intimately associated with such changes.

Before using any new substance, one should be able to answer two questions: (1) Is the administration of the substance harmful to the recipient, and (2) Is there any benefit to be gained by using this substance, even if harmless? In applying this generalization to the use of cortisone in pregnancy, one must know whether cortisone is harmful to either the mother or fetus, and whether it is of any value. Surprisingly, to date there is little information to answer either question. In spite of this, cortisone has been used in pregnant women in the treatment of conditions which may or may not be related to the pregnancy.

It is the purpose of this presentation to evaluate the effects of cortisone on gestation, both in the experimental animal and the human, and to consider the clinical application of cortisone during pregnancy.

4:30 "Hyperthyroidism—Rationale of Modern Treatment"

Carl W. Eberbach, M.D., Milwaukee, Wisconsin
Professor of Surgery, Marquette University Medical School.

Since the important contributions to the treatment of hyperthyroidism in 1923 by Plummer, the management of toxic goiter has followed, until recently, rather clearly defined procedures. The accepted and highly successful therapy consisted in iodinization of the patient, and subtotal resection of the thyroid gland. With the introduction of the anti-thyroid substances by Astwood nine years ago, and radioactive iodine isotopes by Hirst, Roberts and Evans in 1938, interest in the etiology of hyperthyroidism and its treatment has been revived and greatly stimulated. In addition to their therapeutic value, the isotopes have opened the vast field of thyroid physiology for study through a new approach.

With three available methods of treatment for thyroid disease, all of which are now well established as sound and effective procedures, it seems wise to look into their mode of attack in order that the proper procedure may be intelligently selected in a given case.

A discussion of these methods in relation to their ef-

fect on thyroid physiology and pathology will be presented.

5:00 END OF FOURTH ASSEMBLY

—Program of Sections—

THURSDAY

September 25, 1952

5:00 to 6:00 p.m.

SECTION ON ANESTHESIA

Parlors G-H-I, Sheraton-Cadillac Hotel, Detroit

Chairman: A. B. Stearns, M.D., Detroit

"The Clinical Value of Segmental Peridural Block"

John J. Bonica, M.D., Tacoma, Washington

The many advantages of properly administered and completely effective regional analgesia are recognized and well appreciated by surgeons and anesthesiologists who have had sufficient experience with it. The outstanding benefits are the slight degree of disturbance of physiologic function of the patient and the optimal operating condition which it affords the surgeon. Unfortunately the ever-increasing tendency in America to employ thiopental, curare and other deceptively innocuous general anesthetic agents and muscle relaxants for all surgical operations has caused many anesthesiologists to become nonproficient with regional analgesia. The well-rounded anesthesiologist should be able to administer regional analgesia as well as general anesthesia, not only because of the value of the former in surgery, but also because he is being called more and more to execute nerve blocks for the management of pain in patients with nonsurgical diseasess.

Among the many regional anesthetic technics none is more clinically useful than segmental peridural (epidural, extradural) block. This procedure, accomplished by injecting a local anesthetic solution into the space between the dura and periosteum of the spinal canal in a manner similar to spinal anesthesia, can be used to anesthetize any region of the body. After a little experience with it, it can be done as easily and as quickly as subarachnoid block. Moreover, by inserting a polyethylene tube or ureteral catheter in the same manner as continuous spinal, prolonged blocking can be produced and by varying the volume of the solution, the speed of injection and the position of the patient, any number of segments can be blocked. Thus, injection of 10 cc. of local anesthetic solution through a needle inserted in the seventh thoracic interspace produces analgesia involving approximately the fourth through the eleventh thoracic segment. Moreover, by varying the concentration of the solution, the intensity of anesthesia may be varied and muscular relaxation may or may not be produced.

Segmental peridural block affords the same advantages as spinal anesthesia without its disadvantages ,dangers and complications. Since the dura is not pierced, no headaches occur and there is no danger of inadvertently producing total anesthesia and of involving the medullary centers or of producing neurological sequale. Moreover, because in most instances it is not necessary to involve the sacral segments, post-anesthetic difficulty with bladder and rectal function do not occur and there is not the increased tendency for thrombus formation consequent to the inactivity of the lower extremities associated with spinal anesthesia.

Segmental peridural block can be used for intrathoracic, biliary, gastric, and intestinal surgery, for surgery of the chest and abdominal wall, for lumbar-renal and inguinal operations, to control labor pains, for caesarean sections and in neurosurgical procedures involving the spinal column. It is particularly advantageous in the management of pain syndromes involving the trunk and lower extremities.

The essayist will discuss a simple technic of segmental peridural block together with the indications, contraindications, advantages, disadvantages and the possible complications which can occur with this method. A clinical evaluation of the method based on over 1000 surgical and several hundred non-surgical cases will be given.

SECTION ON SURGERY

Grand Ballroom, Sheraton-Cadillac Hotel, Detroit

Chairman: F. P. Husted, M.D., Bay City
Secretary: J. M. Wellman, M.D. Lansing

"Cancer of the Breast"

Carl W. Eberbach, M.D., Milwaukee, Wisconsin

SECTION ON OTOLARYNGOLOGY

English Room, Sheraton-Cadillac Hotel, Detroit

Chairman: C. G. Wencke, M.D., Battle Creek
Secretary: F. A. Lamberson, M.D., Detroit

"External Otitis"

Ben H. Senturia, M.D., St. Louis, Missouri

SECTION ON PUBLIC HEALTH AND PREVENTIVE MEDICINE

Pan American Room, Sheraton-Cadillac Hotel, Detroit

Chairman: M. R. French, M.D., Coldwater
Secretary: P. S. Bradshaw, M.D., Muskegon

"Poliomyelitis Following Injection"

Gaylord W. Anderson, M.D., Minneapolis, Minnesota

This is a critical review of the reports on poliomyelitis occurring subsequent to injection of antigens or other substances. Some previously unpublished data are also presented. The review leads to the conclusion that if an individual contracts poliomyelitis within a month after antigen injection there is a localization of the paralysis in the injected extremity and some tendency toward greater severity of involvement. Evidence for a similar relationship to injections more than a month before onset and to injection of materials other than antigen is inadequate. The hypothesis that the virus is carried into the skin with the needle is rejected.

SECTION ON GASTROENTEROLOGY AND PROCTOLOGY

Founders Room, Sheraton-Cadillac Hotel, Detroit

Chairman: E. F. Sladek, M.D., Traverse City
Secretary: R. L. Fitts, M.D., Grand Rapids

"Regional Enteritis"

Samuel F. Marshall, M.D., Boston, Massachusetts

The treatment of regional enteritis, to be at all successful, must be a combination of medical and surgical measures—not merely medical treatment alone or surgical treatment alone.

The high recurrence rate of approximately 30 per cent vividly emphasizes that either method, medical or surgical, is not the final word in the treatment of regional enteritis. If the diagnosis can be made early enough and the disease process recognized, the results of conservative medical measures are as good as those of early surgical methods. Surgical extirpation should be restricted to those patients in whom complications have developed, such as perforation, persistent hemorrhage from the intestinal tract, abscess and intestinal obstruction.

Although almost everyone now agrees that surgery is the accepted method of treatment for the majority of complicated cases of regional enteritis, there is still considerable controversy over the particular type of surgical procedure to be done and the results to be obtained by the various methods. At this clinic, the mortality of resection has been low, less than 3 per cent. We believe that extirpation of this disease process together with as many of the involved nodes in the mesentery as possible offers the greatest opportunity for complete eradication of the disease by preventing recurrence, eliminating the toxic process and obtaining a better nutritional state for the patient. It is true that ileotransverse colostomy has been used and advocated by many investigators on this subject but the majority of patients so treated are never quite well, they have persistent nutritional problems and

often show evidence of persistent sepsis. Resection and primary anastomosis can be carried out with an extremely low operative risk and offer a much greater opportunity for recovery from this disease. It must be admitted, however, that the recurrence rate after either type of surgical treatment is still too high and that continuation of medical therapy after operation is an important factor in the ultimate prognosis of this serious disease.

THURSDAY EVENING

September 25, 1952

STATE SOCIETY NIGHT

Grand Ballroom, Sheraton-Cadillac Hotel

P.M.

10:30 **An evening of entertainment for all registrants, their ladies and guests.**

Cabaret-style Dance and Floor Show
Host: Michigan State Medical Society
(Admission by card furnished to all upon registration)

ONLY ONE MORE DAY TO VISIT YOUR MANY FRIENDS IN THE EXHIBIT

FRIDAY MORNING

September 26, 1952

Fifth Assembly

Grand Ballroom, Sheraton-Cadillac Hotel, Detroit

Chairman: RALPH W. SHOOK, M.D., Kalamazoo
Secretary: T. V. HOAGLAND, M.D., Detroit

A.M.

9:00 **"The Surgical Correction of Mitral Stenosis**

DWIGHT E. HARKEN, M.D., Boston, Massachusetts

Surgeon, Peter Bent Brigham Hospital, Boston; Surgeon and Chief of Department of Thoracic Surgery, Mt. Auburn Hospital, Cambridge, Mass.

9:30 **"Problems in the Diagnosis and Treatment of Syphilis"**

EVAN W. THOMAS, M.D., Albany, New York

Professor of Clinical Medicine, New York University; Bellevue Medical Center, N.Y.C.; Associate Physician Public Health (V.D. Control), New York State Health Department.

Some of the gaps in our understanding of the immunology and pathology of syphilis are mentioned. The greatest problem in the diagnosis of syphilis is to differentiate between active and inactive or permanently arrested infections. This differentiation is relatively easy in the primary and secondary stages before treatment. Following treatment of secondary syphilis the serologic tests for syphilis fail to become negative in about 20 per cent of non-relapsing cases for more than one year after treatment. The meaning of such prolonged seroresistance is considered.

In the absence of visible or palpable lesions, the differentiation between active and inactive late syphilis is oftentimes impossible except in neurosyphilis where the spinal fluid findings serve as a guide. The importance of this guide to the treatment of all types of late syphilis is discussed.

10:00 **INTERMISSION TO VIEW EXHIBITS**

11:00 **"Intestinal Obstruction"**

PHILIP THOREK, M.D., Chicago, Illinois

Chief Associate Professor, Department of Surgery, University of Illinois; Associate Professor of Surgery, Cook County Graduate School of Medicine; Diplomate, American Board of Surgery; Fellow, American College of Surgeons; Fellow, International College of Surgeons; Fellow, American College of Chest Physicians, American Association of Anatomists; Chief Surgeon, American Hospital; Attending Surgeon, Cook County Hospital; Senior Attending Surgeon, Alexian Brothers' Hospital.

The still too high mortality of intestinal obstruction stands as a glaring challenge to the medical profession in general. Memorized knowledge as to the number of conditions which may be associated with intestinal obstruction is of no diagnostic or therapeutic aid whatsoever. Intestinal obstruction as a symptom complex rather than a disease must be stressed.

With an aim toward simplification in diagnosis four simple questions are asked, the answers to which automatically point to proper diagnostic interpretation. Having obtained the diagnosis, a plan of therapy can be instituted. Such a plan is presented and its clinical applications are discussed thoroughly. By thus simplifying diagnosis and treatment do we attempt to lower the mortality of intestinal obstruction.

11:30 **"The Epilepsies, Their Diagnosis and Treatment"**

ROLAND P. MACKAY, M.D., Chicago, Illinois

Professor of Neurology, University of Illinois College of Medicine; Senior Attending Neuropsychiatrist, St. Luke's Hospital, Chicago; Attending Neurologist, Illinois Neuropsychiatric Institute.

The epilepsies or convulsive disorders may, for convenience, be divided into symptomatic and cryptogenic subgroups. The clinical types are described in detail and their significance discussed. They include grand mal, petit mal, and psychomotor seizures, the last mentioned being subdivided into ictal automatisms, ictal amnesic states, and ictal dreamy states. Additional clinical groups include myoclonic epilepsy and focal epilepsy which latter may be either motor or sensory in type.

Electroencephalography is a highly valuable laboratory method for the study of cases of convulsive disorders and throws light on most diseases of the brain. The abnormalities seen in the epilepsies consist of changes in the basic frequency, and the appearance of paroxysmal bursts of high voltage, high frequency waves or of slow waves. The occurrence of sharp spikes suggests an abnormal discharging focus. Abnormalities are apt to appear more readily during sleep. There is a significant but not an absolute correlation between electroencephalographic abnormalities and the clinical types of seizures. Consequently it is improper to speak of a "grand mal tracing" or "petit mal tracing," and each electroencephalogram must be interpreted in relationship to the known clinical features of each case.

Therapy, of course, can be prescribed only after a careful consideration of both clinical and electroencephalographic data and never upon the electroencephalographic phenomena alone. The treatment of the epilepsies demands the utmost in individualization. The various drugs and procedures used are thoroughly discussed with their specific indications and disadvantages.

12:00 **END OF FIFTH ASSEMBLY**

FRIDAY NOON

(No Luncheons)

September 26, 1952

12:00 to 1:00 p.m.

DISCUSSION CONFERENCE

Grand Ballroom, Sheraton-Cadillac Hotel

Leader: W. S. REVENO, M.D., Detroit
Participants: DANIEL C. DARROW, M.D., New Haven, Connecticut; GARFIELD G. DUNCAN, M.D., Philadelphia, Pennsylvania; DWIGHT E. HARKEN, M.D., Boston, Massachusetts; ROLAND P. MACKAY, M.D., Chicago, Illinois; EARL R. MILLER, M.D., San Francisco, California; EVAN W. THOMAS, M.D., Albany, New York; PHILIP THOREK, M.D., Chicago, Illinois; and CLAUDE E. WELCH, M.D., Boston, Massachusetts

FRIDAY AFTERNOON
September 26, 1952

Sixth Assembly

Grand Ballroom, Sheraton-Cadillac Hotel, Detroit

Chairman: R. S. Breakey, M.D., Lansing
Secretary: C. J. Courville, M.D., Detroit

P.M.

2:00 **"Fluid Requirements in Patients of Different Sizes"**

Daniel C. Darrow, M.D., New Haven, Connecticut

Professor of Pediatrics, Yale University School of Medicine.

Fluid therapy will be considered in patients who have sustained loss of body water and electrolyte. Rational planning is based on:

(1) Replacement of deficits
(2) Administration of fluids to replace obligatory normal expenditure
(3) Additional water and electrolyte to replace abnormal expenditure.

Knowledge of the changes in intracellular as well as extracellular composition is needed for (1), and the amounts are related to body weight. Obligatory expenditure is related to metabolic turnover or heat production. Abnormal expenditure is related to abnormalities in urine and stools and the volumes of gastrointestinal fluid lost. The uses of fluids containing potassium as well as sodium, chloride and glucose will be discussed.

2:30 **"Recent Advances in Radiology"**

Earl R. Miller, M.D., San Francisco, California

Professor of Radiology, University of California School of Medicine; Radiologist, University of California Hospital.

3:00 **INTERMISSION TO VIEW EXHIBITS**

3:30 **"The Surgical Management of Duodenal Ulcer"**

Claude E. Welch, M.D., Boston, Massachusetts

Associate Visiting Surgeon, Massachusetts General Hospital; Clinical Associate in Surgery, Harvard Medical School.

4:00 **"Management of Diabetes During Acute Complications"**

Garfield G. Duncan, M.D., Philadelphia, Pennsylvania

Director of the Medical Divisions, Benjamin Franklin Clinic and Pennsylvania Hospital, and Clinical Professor of Medicine, Jefferson Medical College, Philadelphia, Pennsylvania.

Every diabetic patient suffers from an acute complication sooner or later. Acute complications intensify the disturbances characteristic of diabetes and precipitate hazards which may threaten life.

The more dangerous of the acute complications are pyogenic infections, gastrointestinal disturbances in which vomiting and/or diarrhea are features, and vascular accidents notably occlusion of a coronary artery.

Febrile disturbances, in general, reduce the degree of and duration of the effectiveness of insulin. Three plans of insulin therapy are recommended for the control of the diabetes during acute complications based on the nature of the complications. (a) Some patients need only increases in the precomplication doses of insulin. (b) Others for a short time need regular insulin at four or six-hour intervals superimposed on the precomplication insulin therapy. (c) Those with more severe and prolonged complications need to have their precomplication insulin regimen replaced by regular insulin given at six-hour intervals, with the diet divided into four equal meals, one every six hours.

The management of diabetic coma is simplified by making an early—a bedside—diagnosis by simply testing for the degree of acetonemia when glycosuria is found. A 4-plus reaction for acetone in the plasma confirms the diagnosis and permits prompt institution of therapy. The amount of insulin given initially is regulated by the degree of acetonemia as determined by qualitative tests of serial dilutions of the plasma. The advantages of these simple measures have been amply proved.

4:30 **END OF SIXTH ASSEMBLY**

——Program of Sections——

FRIDAY
September 26, 1952
4:30 to 5:30 p.m.

SECTION ON RADIOLOGY

Founders Room, Sheraton-Cadillac Hotel, Detroit

Secretary: F. K. Wietersen, M.D., Birmingham

Earl R. Miller, M.D., San Francisco, California

SECTION ON MEDICINE

Grand Ballroom, Sheraton-Cadillac Hotel, Detroit

Chairman: D. I. Sugar, M.D., Detroit
Secretary: D. R. Boyd, M.D., Muskegon

"Description of the Selection of Patients for the Surgical Correction of Mitral Stenosis, with a Description of the Results After Surgery"

Dwight E. Harken, M.D., Boston, Massachusetts

SECTION ON GENERAL PRACTICE

English Room, Sheraton-Cadillac Hotel, Detroit

Chairman: E. M. Smith, M.D., Grand Rapids
Secretary: C. J. Williams, M.D., Grosse Pte. Park

"Jaundice"

Philip Thorek, M.D., Chicago, Illinois

Jaundice, or hyperbilirubinemia, is an important subject to both the general practitioner and specialist alike, and always presents an interesting diagnostic challenge. One must have ways and means of co-ordinating and simplifying the subject so that with the diagnostic armamentarium at hand a diagnosis may readily be reached and proper therapy instituted. A thorough understanding of the pathologic physiology involved results in a more rapid and accurate diagnosis than the memorized knowledge of the hundred and one conditions which might be associated with this symptom. It is with this in mind that the subject is presented.

The value of Courvoisier's law is stressed. Pruritus as a diagnostic aid rather than a symptom is discussed.

It has been found advantageous to clinically classify jaundice into three groups, based upon the relationship of the lesion to the liver.

The use of four anatomic divisions of the common duct permits one to standardize the various operative procedures on this structure.

The diagnostic as well as the surgical do's and don't's are emphasized.

SECTION ON NERVOUS AND MENTAL DISEASES

Pan American Room, Sheraton-Cadillac Hotel, Detroit

Chairman: P. N. Brown, M.D., Northville
Secretary: T. V. Hoagland, M.D., Detroit

"Memory as a Biologic Function"

Roland P. Mackay, M.D., Chicago, Illinois

It appears that memory is a basic attribute of all living things, by which patterns of sensitivity and response, both inborn and acquired, are retained and progressively modified under the impact of experience. Memory is thus indispensable in all behavior, making it at once consistent and modifiable. A consideration of some of the classical psychologic features of memory indicates the extent to which it involves multi-modal processes and hence involves extremely widespread cerebral areas. In the higher animals and in man therefore, memory can have no precise localization and thus cannot be said to "reside" in the temporal lobe or in any other restricted area. In the simplest organisms memory seems to be dependent upon modifiable molecular structure; its mechanism in a nervous system is a most elusive function of neuronal networks by which topographic and sequential patterns of stimuli sensitize the network to subsequent stimuli in the same patterns, probably through the device of summation in reverberating circuits rather than by the facilitation of anatomical pathways. Sketchy and hypothetical though our present knowledge is, this dynamic approach to the physiology of memory promises much for our understanding of the behavior of living things.

5:30 **END OF SCIENTIFIC ASSEMBLY AND OF 1952 ANNUAL SESSION**

Technical Exhibits

Abbott Laboratories **Booth No. 46**
North Chicago, Illinois

Abbott presents a special product display featuring six of their latest laboratory developments. Included are ABBOCILLIN 800M, new high concentration penicillin product; DICALETS, balanced-formula vitamins and minerals for pregnancy and lactation; and DAYALETS, Abbott's new fishless, burpless multivitamin tablets. Other products to be displayed are OPTILETS, SELSUN and SUCARYL.

Alkalol Company **Booth No. 94**
Taunton, Massachusetts

The Alkalol Company, Taunton, Massachusetts, will feature Alkalol, the balanced, alkaline, saline solution for the treatment of mucous membranes and irritated tissues. It is bland, nontoxic, and effective, and has been a favorite since 1896. We are also showing Irrigol, a powder which in solution makes an aseptic, slightly astringent vaginal douche. It is widely used also for colonic irrigations and as an effective rectal enema.

A. S. Aloe Company **Booth No. 73**
St. Louis, Missouri

Visit Booth No. 73 where the Aloe representative will show you a cross section of the complete line of physicians' equipment and supplies carried by the A. S. Aloe Company. Highlighted will be New Model Steeline—tomorrow's treatment room furniture today —featuring the body contour table top, magnetic door catches and advanced design all in new decorators' colors.

Americana Corporation **Booth No. 31**
Chicago, Illinois

All members of the Michigan State Medical Society are very cordially invited to visit our Booth No. 31 where we will have on display, for their inspection, the mid-century printing of the *Encyclopedia Americana* and also the fortieth anniversary edition of the *Book of Knowledge*. Both will be combined in a very unique combination offer. Our Mr. Armin Eastman will be in attendance.

American Hospital Supply Corporation **Booth No. 25**
Evanston, Illinois

Scientific Products Division, American Hospital Supply Corporation, will exhibit Baxter intravenous solutions, including Travert, the new invert sugar solution providing twice the calories as dextrose in the same infusion time; Baxter blood transfusion and plasma equipment, together with the complete line of Baxter expendable accessories for the intravenous solutions and blood and plasma bottles.

Ames Company, Inc. **Booth No. 33**
Elkhart, Indiana

The Ames DIAGNOSTIC KIT will be featured. This small kit (3 x 9 inches) contains CLINITEST, ACETEST, BUMINTEST, and HEMATEST, simplified tests for urine-sugar, acetest, albumin, and occult blood. This kit is designed for the physician's office, small laboratory, hospital floor use, etc. The Ames representatives will be demonstrating these tests.

Armour Laboratories **Booth No. 19**
Chicago, Illinois

You are cordially invited to attend The Armour Laboratories' exhibit where our representatives will be pleased to discuss with you ACTHAR Gel, The Armour Laboratories' Brand of Adrenocorticotropic Hormone; TRYPTAR; the Armatinic products; the Crystamin products; and Thyroid.

Ayerst, McKenna & Harrison, Ltd. **Booth No. 17**
New York, New York

Physicians attending the Michigan State Medical Society Session are cordially invited to visit the Ayerst booth where you will receive a warm welcome. Our representatives will be there to answer any inquiries relative to "Premarin" with Methyltestosterone, "Clusivol," "Antabuse," or any other inquiries relative to all products of our manufacture.

Baby Development Clinic **Booth No. 93**
Chicago, Illinois

BABY DEVELOPMENT CLINIC presents psychological and emotional aspects of early feeding in visual as well as printed form. Ideal for use of doctors, nurses, as well as teachers, and others who are in contact with expectant parents, medical students or nurses in training.

MATERNITY COUNSELLING SERVICE — a courtesy service available to doctors for their maternity patients—relieves doctors of discussing layette needs and other preparationss for home and baby. No charge or obligation to doctor or patients. Supported by firms included in exhibit.

Baker Laboratories, Inc. **Booth No. 59**
Cleveland, Ohio

Baker's Modified Milk (Carbohydrate added) and Varamel (no Carbohydrate added) are made especially for infant feeding, from Grade A milk (U. S. Public Health Service Milk Code), which has been modified by replacement of the milk fat with animal and vegetable oils and by the addition of vitamins and iron.

Bard-Parker Company, Inc. **Booth No. 41**
Danbury, Connecticut

Genuine Bard-Parker "Rib-Back" surgical knife blades, "the blade that assures cutting efficiency." A quality product that makes for blade economy; B-P handles of various types; Bard-Parker Germicide—a sporicidal solution; Bard-Parker Chlorophenyl; instrument sterilizing containers; The Reese Dermatome—for simpler, more accurate split-skin grafts with the Dermatape technique.

Barry Laboratories, Inc. **Booth No. 21**
Detroit, Michigan

Barry Laboratories, Inc., will display the most up-to-date advances in diagnostic and therapeutic products in both allergens and sterile injectables. A representative will be in constant attendance to furnish information and discuss any products on display.

Beech-Nut Packing Company **Booth No. 26**
New York, New York

BEECH-NUT STRAINED BANANA and the new CORN CEREAL will be featured at this booth. Nutritionists will be in attendance to answer questions

regarding the nutritive value and use of these foods as well as of the other Beech-Nut Strained and Junior Foods and the Beech-Nut Cereals.

The Borden Company **Booth No. 29**
New York, New York

Borden representatives will be more than pleased to discuss a new powdered infant food with you. BREMIL is a completely modified milk in which nutritionally essential elements of cow's milk have been adjusted in order to supply the nutritional requirements of infants deprived of human milk. Also exhibited will be MULL-SOY, DRYCO, BIOLAC, and other prescription products.

Brooks Appliance Company **Booth No. 16**
Chicago, Illinois

The Brooks Appliance Company will exhibit and describe in detail the technique of applying the combination pressure bandages, the moist medicated Primer plus the Elastic Adhesive Dalzoflex which are used in treating leg ulcers and phlebitis. Elastic Stockings, the Nulast Elastic Crepe Bandages and Surgical Instruments will also be displayed.

Brown & Williamson Tobacco Corp. **Booth No. 83**
Louisville, Kentucky

Doctors and guests alike are cordially invited to visit the booth of the Brown & Williamson Tobacco Corporation. Their booth will exhibit VICEROY (filter tip) Cigarettes, a brand of particular interest to the medical profession. Gift packages of VICEROY Cigarettes will be presented to those who register at the VICEROY booth.

Burdick Corporation **Booth No. 85**
Milton, Wisconsin

Burdick Physical Medicine Equipment to be exhibited will include their Direct-Recording Electrocardiograph, which is distributed in Michigan by The G. A. Ingram Company of Detroit. Other Burdick products to be featured include F.C.C. approved Diathermy equipment, Ultraviolet and Infra-red Lamps and the new McLellan Suction Unit.

Burroughs Wellcome & Co. (U.S.A.) Inc. **Booth No. 55**
Tuckahoe, New York



AEROSPORIN® Sulfate: Polymyxin B. Sulfate, a new antibiotic. Effective against *Pseudomonas aeruginosa*. Destroys most other gram-negative bacilli.

POLYSPORIN®: Polymyxin B—Bacitracin Ointment. Broad spectrum for all pyogenic infections, including external ear infections, styes, acne, furuncles. Rarely sensitizes. Resistance rarely develops.

Camel Cigarettes **Booths Nos. 35, 36**
New York, New York

CAMEL Cigarettes will mark your initials on an attractive plastic cigarette case filled with a package of those mild, flavorful CAMELS. This exhibit features a display of some of the tobaccos used in blending this famous cigarette which leads all other brands by many billions.

Carnation Company **Booth No. 38**
Los Angeles, California

You are cordially invited to visit the Carnation Company Booth No. 38 where you will see an attractive display featuring colorful translites of famous Carnation Babies. Medical representatives will explain the reasons why Carnation Milk deserves consideration as your first choice for infant feeding, child feeding and general diet uses. Valuable literature will also be available for distribution.

Ciba Pharmaceutical Products, Inc. **Booth No. 11**
Summit, New Jersey

The Ciba exhibit will feature APRESOLINE, a phthalazine derivative which is an orally effective and relatively safe therapy in hypertension of diverse etiology.

Representatives in attendance will be very glad to discuss and to provide literature on this and other Ciba products.

Coca-Cola Company **Booth No. 99**
Atlanta, Georgia

Ice-cold Coca-Cola served through the co-operation and courtesy of the Detroit Coca-Cola Bottling Company and The Coca-Cola Company.

Coles Corporation **Booth No. 27**
Philadelphia, Pennsylvania

COLES CORPORATION will exhibit a full complement of surgical equipment of advanced design. Included are precision cutting instruments, both portable and floor models, which permit the use of varied electronic surgical methods to meet the exacting surgical needs of the general practitioner, gynecologist, or proctologist, including certain major surgery interventions. SEE the Portable RADIOSURG SCALPEL and the new RADIOTOME Surgery Unit— a semi-hospital combination tube and gap-type cutting unit. THE RADIOTOME employs a dual foot pedal control and is amply powered to meet the requirements for a moderate sized operating room unit. We invite your inspection of these quality units.

Desitin Chemical Company **Booth No. 65**
Providence, Rhode Island

DESITIN OINTMENT, the pioneer in external cod liver oil therapy. Indications: diaper rash, slow healing wounds, burns of all degrees, lacerations, hemorrhoids and fissures.

DESITIN POWDER, a unique, dainty medicinal powder saturated with cod liver oil.

DESITIN HEMORRHOIDAL SUPPOSITORIES with COD LIVER OIL, coats ano-rectal area with soothing, lubricating cod liver oil, gives prompt relief of pain, allays itching.

DESITIN LOTION, the original cod liver oil lotion, soothing, protective, mildly astringent and healing, in non-specific dermatitis, pruritus, poison ivy, etc.

Detroit Creamery Company **Booth No. 97**
Detroit, Michigan

Dictaphone Corporation **Booth No. 15**
Detroit, Michigan

The most successful dictating machine in history—the electronic Dictaphone Time-Master—will be featured at the Dictaphone booth.

With its unbreakable plastic Dictabelt record, the new Time-Master saves time and effort in every branch of the medical profession. Be sure to see and try the Time-Master and get your copy of "Help for the Busiest Man in Town" at the Dictaphone booth.

Dietene Company **Booth No. 52**
Minneapolis, Minnesota



Visit our exhibit and examine the Free Diet Service for physicians. The diets are nutritionally well-balanced, easy to follow and made to appear as if they were typed in your office.

MERITENE, the economical and palatable whole protein supplement and DIETENE, the "Council - Accepted" reducing supplement will be on display.

Doak Company, Inc. **Booth No. 30**
Cleveland, Ohio

Doak Company, Inc., specializing in dermatological preparations for over thirty years, present the following preparations: Buro-Sol Powder, Buro Sol Cream, Spersol, Solar Cream, Normaderm, Tarpaste and the new products Dalibour Powder and Derma Packs.

Doho Chemical Corporation **Booth No. 10**
New York, New York

Doho Chemical Corporation is pleased to exhibit AURALGAN, the ear medication for the relief of pain in Otitis Media and removal of Cerumen; RHINALGAN, the nasal decongestant which is free from systemic or circulatory effect and equally safe to use on infants as well as the aged; and the NEW OTOSMOSAN, the effective, non-toxic ear medication which is Fungicidal and Bactericidal (Gram negative-Gram positive) in the suppurative and aural dermatomycotic ears. Mallon Chemical Corporation, subsidiary of the Doho Chemical Corporation, is also featuring RECTALGAN, the liquid topical anesthesia, also Bactericidal and Fungicidal for control of secondary invaders, particularly recommended for treatment of mold infections (monilia) occurring after anti-biotic therapy; also for relief of pain and discomfiture in hemorrhoids, pruritus and perineal suturing.

Eaton Laboratories, Inc. **Booth No. 70**
Norwich, New York

Furacin,® an effective antibacterial agent in the presence of exudates is offered, in a new dosage form—Furacin Nasal *plain* for atrophic rhinitis, sinusitis and postoperative treatment. This is a companion product to Furacin Nasal with ephedrine.

When pregnancy is contraindicated Lorophyn Suppositories offer an effective, simple technic with high patient acceptance.

Eisele & Company **Booth No. 77**
Nashville, Tennessee

Eisele & Company will display their line of clinical thermometers, hypodermic syringes—both the regular type and Interchangeables—hypodermic needles, Sanelastic bandages and specialty glassware.

H. G. Fischer & Company **Booth No. 67**
Detroit, Michigan

At Booth No. 67 inspect H. G. Fischer & Co.'s modern, efficient, low priced x-ray and physical therapy equipment. Let their representatives point out many features of advantage in these units and other models not on display. Your visit welcome—No obligation.

C. B. Fleet Company, Inc. **Booth No. 8**
Lynchburg, Virginia

C. B. Fleet Co., Inc., cordially invites you to visit Booth No. 8. Increasingly, during the past fifty years, to the medical profession, sodium phosphate has come to mean Phospho-Soda (Fleet), the pure, stable, aqueous solution of the two U.S.P. sodium phosphates. There is only ONE Phospho-Soda (Fleet).

Freeman Mfg. Company **Booth No. 68**
Sturgis, Michigan

For more than sixty years Freeman has been engaged in making surgical supports and elastic hose. During that time we have worked closely with members of the medical profession. Their assistance has proved invaluable in enabling us to maintain the highest standards of quality and design.

We particularly invite your inspection of our complete line of orthopedic supports being exhibited at the show.

Geigy Pharmaceuticals **Booth No. 49**
New York, New York

BUTAZOLIDIN T.M. a totally new, synthetic, nonhormonal rheumatolytic and analgesic with an exceptionally broad field of usefulness in rheumatism and allied disorders, will be featured. Also on display will be Council Accepted TROMEXAN® a new, safer, faster-acting, less cumulative, oral anticoagulant; EURAX® Cream, a new, long-acting, non-sensitizing, antipruritic and scabicide; and PANPARNIT® indicated for symptomatic relief of Parkinson's Disease.

General Electric Co.—X-Ray Dept. **Booth No. 72**
Milwaukee, Wisconsin

General Electric X-Ray extends a cordial invitation to visit their exhibit. Representatives who call on you will look forward to your visit, and if circumstances beyond our control do not prevent, new equipment will be on display. In any case, we hope that this meeting will again afford an opportunity to visit with you.

Gerber Products Company **Booth No. 34**
Fremont, Michigan



Gerber's of Michigan is proud to serve Michigan's physicians and, through them, Michigan's future citizens. Gerber's Fremont plant processes the best of the State's garden and orchard produce into the wide variety of baby foods that makes prescription selectivity easy for every baby's doctor.

Gerber's professional representatives look forward to greeting you at your Annual Session.

Hack Shoe Company **Booth No. 3**
Detroit, Michigan

It wouldn't be a Michigan State Medical Society Annual Session without this long-time friend of the profession on hand with a display of supportive-type footwear. Over the years, whenever a doctor of medicine has occasion to think of prescription footwear for a patient, the name HACK is the one which comes to his mind—and prescription pad.

This year, the emphasis will be on dressing up therapeutic footwear—sugar-coating what for so long has been a bitter pill for young women forced to wear "Old Ladies' Running Shoes." There are some good-looking shoes for you, too, Doctor.

[anovia Chemical & Mfg. Company **Booth No. 54**
ewark, New Jersey

See Hanovia's new short wave diathermy, possessed of special features, orificial and general body irradiation; ultraviolet quartz lamps, infrared lamps, black light for diagnostic purposes. Competent and courteous representatives will be on hand to greet you.

. F. Hartz Company **Booth No. 64**
)etroit, Michigan

The J. F. Hartz Company is pleased to again have the opportunity to display its Laboratory Controlled Pharmaceuticals and the latest in office and diagnostic equipment. We particularly call your attention to the Microtherm "Radar Type" diathermy which we will be happy to demonstrate for you at this meeting.

I. J. Heinz Company **Booth No. 53**
'ittsburgh, Pennsylvania

Stop at the Heinz exhibit for these: Nutritional Data, Nutritional Observatory. Do you need Baby Gift Folders for distribution among your patients? Have you seen the additions to Heinz Baby Food line—Pre-Cooked Barley Cereal? New Junior Foods are—Sweet Potatoes, Chocolate Pudding, Butterscotch Pudding, and Macaroni, Tomato, Beef and Bacon.

Ioffmann-La Roche, Inc. **Booth No. 76**
Nutley, New Jersey

Roche will feature GANTRISIN, the more soluble sulfonamide which has a wider antibacterial spectrum. GANTRISIN is highly effective in the treatment of systemic and urinary tract infections. Stop at the Roche booth where members of the field staff will be glad to discuss this more effective and better tolerated sulfonamide.

Iolland-Rantos Company, Inc. **Booth No. 92**
Jew York, New York

Holland-Rantos will feature NYLMERATE SOLUTION, a concentrated trichomonicidal, fungicidal and bactericidal preparation used in recommended dilutions as a vaginal douche—either alone or as an adjunct to Nylmerate Jelly. Representatives will gladly answer inquiries regarding Nylmerate preparations, KOROMEX products for *dependable* contraceptive protection, or other specialties of special interest to you.

G. A. Ingram Company **Booth No. 84**
Detroit, Michigan

The G. A. Ingram Company will exhibit a complete line of diagnostic instruments as well as orthopedic instruments which will prove to be of special interest to the profession.

C. B. Kendall Company **Booth No. 78**
Indianapolis, Indiana

Constant efforts in the development laboratories to provide products reflecting the most advanced medical trends, pharmaceutical elegance, and improved production methods will be exemplified in the C. B. Kendall Co. exhibit. Outstanding products of accepted merit and newer products of recent development will be displayed and discussed with visiting physicians by informed representatives.

Kremers-Urban Company **Booth No. 74**
Milwaukee 1, Wisconsin

Kremers-Urban Professional Service Representatives will welcome the opportunity to meet our many Michigan friends. K-U Council-accepted medications and new research developments will be displayed. We hope you will stop and visit with us.

A. Kuhlman & Company **Booth No. 91**
Detroit, Michigan

We invite you to visit our display and see an excellent line of Surgical and Diagnostic Instruments. We are also showing the latest design of Medical Office Furniture and FCC Approved Short Wave Diathermies.

Lea & Febiger **Booth No. 87**
Philadelphia, Pa.

Schedule plenty of time to see the Lea & Febiger display at booth No. 87. New books include McManus, *Progress in Fundamental Medicine;* Master, Walters and Garfield, *Blood Pressure and Hypertension;* Lewin on *The Knee;* Bonica, *The Management of Pain;* Collins, *Principles and Practice of Anesthesiology;* Herbut, *Urological Pathology;* Master, Moser and Jaffe, *Cardiac Emergencies and Heart Failure;* and other works of medical importance.

Lederle Laboratories **Booth No. 51**
New York, New York

You are cordially invited to visit our exhibit in Booth No. 51, where you will find representatives who are prepared to give you the latest information on Lederle products.

Liebel-Flarsheim Company **Booth No. 7**
Cincinnati, Ohio

The Liebel-Flarsheim Company cordially invites you to visit Booth No. 7 in which their latest diathermy apparatus will be available for examination and demonstration. Capable representatives will be on hand at all times and we hope you will stop by so that we may become acquainted.

Eli Lilly & Company **Booth No. 90**
Indianapolis 6, Indiana

Your Lilly medical service representative cordially invites you to visit the Lilly exhibit located in Booth No. 90. Featured will be a demonstration of functional packaging as an aid to medical practice. Modern manufacturing departments will be illustrated. Literature on new therapeutic developments will be available.

J. B. Lippincott Company **Booth No. 1**
Philadelphia, Pennsylvania

J. B. Lippincott Company presents, for your approval, a display of professional books and journals geared to the latest and most important trends in current medicine and surgery. These publications, written and edited by men active in clinical fields and teaching, are a continuation of more than 100 years of traditionally significant publishing.

M & R Laboratories **Booth No. 62**
Columbus, Ohio

Your SIMILAC representatives are happy to take part in this meeting. They are pleased to have the opportunity to discuss with you the role of SIMILAC in infant feeding. They have for you the latest Pediatric Research Conference reports. Current reprints of Pediatric nutritional interest are also available.

Maico Hearing Service **Booth No. 86**
Detroit-Grand Rapids, Michigan

Maico Precision Hearing Aids are fitted in such a way that one's closest friends would never know an instrument was being worn. Scientific adjustments to the individual hearing loss insures maximum results—complete satisfaction is guaranteed to all physicians' patients referred to our offices. Ninety per cent of all precision hearing test instruments used in America by physicians are Maico.

Marion Phillips Maternity Preparations. **Booth No. 69**
Rochester, New York

S. E. Massengill Company **Booth No. 45**
Bristol, Tennessee

You are invited to visit Booth No. 45. Several Massengill specialty products are on display and the feature preparation is the new Tablets Aminodrox. Aminodrox permits wider usefulness for Aminophylline through the dependable blood levels that can be maintained with oral medication. Representatives are glad to discuss the new Tablets Aminodrox with you, and samples and literature will be available upon request.

Mead Johnson & Company **Booth No. 88**
Evansville, Indiana

MEAD JOHNSON & COMPANY, Evansville, Indiana, will feature Lactum and Dalactum, convenient formulas of evaporated milk containing Dextri-Maltose; three water-soluble vitamin preparations, Poly-Vi-Sol, Tri-Vi-Sol and Ce-Vi-Sol; Fer-In-Sol, a palatable, highly concentrated solution of ferrous sulfate. Also Mulcin, a pleasingly flavored vitamin emulsion, for teaspoonful dosage, as well as four Pablum cereals, including Barley and Rice.
Representatives in attendance will be glad to furnish information regarding the above products.

Medical Arts Surgical Supply Company. **Booth No. 81**
Grand Rapids, Michigan

Medical Arts Surgical Supply Company of Grand Rapids will occupy Booth No. 81 showing the new Ritter chair-table, many new diagnostic and treatment items including new instruments.

Medical Protective Company **Booth No. 40**
Fort Wayne, Indiana

Having completed another year in which not a single policyholder suffered involuntary loss from his own pocket in a malpractice claim or suit defended by this unique organization, despite large losses reported elsewhere, The Medical Protective Company, Specialists in Professional Protection Exclusively since 1899, invite your visit to Booth No. 40. Answers to problems in the Doctor-Patient relationship are yours for the asking.

Merck & Company, Inc. **Booth No. 80**
Rahway, New Jersey

MERCK & CO. INC. is featuring CORTONE, HYDROCORTONE, NALLINE, and other medicinal preparations.
CORTONE has produced striking clinical improvement in rheumatoid arthritis and related rheumatic diseases; bronchial asthma; eye diseases including non-specific iritis, iridocyclitis and uveitis; and skin diseases including cases secondary to drug reactions.
HYDROCORTONE is recommended for injection into the articular cavity of a rheumatoid or osteoarthritic joint.
NALLINE is a specific antidote in the treatment of overdosage with morphine and its derivatives, as we as meperidine and methadone.
Representatives at the Merck booth will be glad provide information on these and other medicin preparations such as Antibiotics, NEO-ANTERGA URECHOLINE, and VINETHENE.

Wm. S. Merrell Company **Booth No. 9**
Cincinnati, Ohio

For prompt, effective and COMFORTABLE relax tion of gastrointestinal smooth muscle spasm Merre presents BENTYL Hydrochloride.
BENTYL is a high milligram potency non-narcot antispasmodic with twofold musculotropic and neur tropic action; effective therapeutically witho atropine-like side actions in functional gastrointestin disorders.
BENTYL is particularly suited for prolonged ac ministration without habituation or increased toleranc

Michigan Medical Service **Booth No.**
Detroit, Michigan

Representatives will be present to give full particula regarding the Doctors of Michigan Voluntary Prepai Medical-Surgical Plan. All your questions will b answered and any problems handled.
Various statistical charts showing progress for th past year and from inception to date will be availabl for your inspection.

C. V. Mosby Company **Booth No. 6**
St. Louis, Missouri

The latest in medical literature can be found at th C. V. Mosby Company Booth No. 61, where you ar invited to visit and browse at your leisure. Amon the recent releases are: Hermann "Diseases of Hear and Arteries," Traut "Rheumatic Diseases in Theor and Practice," Litzenberg "Synopsis of Obstetrics, Kosmak "Transactions Fifth American Congress o Obstetrics and Gynecology," and many others.

National Drug Company **Booth No.**
Philadelphia, Pennsylvania

The National Drug Company, pioneer in the clinica application of resin therapy, will feature Resion, a intestinal adsorbent; Resinat H-M-B, a polyamine ex change resin with homatropine methylbromide for th treatment of peptic ulcer; and Natrinil, a cation ex change resin for the control of edema. Traine representatives will be in attendance to discuss ou resin preparations and other specialties: ACTH Ammivin, AVC Improved, Benat, DTP Vaccine Natolone, as well as any of National's vast array o pharmaceutical and biological products.

Nepera Chemical Company, Inc. **Booth No. 4**
Yonkers, New York

Nestlé Company, Inc. **Booth No. 6**
Colorado Springs, Colorado

You are cordially invited to visit Nestlé's Booth No 66, where specially qualified representatives will b on hand to answer your questions on any of Nestlé' milk products—already best known and most use for babies 'round the world. New pieces of valuabl literature will also be available.

Wm. R. Niedelson Company **Booth No. 1**
Detroit, Michigan

Visit our booth for the latest technical advances i office routine E.K.G.'s—B.M.R.'s and X-ray. Th newest models of the *Jones Metabolism Equipmen*

line and *Electro-Physical Lab. Cardiotrons* will be on exhibit.
Literature for the *Profexray* models, as well as other descriptive material, will be available at our exhibit.

Noble-Blackmer, Inc. **Booth No. 5**
Jackson, Michigan

Your friendly representatives from Jackson will be at Booth No. 5 to show you the latest Hamilton office furniture, the Birtcher Bandmaster, Crystal Controlled FCC approved Short-Wave Diathermy and "Light Where You Want It" with Castle office lights.

Ortho Pharmaceutical Corporation **Booth No. 44**
Raritan, New Jersey

ORTHO cordially invites you to visit their exhibit at Booth No. 44. The Ortho display will feature PRECEPTIN® vaginal gel, their new product for conception control designed for use without a vaginal diaphragm. Preceptin vaginal gel has achieved an outstanding record of clinical effectiveness and has been widely acclaimed by the medical profession. Your inquiries on Preceptin vaginal gel are invited.

Parke, Davis & Company **Booth No. 28**
Detroit, Michigan

Medical Service Members of the PARKE, DAVIS & COMPANY staff will be in daily attendance at the exhibit for consultation and discussion of products of particular interest to Society members at this time. Important specialties such as Chloromycetin, Penicillin S-R, Benadryl, Oxycel, Thrombin Topical, Surital, and others will be featured.

Pelton & Crane Company **Booth No. 75**
Detroit, Michigan

The Pelton FL-2 Autoclave reduces minutes to seconds between sterilizing periods. Its 6″ x 12″ chamber is surrounded by an outer jacket that generates and stores steam under pressure for immediate use at any time. Built sturdily of brass and bronze, it will last for years.

Pet Milk Sales Corporation **Booth No. 18**
St. Louis, Missouri

Specially trained representatives will be in attendance to discuss the use of Pet Milk in infant feeding, and to present many services that are time-savers for busy physicians. Miniature Pet Milk cans will be given to visitors at the exhibit.

Philip Morris & Company, Ltd. **Booth No. 6**
New York, New York

Philip Morris and Company will show the results of research on the irritant effects of cigarette smoke. These results show conclusively that Philip Morris are less irritating than other cigarettes. An interesting demonstration will be made on smokers at the exhibit which will show the difference in cigarettes.

Picker X-Ray Corporation **Booth No. 37**
White Plains, New York

The Picker X-Ray Corporation invites you to visit its exhibit where the latest accessories and equipment available for x-ray work are on display. A staff of technical specialists will be pleased to assist you with any x-ray planning or technical problem.

Procter & Gamble Company **Booth No. 20**
Cincinnati, Ohio

The Procter & Gamble Company offers a series of time-saving leaflet pads for doctors, "Instructions—Bathing a Patient in Bed," "Instructions—Routine Care of Acne," "Instructions—Bathing Your Baby," "Hygiene of Pregnancy," "Home Care of Bedfast Patient," and "Instructions—Sickroom Precautions." There will also be samples of other material prepared for physicians. Mrs. Christyne Schwab, in charge.

Professional Management **Booth No. 82**
Battle Creek, Michigan



Residents and Interns, as well as physicians now in practice, are invited to Booth No. 82 for consultation with PM regarding Office Records—Office Design—Partnership Arrangements—Fees—Locations, Taxes or Estate Problems.

Randolph Surgical Supply Company **Booth No. 50**
Detroit, Michigan

Randolph Surgical Supply Company will exhibit outstanding new designs and finishes in Doctors' office equipment. On hand to greet our many friends will be such old timers as Cliff Randolph, Harold Stormhafer and Art Rankin, and a few of our young cubs always. "For Finer Equipment."

A. H. Robins Company, Inc. **Booth No. 12**
Richmond, Virginia

A. H. Robins Company exhibit is featuring PHENAPHEN and PHENAPHEN WITH CODEINE, "the complete analgesics"; and ROBITUSSIN, antitussive-expectorant for rational cough therapy. Robins' Medical Service Representatives welcome the privilege of discussing with physicians attending the Assembly these and other products in the company's line of prescription specialties.

Rystan Company, Inc. **Booth No. 39**
Mount Vernon, New York

Rystan will feature Chloresium Ointment and Solution (plain), water-soluble chlorophyll preparations providing tissue-repairing and deodorizing properties for treatment of wounds, burns, ulcers and dermatoses. Also exhibited will be Chloresium Mucinoid, combining chlorophyll and antacids in mucilaginous okra for peptic ulcer, and Chloresium Tablets, the high-concentration chlorophyll deodorizing tablet.

Sandoz Pharmaceutical Division **Booth No. 60**
New York, New York

Physicians attending the Michigan State Medical Society Convention are cordially invited to visit the Sandoz Pharmaceuticals display which will feature the following:
HYDERGINE—a new approach and new product for hypertension and peripheral vascular diseases.
CAFERGOT—the first effective oral preparation for the treatment of Migraine and related headaches.
BELLERGAL—a time-tested preparation for use in functional disorders.
A new handbook listing our products will be available and representatives in attendance will gladly answer any questions about these and other Sandoz products.

W. B. Saunders Company **Booth No. 2**
Philadelphia, Pennsylvania

Among the many new books and new editions available for your inspection at the Saunders Exhibit will be: "Recent Advances in Medicine and Surgery" from the Graduate School of Medicine of the University of

Pennsylvania; Shaffer & Boyd's "Correlative Cardiology"; Lewis' "Dermatology"; Salter's "Pharmacology"; Alexander's "Treatment of Mental Disorders"; Bland's "Clinical Use of Fluid and Electrolyte"; Cecil's "Specialties in General Practice"; Kroger & Freed's "Psychosomatic Gynecology"; and many others.

Schering Corporation — **Booth No. 22**
Bloomfield, New Jersey

G. D. Searle & Company — **Booth No. 63**
Chicago, Illinois

You are cordially invited to visit the Searle booth where our representatives will be happy to answer any questions regarding Searle Products of Research. Featured will be Banthine, the true anticholinergic drug for the treatment of peptic ulcers; Dramamine, for the prevention and active treatment of motion sickness; and Alidase, Searle brand of hyaluronidase which permits subcutaneous feedings at intravenous speed. Other time proven products of Searle Research on which information may be obtained are Searle Aminophyllin in all dosage forms, Metamucil, Ketochol, Floraquin, Kiophyllin, Diodoquin, Pavatrine, and Pavatrine with Phenobarbital.

Sharp & Dohme, Inc. — **Booth No. 24**
Philadelphia, Pennsylvania

Research data relative to the potentiating effect of the antibiotics, bacitracin and tyrothricin, are featured in the Sharp & Dohme booth. The synergistic effect of penicillin in conjunction with the sulfonamides and clinical data on the use of vitamin B12 are also of major interest. Our representatives will welcome your visit.

Smith, Kline & French Laboratories — **Booth No. 42**
Philadelphia, Pennsylvania

We extend to you a cordial invitation to visit our booth where "Drilitol," SKF's new antibiotic nose drop for local use in upper respiratory disorders will be featured. Our representatives will be happy to discuss this new product containing two antibiotics not in use systemically; anti-gram negative polymyxin and anti-gram positive gramicidin.

E. R. Squibb & Sons — **Booth No. 89**
New York, New York

The Stuart Company — **Booth No. 43**
Pasadena, California

Your Michigan Stuart representative issues a cordial invitation to all members of the State Medical Society to visit the Stuart booth. All of the well known Stuart products will be on display.

Testagar & Company, Inc. — **Booth No. 14**
Detroit, Michigan

The professional service representatives of Testagar & Co., Inc., will be very pleased to welcome their many friends to view many new modern developments in the pharmaceutical field which will be displayed at Booth No. 14. Literature on some of the latest developments in the pharmaceutical field will be available. Vials and ampuls will be displayed, such as, Sodium Ascorbate, Testosterone Propionate, Heparin, etc. Requests for samples, literature, or technical information will be welcome.

Travenol Laboratories, Inc. — **Booth No. 9**
Morton Grove, Illinois

Pyromen® is a sterile, nonprotein, non-antigeni bacterial component in a colloidal dispersion fo parenteral use. Pyromen® is a stimulant for th endocrine and reticulo-endothelial systems, proven o value in the treatment of certain skin disorders, ey disorders, and allergies.

The Upjohn Company — **Booth No. 57**
Kalamazoo, Michigan

It is the sincere desire of The Upjohn Company t make some definite contribution to the success of the 1952 meeting. Stop by at Booth No. 57 to relax and discuss topics of mutual interest.

U. S. Vitamin Corporation — **Booth No. 96**
New York, New York

See the "oil-in-water" demonstration of liposoluble vitamins A and D made completely water soluble . . . a vitamin technical achievement originated and developed by the U. S. Vitamin Corporation Research laboratories.

Three pharmaceutical firsts . . . Vi-Syneral Vitamin Drops—multivitamins in drops solution; Vi-Syneral Injectable—multivitamin parenteral solution; and now Vi-Aqua Therapeutic—aqueous multivitamins in capsules . . . for more rapid absorption, greater therapeutic activity, shorter treatment time.

We cordially invite you to our booth for detailed literature and professional samples.

Vaisey-Bristol Shoe Company, Inc. — **Booth No. 32**
Rochester, New York

Representatives will explain the diagnostic value of Jumping Jack shoes and the criteria for determining whether the early walking child is strengthening his foot by proper foot function or is possibly damaging it by walking poorly.

Jumping Jack shoes are not "corrective" shoes but representatives are equipped to discuss corrective wedging which may be installed in the shoes by prescription. Of especial interest is the Sincock system of determining the precise amount of correction needed to rectify a faulty gait. Many doctors have lauded Dr. Sincock's empirical method as "genius."

Varick Pharmacal Company — **Booth No. 56**
New York, New York

Varick Pharmacal Co., Inc.—E. Fougera & Co., Inc., cordially invite physicians to discuss with Professional Service Representatives new preparations of importance to their everyday practice. Descriptive literature and samples of all products will be available.

Westinghouse X-Ray Company — **Booth No. 79**
Detroit, Michigan

See the model X-Ray Department in the Westinghouse Booth. It's a miniature, well-planned, modern hospital X-ray Department under a clear plastic dome. There will also be a four-bank illuminator with translites, and the new Baby Positioner will be there for you to inspect. Come in and browse around, then relax in a comfortable chair.

White Laboratories — **Booth No. 48**
Kenilworth, New Jersey

nthrop-Stearns, Inc. **Booth No. 71**
w York, New York



WINTHROP-STEARNS, INC., New York, invite you to visit Booth No. 71, where the following products will be featured—TELEPAQUE, the new highly effective and well tolerated oral cholecystopaque medium. Gives denser, clear cut pictures of the gallbladder, and, in a substantial number of cases, also permits visualization of the biliary ducts; MILIBIS SUPPOSITORIES, new, highly effective specific against trichomonal, monilial, bacterial (nongonococcal) and mixed vaginitis; NEOCURTASAL IODIZED, trustworthy salt without sodium, with the addition of 0.01 per cent potassium iodide.

yeth Incorporated **Booth No. 58**
iladelphia, Pennsylvania

You are cordially invited to visit the display of Wyeth Incorporated. This will feature THIOMERIN®, a recently developed, effective mercurial diuretic adaptable to self administration, and WYDASE®, highly purified hyaluronidase with a wide range of clinical applications. Representatives will be on hand to discuss and supply literature concerning these and other widely prescribed Wyeth ethical specialties.

mmer Manufacturing Company **Booth No. 23**
arsaw, Indiana

Mr. Fisher, your Zimmer distributor, extends a most cordial invitation to the members of the Michigan State Medical Society and hopes they will visit his exhibit at Booth No. 23. A complete line of fracture appliances will be on display. ITEMS OF SPECIAL INTEREST INCLUDE THE EICHER, MINNEAPOLIS ORTHOPEDIC, NADEN REITH AND JUDET PROSTHETIC HEADS AND INSTRUMENTS. EVERY TYPE OF INTRAMEDULLARY PIN AND INSTRUMENTS. THE ONE AND ONLY BROWN ELECTRO-DERMATONE, accuracy, simplicity, perfect grafts every time without glue, suction cups, tape or other accessories. A new hand drill which will prove our craftsmanship. Also on display will be Woodruff Cut Pilot Point Bone Screws, Osteotomes, Gauges, Threaded Wires and Pins, Shiffrin Wire Twister, Luck Bone Saw and Blount Instruments. YOUR PROTECTION—LOOK FOR THE NAME ZIMMER, OUR TRADE MARK (Z).

ORLD MEDICAL ASSOCIATION

The World Medical Association is an organization ıose membership is the medical associations of forty-ree countries throughout the world. The United ates member is the American Medical Association. It a non-governmental body, and it is the voice of me 700,000 individual practicing physicians. Since its unding in 1947, it has met annually in General Asmblies in different cities throughout the world. Its uncil of thirteen members holds annual meetings in ɔrld capitals between General Assemblies, and its ɔrking committees hold meetings whenever necessary carry on assigned tasks. Its work is supported by dues d voluntary contributions, largely raised through the ıited States Committee whose membership consists of dividuals in the medical profession and allied fields, ɔciations, foundations and industries.

The general objective of the World Medical Association is "to assist all people of the world to attain the highest possible level of health." This objective is being accomplished by WMA through:

1. Promotion of closer ties among national medical associations, their physician members and allied professions and industry.

2. Maintenance and protection of the honor, ethics and interest of the medical and allied professions.

3. Study and reporting on professional problems.

4. Organization of an exchange of information on matters of interest to the medical and allied professions.

5. Presentation of the opinions of practicing physicians and those of allied professions to WHO and UNESCO and

6. Raising the standards of medical education, medical care, and health throughout the world.

7. Conducting surveys and studies on medical educational standards, geographical distribution of physicians and members of allied professions, statistics on disease incidence, availability of antibiotics and scarce pharmaceuticals, et cetera.

8. Publishing of a quarterly bulletin in three languages for the dissemination of information of international interest and importance of the physicians and members.

Benefits the average practicing physician receives from membership on the United States Committee of WMA:

1. Contact with 700,000 doctors, forty-three national medical associations, and medical facilities in foreign lands.

2. A subscription to the *World Medical Association Bulletin,* issued quarterly, and copies of all available published studies.

3. A membership card entitling the holder to observer status at all World Medical Association Assemblies and a Federal income tax deduction on annual dues or contributions.

4. A share in defending the interest of practicing physicians and members of allied professions before international groups, such as UNESCO and WHO.

5. The satisfaction of sharing the advantages of our medical program with other lands, thus repaying a debt for the inspiration we have drawn from many countries through the generations.

Individual membership on the United States Committee of the World Medical Association is $10 annually, sponsoring membership $100 or more a year, and life membership is $500.

The World Health Organization (WHO) is an official branch of the United Nations, representing the governments of the world in the field of medicine, whereas the World Medical Association (WMA) represents the practicing physicians and national medical associations of the world. The latter is a non-governmental organization, and its funds are received from membership dues and voluntary contributions.

Members of the Michigan State Medical Society may join the World Medical Association's United States Committees for $10, the annual dues. The Secretariat of the Association is located in the Academy of Medicine, 2 East 103rd Street, New York 29, N. Y.

Annual Reports

ANNUAL REPORT OF THE COMMITTEE ON POSTGRADUATE MEDICAL EDUCATION—1951-52

The Committee on Postgraduate Medical Education reports that the extramural program was held in the following centers in the year 1951-52: Alpena, Battle Creek, Bay City, Benton Harbor, Flint, Jackson, Lansing, Midland, Mt. Clemens, Muskegon, Saginaw, Traverse City in the lower peninsula; and at Escanaba, Houghton, Iron Mountain, Ironwood, Marquette, Menominee, and Sault Ste. Marie in the upper peninsula.

The subjects given on the *Fall Program* were:

Avoidable Obstetrical Deaths.
The Adrenals.
Selecting a Proper Antibiotic.
Cholesterol.
Convulsive Disorders.
Practical Aspects in the Medical Treatment of Heart Diseases.
Injuries to the Thoracic Cage.
Fractures of the Tibia.
The Use of ACTH and Cortisone in the Treatment of Blood Disorders.
Ulcerative Colitis.
Carcinoma of the Breast.

The subjects given on the *Spring Program* were:

Recent Advances in the Management of Diabetic Acidosis.
Common Foot Disorders and their Treatment.
The Treatment of the Compound Fracture.
Injuries to the Genito-Urinary Tract.
The Treatment of Fractured Ribs.
Physiology of the Male Hypogonadism—Diagnosis and Treatment.
Recognition and Treatment of the Complications of Blood Transfusion.
Medical Aspects of Atomic Warfare:
(a) Care of Casualties Surgical
(b) Care of Casualties Medical
Stab wounds of the Heart.
Lacerations of the Neck.
Injuries to the Rectum.
Principles in the Practical Use of Antibiotics.
Practical Approach to Venous Disorders.
Intestinal Obstruction.
Correctable Congenital Abnormalities in the Infant and Child.
Surgical Problems of the Newborn and Infant.
The Heart in Pregnancy—What does that Murmur mean?
Evaluation of Gastro-Intestinal Symptoms.
Management of the Severely Burned Patient.
Rheumatic Diseases.
Old Problems and New Methods in the Diagnosis and Treatment of Thyroid Disease.

Attendance 1951-52

Extramural Program	*Fall*	*Spring*	*Individual Physicians*
Alpena	14	15	19
Battle Creek	74		74
Bay City	40	38	57
Benton Harbor		40	40
Flint	54	50	86
Jackson	64	40	77
Lansing	47	50	73
Midland	26		26
Mt. Clemens	58	47	45
Muskegon	40	52	65
Saginaw		97	97
Traverse City	35	38	55
Upper Peninsula			
Escanaba	21	13	22
Houghton	13	18	21
Iron Mountain	19	19	19
Ironwood	20	15	23
Marquette	19	19	26
Menominee	28		28
Sault Ste. Marie	18	17	23
TOTAL	590	568	876

The following named physicians participated in th extramural postgraduate program during the year.

W. H. Beierwaltes, M.D.
Clifford Benson, M.D.
R. E. L. Berry, M.D.
Frank H. Bethell, M.D.
Abraham I. Braude, M.D.
Robert W. Buxton, M.D.
Duncan Cameron, M.D.
Muir Clapper, M.D.
Jerome W. Conn, M.D.
A. Jackson Day, M.D.
Russell N. DeJong, M.D.
C. Jackson France, M.D.
F. E. Greifenstein, M.D.
Sam Jacobson, M.D.
Louis Jaffe, M.D.
George H. Lowery, M.D.
Don W. McLean, M.D.
Wm. O. Maddock, Ph.D.
Rudolf J. Noer, M.D.
Sylvester J. O'Connor, M.D.
John Orebaugh, M.D.
Paul V. O'Rourke, M.D.
Eugene A. Osius, M.D.
Harold D. Priddle, M.D.
Henry K. Ransom, M.D.
Wm. D. Robinson, M.D.
Carlisle P. Schroeder, M.D.
Charles Sears, M.D.
Homer M. Smathers, M.D.
Harry A. Towsley, M.D.
Francis P. Walsh, M.D.
Charles F. Wilkinson, Jr., M.I.
Joseph A. Witter, M.D.

During the year, fourteen physicians were recommend ed to the Michigan Foundation for Medical and Healt Education for Fellowship Certificates, and thirty-si physicians for Associate Fellowship Certificates in post graduate medical education.

Registrations at the following meetings throughout th State have been received. Although requests for attend ance reports on all these activities have been sent t those in charge, we have received reports only from th following:

St. Clair County Medical Society. June 5, 1951. Port Huron	7
AMA Annual Session. June 10-14, 1951. Atlantic City	22
Upper Peninsula Medical Society. June 22-23, 1951. Marquette	10
Coller-Penberthy Conference. July 26-27, 1951. Traverse City	12
Michigan State Medical Society. Sept. 26-28, 1951. Grand Rapids	1,48
Mt. Carmel Mercy Hospital Clinic Day. January 30, 1952. Detroit	43
Jackson Clinic Day. March 3, 1952. Jackson	9
Michigan Clinical Institute. March 12-14, 1952. Detroit	1,32
Genesee County Medical Society. Cancer Day. April 9, 1952. Flint	24
TOTAL	4,10

Intramural Activities

The postgraduate courses listed below were given a the University of Michigan Medical School with th following attendance:

Allergy	
Anatomy	6
Basic Sciences	2
Clinical Exercises for Practitioners	2
Clinical Internal Medicine	5
Clinical Neurology	1
Diagnostic Methods. Clinical and Laboratory Interpretation	
Diagnostic Roentgenology	2
Diseases of the Blood and Blood-Forming Organs	1
Diseases of the Gastro-Intestinal Tract	
Diseases of the Heart	1
Electrocardiographic Diagnosis	5
Foreign Physicians	2
Interns, Assistant Residents, and Residents	28
Metabolism and Endocrinology	2
Miscellaneous	
Obstetrics and Gynecology	4
Ophthalmology	11
Pediatrics	1
Recent Advances in Therapeutics	3
Rheumatic Diseases	
TOTAL	86

The Committee held one meeting during the year which was well attended by the Committee members. At his meeting on December 6 a review of interest in the educational program was given and suggestions made for increasing attendance in all the teaching centers. A request was received from the Saginaw Veterans Hospital for a postgraduate program and the Committee asked that contact for such co-operation be made with the Saginaw County Medical Society and the District Councilor. The request for re-establishment of a teaching center in Berrien County was received favorably, and a postgraduate meeting was held in Benton Harbor in May, 1952. After discussion of subject material and teaching centers, Drs. Cummings and Sheldon were asked to prepare and submit to the whole committee the suggested program for the 1952 spring courses.

Dr. Cummings discussed the advisability of a survey to determine the interest in and results of postgraduate education, and the Committee agreed that a questionnaire be sent to all members of the Michigan State Medical Society. This survey was made for the year 1951 and the results are as follows:

Total number of questionnaires sent out	5,125	
Total number of questionnaires returned	2,089	
Attendance on		
1. Hospital Staff Meetings	1,871	physicians
2. County Medical Society Meetings	1,653	"
3. State Society Meeting	1,094	"
4. Michigan Postgraduate Clinical Institute	744	"
5. Postgraduate Programs at Extramural Centers in State	383	"
6. Postgraduate Meetings and Clinic Days in State		
(a) Cities list	489	"
(b) Others	83	"
7. Intramural Courses at Wayne University and University of Michigan	288	"
8. American Medical Association meeting	196	"
9. Courses for Specialists or General Practitioners.		
(a) In State	292	"
(b) Out of State	427	"
10. Meetings not listed on questionnaire.		
(a) In State	484	"
(b) Out of State	527	"

Further study of the questionnaires on the basis of the number of activities which each physician attended gave the following findings:

Maximum number of Activities listed on Questionnaire: *Ten*

Number of physicians attending	
One activity	41
Two activities	139
Three activities	405
Four activities	564
Five activities	419
Six activities	264
Seven activities	112
Eight activities	51
Nine activities	9
Ten activities	3
Number of physicians attending no meetings because of retirement, service in the Armed Forces, illness, et cetera	82

Although further studies and analyses are necessary before conclusions can be drawn from this survey, it is apparent that the great majority of practicing physicians in Michigan are attending from one to ten medical activities each year. This is most encouraging and reflects the result of the State Society's work in postgraduate medical education during the past 25 years. The great expansion and development of local medical meetings, especially in the hospitals, and the large attendance upon annual clinical institutes and conferences held in our larger centers demonstrate the continuing interest of Michigan physicians in the progress of medicine. When the analysis of this survey has been completed, a report will be presented to the Society through THE JOURNAL.

* * *

It is hardly necessary to state that the four integrated agencies working in the Michigan State Medical Society program of postgraduate medical education have continued their interest and support to the work. This has made for a very successful year. The Committee is most grateful to the teachers who have given of their time to travel to the various centers in the State for the purpose of keeping the physicians who attend these meetings informed as to newer methods in diagnosis and treatment of disease. Great credit for continuing interest in postgraduate medical education must be given to the physicians in local hospitals who plan, conduct and take part in staff activities as well as to those who arrange local annual clinics and conferences and provide such outstanding authorities to address these meetings. Too much praise cannot be given to the officers of the Society for maintaining the high standards of programs and speakers at the Annual Michigan State Medical Society meeting and the Michigan Clinical Institute. Also, much credit must be given to the busy practitioners of medicine in both the general and special fields for their continuing interest in medical education in Michigan.

Wayne University College of Medicine
Postgraduate Medical Education

Courses	Number in Class by Quarters 1st (Sept.-Dec.) 1951	2nd (Dec.-Mar.) 1951-52	3rd (Mar.-June) 1952
Surgical Anatomy (Two quarters)		14	14
Regional Anatomy—			
Head & Neck			2
Thorax, Abdomen & Pelvis			18
Back and Extremities			6
Seminar in Physiological Chemistry	2	2	2
Recent Developments in Pharmacology & Therapeutics	18		
Blood (Two quarters)		2	2
Beginning Hematology	5		
Pathology of Ear, Nose & Throat		5	
Pathology of Bone & Joint Diseases		8	
Advanced Hematology		5	
Neuropathology			10
Seminar in Dermatology	6	4	4
Dermopathology Seminar	2	2	2
Superficial Mycoses	2		
Deep Mycoses		2	
Medical Conference	5		4
Electrocardiography (Three quarters)	30	30	30
Hematology Clinic	4	2	
Clinical Hematology	9	2	
Surgery Seminar	6	4	6
Obstetrics	10		5
Ophthalmic Surgery		1	
Cancer Detection	1	2	2
Gastroenterology		2	2
Medical X-Ray Conference		2	2

It has been a privilege for the Committee to serve the Michigan State Medical Society and the physicians of the State. The activities and programs have been far from perfect and it has been the policy of the Committee to establish no hard and fixed rules in conducting its work. Consequently, suggestions from the physicians of the State, from the officers of the Society, and from other Committees have been most welcome. It is the hope of the Committee that the members of the Michigan State Medical Society will feel free to make suggestions and recommendations to the Committee for the improvement of this program.

Respectfully submitted,
H. H. CUMMINGS, M.D., *Chairman*
E. I. CARR, M.D., *Vice Chairman*
C. E. BADGLEY, M.D.
B. R. CORBUS, M.D.
A. C. FURSTENBERG, M.D.
L. J. GARIEPY, M.D.
J. R. HEIDENREICH, M.D.
D. H. KAUMP, M.D.
ALFRED LABINE, M.D.
J. M. ROBB, M.D.
G. H. SCOTT, Ph.D.
J. M. SHELDON, M.D.
E. F. SLADEK, M.D.
E. D. SPALDING, M.D.
F. A. WEISER, M.D.

ANNUAL REPORT OF HOSPITAL RELATIONS COMMITTEE—1951-52

This Committee was appointed as a liaison Committee of the Michigan State Medical Society to confer with a similar committee of the Michigan Hospital Association to consider procedures and problems of mutual interest to both organizations. There were two meetings, the first of the committee itself, the second a joint meeting with the committee of the Michigan Hospital Association.

At the first meeting a proposed autopsy bill was studied and an autopsy bill for the State of Michigan was written. A hospital licensing bill prepared by A. E. Heustis, M.D., State Health Commissioner, at the request of Governor Williams was considered. A Michigan Hospital Association resolution asking that the Commission on Financing of Hospital Care, a project of the American Hospital Association, make one or more of its studies in Michigan was discussed with a view to support by the MSMS. Action on the hospital licensing bill and the resolution of the Michigan Hospital Association was postponed until the joint meeting with the Liaison Committee of that Association.

At the joint meeting with the Michigan Hospital Association it was reported that the autopsy and hospital licensing bills had died in Committee in the Legislature and that lack of finances would prevent the Commission on Financing of Hospital Care from making any of its studies in Michigan.

A recommendation by the MSMS Tuberculosis Control Committee that chest x-rays be taken on every hospital patient was approved in principle.

The Hospital Cost Commission Bill was approved with amendments drafted by several of the hospital trustees and a reimbursable cost formula. The Practical Nurse Bill was approved with the proviso that Amendment 5 be deleted.

The so-called "privilege tax" bills, which would impose a tax on Blue Cross-Blue Shield were discussed but no action taken. It was reported to the two Committees that so many requests for surveys by means of questionnaires from the Federal Security Agency were being sent to individual hospitals that the Trustees of the Michigan Hospital Association require that such questionnaires be sent to them for approval prior to their execution.

It is hoped that the liaison committees may be of service to and further accord between MSMS and MHA.

Respectfully submitted,

L. W. Hull, M.D., *Chairman*
A. H. Kretchmar, M.D.
J. W. Logie, M.D.
W. S. Reveno, M.D.
C. E. Umphrey, M.D.
Ralph Wadley, M.D.

ANNUAL REPORT OF THE SCIENTIFIC RADIO COMMITTEE—1951-52

During the year 1951-52, a total of forty-six scientific radio programs were prepared and presented by members of the Michigan State Medical Society and of the faculties of the University of Michigan Medical School and Wayne University College of Medicine. These programs have been broadcast over thirteen stations in Michigan and three out-of-state stations.

Topics for these talks have included the fields of pediatrics, psychiatry, surgery, cancer, dermatology, allergy, obstetrics and gynecology, internal medicine, endocrinology and metabolism; in addition, there were talks given on hospital care and voluntary hospital insurance. Thoroughly scientific, the talks are given in simple terms understandable to the layman. Emphasis is given to the "ordinary" medical problems which anyone might someday encounter.

The Committee feels that the programs help to foster and extend the interest of the lay public in medical subjects and serve to provide health education to a fairly large group of people in the state. These programs have been on the air longer than any other University of Michigan series—evidence of their continuing popularity.

We should like very much to have a broader reception of these programs and hope that through the co-operation of county medical societies the programs may be carried by a larger number of stations.

We shall be very glad to have members of the State Society volunteer to aid us in this public service program, so that we may be assured of its successful continuation.

Respectfully submitted,

John M. Sheldon, M.D., *Chairman*

C. B. Beeman, M.D.
F. J. Kemp, M.D.
R. J. Noer, M.D.
K. L. Swift, M.D.
K. W. Toothaker, M.D.
E. C. Vonder Heide, M.D.

ANNUAL REPORT OF GERIATRICS COMMITTEE—1951-52

The Geriatrics Committee held two meetings this year with the majority of the members present each time. There was a good medical representation each day at the Michigan Conference on Aging which convened at Lansing, May 12-13, 1952. Members of the Geriatrics Committee and other physicians interested in any of the problems of aging expressed their opinions on the various propositions offered for discussion. This included the health group, which discussed facilities and health programs for mental and non-mental chronically ill; the economic status of older people in Michigan, employment practices and opportunity for older people; problems in education of older adults; and community planning for housing.

During July all the members of the Committee participated in the 5th Annual Conference on Aging held in Ann Arbor, under the auspices of the University of Michigan Institute for Human Adjustment, Department of Gerontology, Dr. Wilma Donahue, Director. All problems of housing and living arrangements were conclusively covered at this three day Conference.

The Subcommittee on Study Courses for Directors of Nursing Homes, directed by Dr. F. A. Weiser met and reported to the Geriatrics Committee at its last meeting. Plans are being formulated in conjunction with Dr. Donahue for the setting up of two to three-day institutes on a regional basis for directors and attendants in nursing homes. Consideration was also given to the establishment of a course for those persons wishing to make a career as nursing attendants.

Under the leadership of Dr. F. A. Swartz, plans are under way to devote one issue of The Journal of the Michigan State Medical Society entirely to subjects of interest in preventive geriatrics and gerontology.

The Committee hopes to co-operate in the establishment of a Health Pavilion at the Michigan State Fair next year. Diabetes detection and preventive Geriatrics will be stressed.

Under the Chairmanship of Dr. W. M. LeFevre, the Subcommittee on Diabetes Control reports there are forty-two Diabetic Detection Committees throughout the state. Through newspapers, radio talks, talks to service clubs and P.T.A., the program has progressed quite well. Six counties have given free urine tests and out of 9,800 tests made, seventy-six positive urines were discovered in persons not previously classed as having diabetes. Fifty of these were proved to be true diabetics.

Respectfully submitted,

A. Hazen Price, M.D., *Chairman*
F. A. Weiser, M.D., *Vice Chairman*
W. M. LeFevre, M.D., *2nd Vice Chairman*

R. M. Athay, M.D.
F. W. Baske, M.D.
J. R. Brink, M.D.
P. C. Gittens, M.D.
R. A. Johnson, M.D.
J. J. Lightbody, M.D.
Mark Marshall, M.D.
H. H. Riecker, M.D.
D. R. Smith, M.D.
F. C. Swartz, M.D.
G. C. Thosteson, M.D.
S. C. Wiersma, M.D.
W. J. Wilson, Jr., M.D.

ANNUAL REPORT OF THE MENTAL HYGIENE COMMITTEE—1951-52

The Mental Hygiene Committee of the Michigan State Medical Society has held five meetings during the past year. All but one of these meetings have been very well attended by members of the Committee.

A number of important problems were brought to the attention of the Committee for discussion during the year. A consideration of the use of carbon dioxide treatment was further discussed following the editorial in the Michigan State Medical Journal, sponsored by the Committee last year. Two physicians took exception to this editorial and one of these appeared before the Committee to discuss this treatment and to demonstrate its use by motion pictures. No further action was considered necessary.

The Committee sponsored an editorial, which was written by a member of the Committee and published in The Journal of the State Medical Society, having to do with the Mental Health Program in Michigan. An expression of the need for more physicians on the Mental Health Commission was indicated, with a resolution that the President of our Society make such a recommendation to the Governor.

At the request of the President of the State Medical Society a program for the Department of Mental Health was discussed at length and a preliminary draft was prepared which was amended and approved by the Committee and forwarded to the Council for its approval, with the recommendation that it be presented to the Legislature for its consideration. This represented a very careful consideration of the problem of the mentally ill in Michigan and the best way to meet the problem. This was entitled, "Suggested Plan for the Department of Mental Health as presented by the Michigan State Medical Society."

In view of the difficulty expressed by members of the Legislature concerning the definition of a psychiatrist, the Committee attempted to formulate such a definition in a manner which would be acceptable to the Michigan Society of Neurology and Psychiatry, as well as to the Michigan State Medical Society. Such definition was formulated and forwarded to the Council for its acceptance in the hope that it would be made available to members of the Legislature. This was disapproved by the Council. Apparently the result of a misunderstanding and on rediscussion of it in Committee, it was moved that the recommendation be re-submitted to the Council. It was requested that the Council permit the attendance of the Chairman of our Committee and of Doctor Martin Hoffman (MSMS representative to the Special Legislative Committee) to explain to the Council the purpose of the re-submission of this matter.

Considerable discussion was had also concerning the problem of narcotic addiction. Reports from the Detroit Committee on Narcotic Addiction and of the State Board of Alcoholism were accepted at the last meeting of the Committee.

At the last meeting the Committee recommended to the Council that the State Society request the Governor and the Legislature to appoint a Commission to investigate and prepare standards regarding the teaching of mental hygiene in public schools. It was felt that this Commission should be constituted of at least two Doctors of Medicine, two educators, two lawyers, three clergymen, one Journalist, one member of the Parent-Teacher's Association and a member of the Juvenile Court. It seemed that this is an important step forward and it is hoped that this recommendation may be activated eventually.

Re-emphasis of the need for the Governor to keep in mind the appointment of two medical men, preferably psychiatrists, on the Commission of the Department of Mental Health was made.

The members of the Committee have expressed enthusiasm of its accomplishments during the past year and the hope that these activities have been of assistance to the State Medical Society. The Chairman particularly wishes to express his feeling of appreciation for the active participation and co-operation of the members of the Committee, and in particular to President Beck and Past President Umphrey for their attendance and counsel at some of the meetings of the Committee.

Respectfully submitted,
Raymond W. Waggoner, M.D., *Chairman*
H. E. August, M.D.
C. D. Benson, M.D.
I. C. Berlien, M.D.
F. P. Currier, M.D.
W. W. Dickerson, M.D.
J. M. Dorsey, M.D.
G. C. Fink, M.D.
E. M. Gates, M.D.
T. J. Heldt, M.D.
L. E. Himler, M.D.
M. H. Hoffman, M.D.
C. G. Jennings, M.D.
R. F. Kernkamp, M.D.
Morris Marks, M.D.
F. O. Meister, M.D.
Sidney Miller, M.D.
O. R. Yoder, M.D.
H. A. Luce, M.D., *Advisor*

ANNUAL REPORT OF CONTACT COMMITTEE WITH UNIVERSITY OF MICHIGAN PRESIDENT—1951-52

No problems have arisen during the year 1951-52 that required a meeting of this Committee.

Respectfully submitted,
E. I. Carr, M.D., *Chairman*
R. J. Hubbell, M.D.
L. Fernald Foster, M.D.

ANNUAL REPORT OF LIAISON COMMITTEE WITH MICHIGAN MEDICAL SERVICE—1951-52

This newly formed committee met on April 16, 1952, with the personnel of the Professional Relations Department of Michigan Medical Service. The doctor members will serve as counselors to the area field representatives in the effort to increase mutual understanding, reduce problems and aid in adjusting specific situations. It is the intent of all members of the committee that the orderly expansion of this service program has close liaison with its participating physicians.

Respectfully submitted,
William Bromme, M.D., *Chairman*
R. S. Breakey, M.D.
L. C. Carpenter, M.D.
B. M. Harris, M.D.
W. H. Huron, M.D.
G. W. Slagle, M.D.
J. M. Wellman, M.D.
D. B. Wiley, M.D.

ANNUAL REPORT OF MEDICAL PROCUREMENT ADVISORY COMMITTEE—1951-52

The Medical Procurement Advisory Committee held no meetings during the past year. No business was referred to this Committee from the Executive Office.

Respectfully submitted,
C. I. Owen, M.D., *Chairman*
M. J. Capron, M.D.
C. H. Frantz, M.D.
W. H. Huron, M.D.
E. C. Miller, M.D.
G. C. Penberthy, M.D.
J. R. Rodger, M.D.
H. H. Stryker, M.D.

ANNUAL REPORT OF ADVISORY COMMITTEE TO NATIONAL FOUNDATION FOR INFANTILE PARALYSIS—1951-52

Inasmuch as the Advisory Committee to the National Foundation for Infantile Paralysis has had no meetings during the year 1951-1952 there is nothing further to report.

Respectfully submitted,
M. F. Osterlin, M.D., *Chairman*
E. R. Elzinga, M.D.
E. E. Martmer, M.D.
N. R. Moore, M.D.
F. H. Purcell, M.D.
F. P. Walsh, M.D.
J. E. Webber, M.D.

ANNUAL REPORT OF MEDIATION COMMITTEE—1951-52

There have been no meetings held of the Mediation Committee as no incidents of importance have been brought to my attention which have required a meeting. The various county mediation committees have been functioning very well and no problems have been referred to the state committee.

Respectfully submitted,
W. Z. Rundles, M.D., *Chairman*
L. R. Leader, M.D.
E. W. Meredith, M.D.
E. T. Morden, M.D.
J. R. Ralyea, M.D.
R. W. Teed, M.D.
E. H. Terwilliger, M.D.
C. F. Vale, M.D.
Ralph Wadley, M.D.

ANNUAL REPORT OF ADVISORY COMMITTEE TO WOMAN'S AUXILIARY—1951-52

No major problems have arisen, as yet, that have required the services of this committee.

We have offered our services and the Chairman has consulted frequently with Mrs. Robert Breakey, the efficient President of the Woman's Auxiliary, on minor matters.

The Chairman suggests that a joint yearly meeting be held with the Public Relations Committee to facilitate the efforts of the Auxiliary.

We heartily commend the efforts of the Auxiliary and the splendid work that they accomplish.

Respectfully submitted,
J. S. Rozan, M.D., *Chairman*
A. B. Aldrich, M.D.
F. C. Brace, M.D.
W. G. MacKersie, M.D.
C. O. Willits, M.D.

ANNUAL REPORT OF THE SPECIAL COMMITTEE TO MEET WITH MICHIGAN DEPARTMENT OF SOCIAL WELFARE—1951-52

As stated in our report of one year ago, your committee was made an integral part of a permanent Advisory Committee appointed by the State Welfare Commission and, as such, met in September and December, 1951, and on May 2, 1952.

The bulk of these meetings were devoted to developing plans for providing Medical care for recipients of categorical assistance in selected counties as pilot studies. As reported to The Council in January, 1952, plans were completed, Calhoun County Medical Society had voted to co-operate in this study, and Michigan Medical Service offered us their help in order to obtain actuarial information. All of this information was submitted to the Federal Security Agency and after much delay we were informed on April 15, 1952, that they could not approve such a plan, hence the matching Federal funds would not be forthcoming if we attempted same. The committee voted to table the plan for the time being.

Many other problems were discussed, chief of which were those dealing with the new Social Security Amendments affecting eye examinations for the Aid to the Blind, the extended use of the local Medical Consultants by the Department, and the formulation of a liberalized definition for Aid to the Disabled.

The Michigan Department of Social Welfare has extended thanks to each member of the Advisory Committee and desires that such a committee be a permanent policy. As during the first year, our relations with the Department have been most cordial and mutually beneficial.

Respectfully submitted,
G. W. Slagle, M.D., *Chairman*
Wilfrid Haughey, M.D.
R. J. Hubbell, M.D.
L. G. Christian, M.D., *Ex-Officio Representing Welfare Commission*

ANNUAL REPORT OF SUBCOMMITTEE FOR TRAINING PROGRAMS FOR MEDICAL AND PARA-MEDICAL PERSONNEL (SUBCOMMITTEE OF EMERGENCY MEDICAL SERVICE COMMITTEE)—1951-52

Public and professional apathy was recognized as perhaps the greatest problem in the educational and training program. Since many physicians, e.g., dermatologists, would be called upon to do things with which they were unfamiliar, a basic training program for all, on atomic casualty treatment was agreed upon. Dentists and nurses should have similar training. The former would be given particular information on anesthesia and shock.

In the case of nurses, education to enable them to use more initiative in the administration of morphine, transfusions, and other parenteral fluids is to be stressed. Nonprofessional workers assigned to medical units will have a modified first aid course such as given by the Red Cross, but limited to matters relevant to emergency medical care in the event of disaster. Co-operation between the office of civil defense and the medical society on state and county levels is essential.

It was urged that the Michigan Hospital Association be invited to participate in the Emergency Medical Service Committee.

Respectfully submitted,
Louis Jaffe, M.D., *Chairman*
A. G. Baker, M.D.
R. F. Hague, M.D.
D. H. Kaump, M.D.
J. A. Witter, M.D.

ANNUAL REPORT OF COMMITTEE ON STANDARDIZED MEDICAL CARE FOR CASUALTIES IN ATTACK (SUBCOMMITTEE OF EMERGENCY MEDICAL SERVICE COMMITTEE)—1951-52

It was soon realized that a policy of uniform medical care was desirable both from the standpoint of training purposes and procurement of suitable supplies in quantity for use in the care of casualties. Furthermore since, in the event of disaster, the state will function as a unit it is essential that medical care throughout the state be integrated. Many adequate procedures for the care of burns, fractures, etc., were evaluated. Since the Wayne County Medical Society was well along in formulating uniform medical procedures, it was felt that the state as a whole adopt these procedures, with whatever minor modifications might later be necessary.

Respectfully submitted,
Louis Jaffe, M.D., *Chairman*
R. F. Hague, M.D.
D. H. Kaump, M.D.

ANNUAL REPORT OF LIAISON COMMITTEE WITH MICHIGAN VETERANS' ORGANIZATIONS —1951-52

This newly formed committee held its first meeting on February 7, 1952. Service representatives from the Veterans of Foreign Wars, American Legion, Disabled American Veterans and Amvets were present. It was mutually agreed that there has been need for such a meeting for a long time in view of the increasing group of the public which has seen military service, the widely recognized value of the Michigan Home Town Care Program for Veterans which utilizes Michigan Medical Service as an intermediary, and other mutual problems.

Respectfully submitted,
William Bromme, M.D., *Chairman*
R. H. Baker, M.D.
G. W. Slagle, M.D.
Mr. J. W. Castellucci

ANNUAL REPORT OF COMMITTEE ON BLOOD BANKS—1951-52

The Blood Bank Committee has held no formal meetings during the year. Members of the Committee have co-operated with other Committees in problems of mutual interest. Such examples might include work with the Emergency Medical Service Committee of the Michigan State Medical Society, and the Blood Bank Committee of the Wayne County Medical Society.

It might be advantageous for The Council to incorporate the Blood Bank Committee as a subcommittee of the Emergency Medical Service Committee.

Respectfully submitted,
D. H. Kaump, M.D., *Chairman*
W. B. Cooksey, M.D.
R. H. Holmes, M.D.
A. A. Humphrey, M.D.
H. R. Prentice, M.D.

ANNUAL REPORT OF ADVISORY COMMITTEE TO THE CANCER FOUNDATION OF THE MICHIGAN FEDERATION OF BUSINESS AND PROFESSIONAL WOMEN'S CLUBS—1951-52

No problems have arisen during the year 1951-52 that required a meeting of this Committee.

Respectfully submitted,
E. I. Carr, M.D., *Chairman*
C. H. Keene, M.D.
H. M. Nelson, M.D.

ANNUAL REPORT OF THE COMMITTEE ON INDUSTRIAL HEALTH—1951-52

The third "Michigan Industrial Health Day" was held on May 7, 1952, at Flint. The program was arranged by a committee from the Michigan Association of Industrial Physicians and Surgeons and co-sponsored by the Michigan State Medical Society's Committee on Industrial Health, the American College of Surgeons, the University of Michigan, Wayne University and the Michigan State Department of Health.

The Clinical Program was presented at the Merliss Brown Auditorium of Hurley Hospital. The largest registration of any of the previous Industrial Health Days was experienced. A reception and banquet sponsored by Flint industrial groups followed the clinical program. Guests included members of the Genesee County Medical Society and representatives of the American Medical Society's Committee on Industrial Health, the Industrial Medical Association and the University of Michigan's Institute of Industrial Health. A. C. Ivy, M.D., Professor of Physiology, University of Illinois, gave the banquet address.

During 1951-1952, the individual activities of the Committee on Industrial Health rose to new heights. Members of your committee served as President of the Industrial Medical Association, President of the Michigan Association of Industrial Physicians and Surgeons, Vice-Chairman of the Committee of State Chairmen on Industrial Health and on the Program Committee for the annual Industrial Health Day.

Committee members attended the Twelfth Annual Congress on Industrial Health at Pittsburgh in January and the Industrial Physicians Association meeting in Cincinnati in April.

Objectives of the Committee on Industrial Health continue as previously outlined: (1) Encourage the introduction of subjects on industrial medicine in the various county medical societies' programs. (2) Arrange "in-plant" meetings—visits to industrial medical departments —outlining health maintenance programs conducted by industrial physicians. (3) Co-operate with the Council on Industrial Health of the A.M.A. in interesting physicians in general practice in the field of industrial health. (4) Review proposed state legislation affecting industrial medical practice. (5) To aid in the establishment of a better understanding of the problems which mutually affect the industrial medical director and the physician in private practice.

Respectfully submitted,
Max R. Burnell, M.D., *Chairman*
W. P. Chester, M.D.
E. B. Cudney, M.D.
W. A. Dawson, M.D.
E. A. Irvin, M.D.
O. J. Johnson, M.D.
V. S. Laurin, M.D.
E. F. Lutz, M.D.
Otto Preston, M.D.
N. W. Scholle, M.D.
H. T. Sethney, M.D.
M. W. Shellman, M.D.
J. L. Zemens, M.D.
C. D. Selby, M.D., *Advisor*

ANNUAL REPORT OF COMMITTEE ON PLANNING AND ORGANIZATION (SUBCOMMITTEE OF EMERGENCY MEDICAL SERVICE COMMITTEE)—1951-52

The subcommittee held one meeting in February, 1952. At the meeting a considerable amount of discussion was applied to the problem of statewide medical civil defense plan so that all members of the Michigan State Medical Society could be integrated into this important responsibility. As a result of detailed deliberation the subcommittee prepared recommendations which were submitted in the form of resolutions to the Committee on Emergency Medical Service. These were approved by the Committee and subsequently by the Council of the Society. It should be stated that present at the subcommittee meeting were representatives of the Michigan State Health Department and of the Michigan State Office of Civil Defense.

Further action taken at the meeting was the decision that study should be given to the problem of chemical and bacteriological warfare. Dr. Schmidt of Jackson was requested to do the preliminary investigation on the subject for submission to the subcommittee at a future meeting. He has completed this task in a most commendable manner and it proposed that the subcommittee meet shortly to consider this topic.

The chairman recommends that the subcommittee as well as the full committee concern themselves with the problem of a uniform state medical civil defense plan. Any planning which involves participation by members of the Michigan State Medical Society and its component county medical societies should be developed by responsible agencies in the fullest co-operation with the

Society. It is felt that the Society should assume a leading part in the development of such planning.

Respectfully submitted,

M. L. Lichter, M.D., *Chairman*
C. P. Anderson, M.D.
A. G. Baker, M.D.
G. J. Curry, M.D.
R. F. Hague, M.D.
J. A. Ramsey, M.D.
T. E. Schmidt, M.D.

ANNUAL REPORT OF COMMITTEE ON TUBERCULOSIS CONTROL—1951-52

The principal items brought up for discussion before the Committee on Tuberculosis Control were as follows:

1. *Management of Recalcitrant Tuberculosis Patients.*—This was discussed by State Health Commissioner A. E. Heustis, M.D., who gave the Attorney General's opinion that the present law is not adequate to cope with this problem, as follows: "Elbern Parsons, Assistant Attorney General, advised me on January 27, that the present statute does not permit the use of the tuberculosis units of state mental or penal institutions for the confinement of the committed patient who leaves against advice. Mr. Parsons made reference to A.G.O. 0-4093 date 11/6/45 and stated that the same opinion would apply to mental institutions and that so far as he knew there had been no change in the statutes since that time which would alter the situation.

"Mr. Parsons was asked to review the penalty provision in the proposed new statute. He feels that it would be best if Chapter VII, Section 1 were to be amended to read as follows:

" 'Section 1. Any person committeed to any approved hospital or institution established for the care and treatment of persons suffering from tuberculosis as in Chapter III, Section 7, hereinbefore provided, who shall willfully escape from or leave such hospital or institution prior to the termination of such commitment by the medical director of the hospital or institution, shall be guilty of a high misdemeanor and shall be punished by imprisonment for not more than one year IN THE TUBERCULOSIS UNIT OR HOSPITAL OF A STATE PRISON or a fine not to exceed $1,000 or both.' "

The matter was discussed by Chairman Towey, Drs. Egle, Stringer, and Heustis, during which the difference between commitment and quarantines was brought out.

Motion: That the Tuberculosis Control Committee approve the inclusion in the proposed codification of the tuberculosis laws of the State of Michigan the recommendation of the Attorney General and of the State Health Commissioner that patients violating their commitment to TB hospitals shall be guilty of a misdemeanor. Carried.

2. *Routine General Admission X-Rays.*—The State Health Commissioner stated that there are 18 photo roentgen units belonging to the State Department of Health now being used in various hospitals throughout the state. There is a wide variance as regards their use, from 2.1 per cent up to 91.6 per cent. There is also considerable variance as regards the hospital charge for this routine x-raying. In two hospitals there is no charge but the others charge ranging up to a maximum of $2.00.

Motion: That the Tuberculosis Control Committee recommend to the Hospital Relations Committee that in every possible case on admission a chest x-ray should be taken. Also it was suggested that the staffs of the hospitals which have these photo roentgen units on loan from the State Department of Health be asked if they wish to continue use of the instrument or to give the unit to another hospital.

3. *The need for more tuberculosis beds in Wayne County* to take care of the great needs in this area was discussed together with the need for a better state subsidy to counties now hospitalizing their tuberculosis patients there.

4. *A proposed revision of the Michigan Tuberculosis Laws* was discussed at some length.

Motion: That the TB Control Committee approve in principle the proposed recodification of Michigan's TB laws, as proposed by the State Health Commissioner, with the exception that certain features require further study prior to active approval or disapproval.

Respectfully submitted,

J. W. Towey, M.D., *Chairman*
J. L. Egle, M.D.
J. F. Failing, M.D.
Cameron Haight, M.D.
A. E. Heustis, M.D.
V. C. Johnson, M.D.
C. E. Lemmon, M.D.
G. T. McKean, M.D.
C. P. Mehas, M.D.
C. J. Stringer, M.D.

ANNUAL REPORT OF COMMITTEE ON EMERGENCY MEDICAL SERVICE—1951-52

Since the last report, this Committee has met on the following dates: January 16, 1952, and April 2, 1952. In addition the Sub-Committee on Planning and Organization of Emergency Medical Service met on February 2, 1952. Also the Sub-Committee on Training Programs for Medical and Paramedical Personnel of the Emergency Medical Service met on April 30, 1952. Further, the Committee on Standardized Medical Care for Casualties in Attack met and advised that the Emergency Medical Service Committee recommend to The Council of the Michigan State Medical Society the acceptance of the papers as published by the Wayne County Medical Society in the Michigan State Medical Society Journal of March, 1952, as standard operating procedures for emergency medical service in case of an attack. It was also recommended that these be bound in a pocket size book for distribution to the medical profession of the State of Michigan.

The Chairman of the Committee has attended two meetings, one in St. Louis, the First Regional Conference on June 10, 1951, and the Second Medical Mid-west Civil Defense Conference at Chicago, November 9-10, 1951. At this meeting there were three other members of the Emergency Medical Service Committee present. He has also attended meetings of the Technical Committee on Medical and Health Services under the Chairmanship of Albert E. Heustis, M.D., on March 16, 1951, February 7, 1952, and April 10, 1952.

From the above meetings and the information obtained the following observations can be made:

Civil Defense plans are in various stages of development in a large number of the key cities of Michigan. They would proceed much faster and better if there was not as much apathy among the civic, fraternal and other leaders. This apathy has been transferred to the legislative bodies at the level of cities, counties and state.

The medical profession of the State as a whole is well aware of the importance of civil defense. Physicians in every community hold important positions on the civil defense committees. They have been addressed in the past year by Dr. Stafford L. Warren and Dr. Norvin C. Kiefer as well as other physicians whose names are nationally known in this field.

An all-over State Medical Plan is being developed by Dr. Arthur G. Baker who represents Dr. Heustis on the staff of Brig. General L. J. Maitland assisted by Dr. M. L. Lichter and other members of this Committee. The liaison with the two medical schools of the state ha

)een accomplished by the appointment of the two deans o the committee for their expert advice. Lectures are)eing given on civil defense, and the recruiting of personnel both professional and lay is being encouraged.

The Wayne County Medical Civil Defense Committee ıas enlisted the women of the Woman's Auxiliary to the Wayne County Medical Society and have notarized their oyalty oath. Over 1,100,000 people in Michigan have)een blood typed and have received their tags.

Our agenda for 1952-1953 is as follows:

Develop a State Medical Plan into a functioning plan.

Complete our Standard Operating Procedures and if he money is obtainable publish them, in pocket-size book orm.

Continue recruiting Professional and non-professional)ersonnel, organize and train them, establish the role of nedical students.

Plan Postgraduate training programs for the physicians.

Lecture to the lay organizations and recruit their co-)peration.

Encourage the continued co-operation and participation)f hospital and hospital staffs.

Respectfully submitted,

W. H. Gordon, M.D., *Chairman*
W. H. Alexander, M.D.
C. P. Anderson, M.D.
A. G. Baker, M.D.
A. C. Furstenburg, M.D.
R. F. Hague, M.D.
S. W. Hartwell, M.D.
Louis Jaffe, M.D.
D. H. Kaump, M.D.
M. L. Lichter, M.D.
J. A. Ramsey, M.D.
G. H. Scott, Ph.D.

ANNUAL REPORT OF COMMITTEE TO CO-)PERATE WITH MICHIGAN HEALTH COUNCIL RE PERIODIC HEALTH APPRAISAL—1951-52

This Committee has met with the committee of the Michigan Health Council and with a special subcommittee to help in developing a program of periodic ıealth appraisal. It is feared that the educational programs of the various voluntary health agencies, however vell conceived, have the disadvantage of directing ıttention to a single organ or system or to a particular ype of disease. A periodic, comprehensive general)hysical examination and health appraisal are to be)referred. Many voluntary health agencies are in ıccord with this. The Michigan Health Council, with he co-operation of the Michigan State Medical Society, s providing the leadership which is needed to present his idea to the profession and to the people. It is an :ssential part of the Know Yourself section of the Formula for Freedom. It is a long-term, continuing)rogram. It offers better health and better medical :are to the people through closer contact with their)hysicians, the application of preventive measures, and the detection of unsuspected disease and its treatment.

It is agreed that the first step is to acquaint the profession with the program, the need for it, the type of examination which is needed and which is practical, and he benefits to be expected. It is hoped that the program)f postgraduate medical education may include this subject, and that it may be presented at meetings of county nedical societies, hospital staffs and various other medical groups, and that articles will be prepared for the various nedical journals and bulletins which reach the profession)f this state.

The second step is to acquaint the public with this)rogram, the need for it, the type of examination to be :arried out and the benefits to be expected from it. Emphasis is on the family physician. A questionnaire ıas been devised for presentation to the general public, lesigned to stimulate interest in the periodic health ppraisal.

The committee should be continued because this is a long-term, continuing program.

Respectfully submitted,

J. S. DeTar, M.D., *Chairman*
P. S. Barker, M.D.
J. G. Bielawski, M.D.
W. B. Cooksey, M.D.
D. C. Ensign, M.D.
W. A. Irvin, M.D.
W. M. LeFevre, M.D.
J. J. Lightbody, M.D.
E. F. Lutz, M.D.
O. T. Mallery, M.D.
H. M. Pollard, M.D.
H. W. Porter, M.D.
F. L. Rector, M.D.
W. S. Reveno, M.D.
R. F. Salot, M.D.
E. F. Sladek, M.D.

ANNUAL REPORT OF COMMITTEE ON STUDY OF MEDICAL PRACTICE ACT—1951-1952

No meetings of this Committee or the Joint Committee with the Michigan State Board of Registration in Medicine were held.

Respectfully submitted,

W. B. Harm, M.D., *Chairman*
L. A. Drolett, M.D.
Mr. J. Joseph Herbert
J. E. Livesay, M.D.
J. D. Miller, M.D.

ANNUAL REPORT OF COMMITTEE ON RHEUMATIC FEVER CONTROL—1951-52

This Committee has had five meetings and contemplates one more. In addition to the routine business of the Committee which consists of analyzing in detail the reports of the various diagnostic centers and studying a progress report of the co-ordinator, Dr. Leon DeVel, the Committee has passed upon several desk reference cards which in turn have been forwarded to the membership of the State Society. These cards have summarized important features in diagnosis of rheumatic fever and rheumatic heart disease, management, and treatment as well as one card which takes up exclusively congenital heart lesions with a short résumé of surgical procedures in congenital and acquired heart lesions.

The standard forms used by the Rheumatic Fever Diagnotic and Consultation Centers have been completely revised and distributed.

A Cambridge electrocardiograph-stethograph has been purchased by the Committee for the use of the various Rheumatic Fever Centers, under the supervision of the State Committee.

Four new Rheumatic Fever Diagnostic and Consultation Centers have been activated: the St. Joseph-Benton Harbor Rheumatic Fever Center, sponsored by the Berrien County Medical Society, to serve Berrien, Cass and part of Van Buren counties; the Sault Ste. Marie Rheumatic Fever Center, sponsored by the Chippewa-Mackinac County Medical Society, to serve Chippewa, Mackinac and Luce Counties; the Northern Michigan Rheumatic Fever Center at Petoskey, sponsored by the Northern Michigan Medical Society, to serve Emmet, Charlevoix, Cheboygan, Antrim and Otsego counties; the Royal Oak Rheumatic Fever Center, sponsored by the Oakland County Medical Society, to serve southern Oakland county and adjacent areas of Macomb and Wayne counties. This brings the number of organized Rheumatic Fever Centers under the Rheumatic Fever Control Program of the Michigan State Medical Society to thirty: fifteen in Wayne county, fifteen out-state.

The situation in Wayne County has clarified considerably after several meetings with the officers of the Wayne County Medical Society and members of the Wayne County Rheumatic Fever Control Committee.

The present plan in Wayne County calls for continuation of the Rheumatic Fever Diagnostic Centers in those hospitals which do not already have an out-patient program. In those hospitals and teaching institutions where an out-patient program is already in operation the statistical information from this source will be available to the State Committee and the present plans call for its incorporation in the overall state picture.

The trial program in Pontiac under the direction of Dr. Smith where part of the expense for the clinic visit was defrayed by a special grant from the State Committee has been in operation for over a year. It's the feeling of Dr. Smith and shared by the State Committee that this program has worked out to the very marked advantage of the local area and the State Committee feels that additional monies should be made available for the extension of the plan in other areas. Parenthetically, some of the officers of the Michigan Heart Association feel very favorably toward this plan.

Four Postgraduate Fellowships for the study of rheumatic fever and rheumatic heart disease have been awarded by the Committee for 1952, on the basis of the personal merits of the applicants and in relation to the overall needs throughout the State. The Committee approved the Comprehensive Course in Rheumatic Fever given at St. Francis Sanatorium, Roslyn, Long Island, May 19 to May 31. Recipients of the 1952 Fellowships are: Anthony Cefai, M.D., Pontiac; John D. Littig, M.D., Kalamazoo; S. T. Harris, M.D.; Ypsilanti; David P. Gage, M.D., Saginaw. Two additional Fellowships have been made available for 1952 and the Committee hopes to fill these with postgraduate opportunities elsewhere.

The Committee has requested a liaison appointment with the Child Welfare Committee of the Michigan State Medical Society to study the advisability of more detailed school health examinations as a demonstration project not only for its own merits but in an attempt to evaluate the amount of rheumatic fever and rheumatic heart disease among school children. This request has been granted by the Council and a new Committee is charged with this project.

Because of pressure of other projects, the Michigan Society for Crippled Children and Adults, Inc., has withdrawn its support from this Committee's activities and Mr. Angove has tendered his resignation as a member of the Committee. The Committee wishes to express its sincere thanks to the Society both for its financial aid and the fine counsel in the past six years.

Respectfully submitted,
Frank Van Schoick, M.D., *Chairman*
P. S. Barker, M.D.
W. B. Cooksey, M.D.
Carleton Dean, M.D.
Douglas Donald, M.D.
Thomas Francis, Jr., M.D.
S. T. Harris, M.D.
H. S. Heersma, M.D.
F. D. Johnson, M.D.
J. A. Johnston, M.D.
E. C. Long, M.D.
C. J. Poppen, M.D.
L. Paul Ralph, M.D.
Mr. Emmet Richards
H. H. Riecker, M.D.
Saul Rosenzweig, M.D.
D. S. Smith, M.D.
R. D. Tupper, M.D.
Bertram Zheutlin, M.D.
L. Fernald Foster, M.D., *Secretary*
Leon DeVel, M.D., *Co-ordinator*

ANNUAL REPORT OF COMMITTEE ON VENEREAL DISEASE CONTROL—1951-52

One meeting of the full Venereal Disease Control Committee was held during the year. Other discussions were held by personal communications throughout the year.

The Committee endorsed the present waiting period of one year after syphilis treatment before marriage.

The Committee also recommended the enforcement the Michigan Department of Health of the rule requ ing private laboratories to report positive evidence acute communicable disease.

The Committee recommended that a copy of the "Ha ilton Kircher Act," which requires prenatal blood te be sent to each member of the Michigan State Medi Society and direct attention to the penalty clause.

Other topics of discussion included the spirochae immobilization test, various means of publicizing inforn tion about venereal disease, the increase of venereal c ease in Michigan military installations, case finding p grams, and the ban on the terms "gonorrhea" and "syp lis" on radio and television.

Respectfully submitted,
A. C. Curtis, M.D., *Chairman*
J. A. Cowan, M.D.
Ruth Herrick, M.D.
R. H. Holmes, M.D.
H. L. Keim, M.D.
R. M. Kempton, M.D.*
L. W. Shaffer, M.D.
Frank Stiles, M.D.
R. S. Breakey, M.D.

*Deceased.

ANNUAL REPORT OF CANCER CONTROL COMMITTEE—1951-52

The Committee had two meetings during the ye November 8, 1951, and May 8, 1952. Its program v devoted largely to educational activities. It has operated wherever possible with other organizations in cancer field.

The Third Michigan Cancer Conference, sponso by the Cancer Control Committee and held at the K logg Continuing Education Center, East Lansing, on O tober 12, 1951, in conjunction with the annual meet of the Michigan Division, American Cancer Society a co-sponsored by the Michigan Department of Hea and the Southeastern Michigan Division, American C cer Society, was attended by about 200 lay and pro sional delegates. The program was followed by a lun eon and question and answer period. The following p gram was presented:

Introductory Address.....A. E. Heustis, M
Home Care of Cancer Patients:
Nursing Problems.....Hulda Edman, R
Home Care of Cancer Patients:
Psychiatric Problems.....Harrison Sadler, M
The Problem of Heredity in Cancer
Control.....Madge Thurlow Macklin, M
Rural Organizations and the Cancer
Problem.....Mrs. Marjorie Kar
Cancer Education in Schools.....F. L. Rector, M

The papers given at the Conference were published the April, 1952 issue of the Journal MSMS.

The program for the Fourth Michigan Cancer C ference has been completed. It will be held at the K logg Continuing Education Center, East Lansing, Thursday, October 9, 1952, in conjunction with Annual Training School of the Michigan Division, An ican Cancer Society and will be co-sponsored by Michigan Department of Health.

At the request of the MSMS, the Committee has dertaken the organization of a half-day cancer symposi at the 1953 Michigan Clinical Institute. The two Mi gan Divisions, American Cancer Society, and the Mi gan Department of Health have agreed to co-sponsor session. Subjects have been selected and speakers vited for this special program.

During the year, the office of the Committee moved to the Lansing headquarters of the MSMS wh it has access to the facilities of the state office for better conduct of its activities.

The Committee has published "The Role of the C cer Committee of the County Medical Society in Ca

ontrol." Copies have been sent to all officers and Coun-
lors, MSMS; officers and cancer committee members
all local medical societies; local health officers; mem-
ers of the State Board of Directors and officers, also
ommanders of all local units of the Michigan Division,
merican Cancer Society. This pamphlet discusses in
etail the duties and responsibilities of cancer committees
their local areas. The necessity for leadership by the
edical profession in all local cancer programs is em-
hasized.

The Cancer Manual for high schools has undergone
nal revision and is awaiting funds for its publication
nd distribution to the public and parochial high schools
Michigan. To place five copies in each high school
brary for reference purposes, 5,000 copies will be re-
uired. It will be too expensive to furnish a copy for
ch high school student.

A meeting with representatives of the State Depart-
ent of Public Instruction on February 14, last, was
ttended by the Chairman and Secretary of this Com-
ittee, also by Dr. B. E. Luck, representing the Michigan
tate Dental Society, and Dr. C. Allen Payne, representing
e Michigan Division, American Cancer Society. At
is meeting cancer education in high schools was dis-
ussed and the desire of this Committee to provide an
uthoritative source book of information on the subject
r both teachers and students was stressed. A copy of
e proposed Manual was left with Dr. E. L. Grim and
frs. McEnaney, representing the Department of Public
nstruction, for their examination with the request that,
in their opinion the Manual had value as a source
ook in its field, the Cancer Control Committee would
ppreciate a letter of approval from the Superintendent
f the Department, Dr. Lee M. Thurston, for inclusion in
e printed edition. Such a letter was received from
r. Thurston promptly (see April, 1952, issue JOURNAL
MSMS, page 414).

The Committee has supplied copy for the Cancer
omment page of the JOURNAL MSMS throughout the
ear.

Representatives of the Committee participated in the
eetings of the Committee to Co-operate With Michi-
an Health Council re Periodic Health Appraisal.

All requests for information or service the Committee
ould render have been complied with, of which the
llowing are of importance:

At the request of several local Cancer Units a com-
ittee member has participated in their lay cancer edu-
ation programs, especially in the high schools.

By invitation, the Committee was represented at the
nnual health education conference of the public school
eachers of Isabella County in December, 1951.

During the year, two addresses were given at the
chool of Public Health, University of Michigan.

A Committee member was the speaker at the annual
ublic Relations dinner meeting of the Macomb County
Voman's Auxiliary, MSMS.

Consultations were held with the Health Council and
igh school authorities of Ottawa County regarding
ancer education programs in that county.

Development of cancer programs by local health de-
artments was discussed with representatives of the
Michigan Health Officers Association.

The Committee was represented at the Second Na-
ional Cancer Conference in Cincinnati, Ohio, in March,
952.

The program of "Every Doctor's Office a Cancer
Detection Center" has continued to be stressed in all
ontacts with physicians and medical groups.

The Hillsdale Plan for Tumor Detection completed its
ourth year of operation in Hillsdale County. During the
our years, 106 cases of cancer were discovered among the
,365 individuals examined, a record of 4.58 per cent pos-
tive findings. On the basis of total number of examina-
ions made, 4,733, this percentage of positive findings be-
omes 2.24. These and other details of this project are
ound on page 412 of the April, 1952 issue of the JOURNAL
MSMS.

It is worth noting that, at the 1952, Michigan Clinical Institute, the Hillsdale County Medical Society received from the MSMS a Scroll of Commendation for its cancer detection program which has been widely copied in this country and abroad.

The co-operation of all organizations and individuals that have made the Committee's work effective is gratefully acknowledged.

Respectfully submitted,
HORACE WRAY PORTER, M.D., *Chairman*
F. L. RECTOR, M.D., *Secretary*
F. W. BASKE, M.D.
D. C. BURNS, M.D.
L. C. CARPENTER, M.D.
E. I. CARR, M.D.
R. C. CONNELLY, M.D.
M. A. DARLING, M.D.
H. B. FENECH, M.D.
L. E. HOLLY, M.D.
W. A. HYLAND, M.D.
C. H. KEENE, M.D.
B. E. LUCK, D.D.S.
H. F. MATTSON, M.D.
C. C. MCCORMICK, M.D.
A. B. MCGRAW, M.D.
H. L. MILLER, M.D.
J. D. MONROE, M.D.
H. M. NELSON, M.D.
R. E. OLSEN, M.D.
H. M. POLLARD, M.D.
C. J. POPPEN, M.D.
H. R. PRENTICE, M.D.
J. C. VOLDERAUER, M.D.
J. M. WELLMAN, M.D.
NORMAN F. MILLER, M.D., *Advisor*

ANNUAL REPORT OF MICHIGAN STATE MEDICAL ASSISTANTS ADVISORY COMMITTEE—1951-1952

There have been no formal meetings of the Committee as such during the past year, but on numerous occasions consultation has been sought from various members of the Society individually by members of the Medical Assistants group. Help was given in the revision of the Constitution, and one of our members, Dr. Bromme, was attendant at the annual meeting of the Michigan State Medical Assistants Society, where advice and assistance was rendered in the topics which came up during the meeting. It is the belief of the Committee that the Society is prospering, that it is fulfilling the functions for which it was organized in admirable style, and that excellent co-operation is being accorded the Council of the Michigan State Medical Society, and the profession at large.

Respectfully submitted,
E. A. OSIUS, M.D., *Chairman*
JANE BLUE, M.D.
A. O. BROWN, M.D.
H. H. HEUSER, M.D.

ANNUAL REPORT OF ADVISORY COMMITTEE TO BUREAU OF MATERNAL AND CHILD HEALTH—1951-52

There has been no meeting of this Committee for the past twelve months and there have been no communications from the director, G. B. Corneliuson, M.D.

Respectfully submitted,
FRANK VAN SCHOICK, M.D., *Chairman*
C. F. BRUNK, M.D.
A. M. CAMPBELL, M.D.
H. A. FURLONG, M.D.
W. G. HOEBEKE, M.D.
R. B. KENNEDY, M.D.
W. R. KLUNZINGER, M.D.
S. L. LOUPEE, M.D.,
R. H. PINO, M.D.
L. P. SONDA, M.D.

ANNUAL REPORT OF THE COMMITTEE ON DEVELOPMENT OF A MODEL CODE FOR M.D. ANNOUNCEMENTS—1951-52

This Committee held two meetings during the year for the purpose of developing a model code covering recommended practices in reference to physician's signs, newspaper, mail and radio announcements and other forms of advertising of any type.

The Committee found that many of the county medical societies have established regulations governing the type and size of physician's signs, and the type of other forms of announcements which may be used. It was the consensus of opinion of the committee that problems of ethics in the last analysis are decided upon according to the Principles of Medical Ethics of the American Medical Association.

The following conclusions were made:

1. The sponsoring of a bowling team or any other athletic team for the purpose of advertising is unethical.
2. Donations to support athletic teams or events is ethical and this applies equally to individuals and to clinics.
3. A neon sign or any other type of advertising of the name of a doctor or of a clinic must conform with the regulations of the local County Medical Society.
4. The problem of advertising of physicians or clinics is a local one and no hard and fast regulations can be set down on a state-wide basis.

Respectfully submitted,
D. Bruce Wiley, M.D., *Chairman*
W. D. Barrett, M.D.
J. E. Livesay, M.D.

ANNUAL REPORT OF COMMITTEE ON ATOMIC AND ALLIED PROCEDURES

An effort was made to have a committee meeting in January, 1952. At this time a letter was forwarded to members of the committee requesting an acceptable date for each individual, and also material for the agenda. Only one written reply was received by the chairman and it was felt that possibly the meeting should be delayed, so the intent was to hold one sometime during the course of the summer, as a number of the members have since been solicited personally for their opinions.

While apparently interest in what this committee might be able to do has lagged, the chairman suggests that it still be retained as a Committee of the Michigan State Medical Society, inasmuch as it still may form a valuable liaison with the physicists, chemists and radiologists composing it, in the event of emergency.

Respectfully submitted,
A. A. Humphrey, M.D., *Chairman*
H. F. Becker, M.D.
O. A. Brines, M.D.
J. E. Cole, M.D.
K. H. Corrigan, Ph.D.
J. J. Grebe, Ph.D.
L. E. Holly, M.D.
Traian Leucutia, M.D.
H. B. Lewis, Ph.D.
M. L. Lichter, M.D.
A. B. McGraw, M.D.
W. L. Mallmann, Ph.D.
W. J. Nungester, M.D.
L. L. Quill, Ph.D.

ANNUAL REPORT OF COMMITTEE ON RURAL MEDICAL SERVICE—1951-52

There have been no formal meetings of the entire Committee to date. Individual members of the Committee have been working and carrying through on the plans and recommendations of the Committee of last year. There has been an increased emphasis on the plan that all county medical societies arrange for coverage and rotating service on days off so that the areas may be covered at all times. The plan of having county medical societies establish information and placement service has been pushed and already this idea has been put into action in several counties. There is a growing need for this type of service each year.

Individual members are working on the above plan in their respective districts at this time. Report to the Committee as a group will be made at a later date.

Respectfully submitted,
E. S. Oldham, M.D., *Chairman*
W. B. Crane, M.D.
J. H. Fyvie, M.D.
O. R. MacKenzie, M.D.
W. H. Mast, M.D.
C. E. Merritt, M.D.
E. S. Parmenter, M.D.
J. R. Rodger, M.D.
F. R. Smith, M.D.
W. F. Strong, M.D.
O. D. Stryker, M.D.
H. B. Zemmer, M.D.

ANNUAL REPORT OF LIAISON COMMITTEE WITH MICHIGAN STATE PHARMACEUTICAL ASSOCIATION—1951-52

One meeting of this Committee was scheduled but was cancelled due to illness of chairman of Pharmaceutical Section. No problems were referred to this Committee.

Respectfully submitted,
J. D. Miller, M.D., *Chairman*
C. G. Clippert, M.D.
C. W. Colwell, M.D.
E. G. Merritt, M.D.
G. H. Rigterink, M.D.

ANNUAL REPORT OF PREVENTIVE MEDICINE COMMITTEE—1951-52

The detailed reports of the several advisory committees offer ample evidence of their accomplishments and continuing good work during the past year.

The Rheumatic Fever Control Committee continues to have as its main objective the maintenance and development of the Rheumatic Fever Centers and has this year sent four Center Representatives to St. Francis Sanatorium in New York for additional education in rheumatic fever control. Next year it is hoped that six chairmen may receive similar fellowships. These will, on their return, spread their acquired information among their respective associates. Periodically the committee is mailing to the profession a desk card of pertinent information on rheumatic fever and plans more educational pamphlets in the future.

The Cancer Control Committee is preparing a cancer manual for use in high schools, a pamphlet for distribution to county medical societies on the role of their cancer committees, and is arranging the program for the Fourth Annual Michigan Cancer Conference in Lansing, October 9 and 10, 1953.

The Venereal Disease Control Committee is currently concerned with the problem of the false positive serological test, the increasing shortage of venereal disease material for teaching purposes and the more complete reporting of venereal disease.

The Industrial Health Committee together with the Michigan Association of Industrial Physicians and Surgeons, sponsored the Third Michigan Industrial Health Day at Flint last May and was represented at the Twelfth Annual Congress on Industrial Health at Pittsburgh last January. "In-Plant" meetings with County Medical Societies are continuing under the sponsorship of the committee and are productive of better understanding between private and industrial physicians of mutual health problems.

The Mental Hygiene Committee has considered a variety of problems, such as "dianetics," the practice of psychotherapy by psychologists and the location of the psychiatric children's hospital. It has prepared and presented

plan of operation for the State Department of Mental Health. It also prepared an article on the psychiatric spects of civilian defense which was published in our OURNAL.

The Geriatrics Committee has devoted most of its time o the study of nursing home regulations and needs. Plans or two three-day institutes throughout the State for nurs- ng home operators and attendants are under way. The ublication of a geriatrics number of the MSMS JOURNAL ; contemplated.

The Iodized Salt Committee completed a fourth survey f goiter incidence in four Michigan counties and also nvestigated the availability of iodized salt in Michigan tores.

The Committtee on Infectious Diarrhea plans to publish brochure on its findings and has arranged to study hild deaths in certain areas of the State similar to he studies on maternal mortality.

The Scientific Radio Committee and the Committee on 'ostgraduate Medical Education continue their very xcellent programs which are being modified constantly o meet changing needs.

The committee is grateful for the full and enthusiastic o-operation of the State Health Department and our ery capable Health Commissioner, Albert E. Heustis, M.D.

Respectfully submitted,
W. S. REVENO, M.D., *Chairman*
M. R. BURNELL, M.D.
B. E. BRUSH, M.D.
A. C. CURTIS, M.D.
H. H. CUMMINGS, M.D.
A. E. HEUSTIS, M.D.
R. J. MASON, M.D.
H. A. PEARSE, M.D.
H. W. PORTER, M.D.
A. H. PRICE, M.D.
J. M. SHELDON
O. D. STRYKER, M.D.
J. W. TOWEY, M.D.
FRANK VAN SCHOICK, M.D.
R. W. WAGGONER, M.D.

ANNUAL REPORT OF THE MATERNAL HEALTH COMMITTEE—1951-52

Meetings were hcld August 23, 1951, December 4, 1951, and April 23, 1952. The committee during the year ias been co-operating with and assisting the Michigan State Department of Health in setting up rules governing he licensing of Maternity Hospitals.

The problem of the Kahn test during the last thirty days of pregnancy was considered at the April 23, 1952, meeting in Ann Arbor. At that time it was the consensus of opinion that the recommendation of the Venereal Dis- ease Committee favoring this procedure, should stand and that it was written properly by State Department of Health Regulations.

The problem debated throughout the year was the proper method of publishing the maternal mortality statistics so the physicians of the State would derive the most benefit. The yearly report is to be sent to the JAMA and the individual articles to the JMSMS on important causes of death the exact method of contact- ng the physician was not determined.

Respectfully submitted,
HARRY A. PEARSE, M.D., *Chairman*

G. M. BYINGTON, M.D.
A. M. CAMPBELL, M.D.
G. B. CORNELIUSON, M.D.
A. L. FOLEY, M.D.
FRANCIS JONES, JR., M.D.
H. W. LONGYEAR, M.D.
S. T. LOWE, M.D.
L. C. SPADEMAN, M.D.
P. E. SUTTON, M.D.
D. W. THORUP, M.D.
C. E. TOSHACH, M.D.
KATHRYN O. WEBURG, M.D.
H. R. WILLIAMS, M.D.
P. W. WILLITS, M.D.

ANNUAL REPORT OF COMMITTEE ON INFECTIOUS DIARRHEA—1951-52

There have been no meetings of the Committee on Infectious Diarrhea this year and therefore no report.

Respectfully submitted,
OSCAR D. STRYKER, M.D., *Chairman*
F. M. ADAMS, M.D.
BERNARD BERNBAUM, M.D.
G. D. CUMMINGS, M.D.
J. H. LEWIS, M.D.
K. W. MCLEOD, M.D.
J. G. MOLNER, M.D.

REPORT OF THE COMMITTEE TO STUDY THE LITTLE HOOVER COMMISSION. Report No. 8—1951-52

This committee considered primarily the recommendations of the Little Hoover Commission Report No. 8 concerning the plan for administration of health functions of state government.

The following report was made to The Council as instructed by the House of Delegates:

1. That a strong, over-all central office of health affairs be avoided.
2. (a). To accomplish uniformity of administration that each of the five major divisions of health affairs be controlled by a board having statutory powers. That the administrative or executive head of the department serve at the pleasure of his respective board.
 (b). That an over-all planning commission be established. It would be composed of one member from each of the five governing boards. Its functions would be advisory only and would serve to integrate the health functions of the State and advise the Governor on health functions. The Governor to select the Chairman.
 (c). For instance, the Department of Health would have a governing board with statutory powers which would replace the Health Advisory Committee which now is advisory only. This would then place this department on a parallel with the Crippled Children Commission which already governs with statutory powers. This new governing board would then hire the State Commissioner of Health in the same fashion as the Crippled Children Commission hires its director. In short, we recommend that all five sections of health functions be administered in this fashion.
3. Certain health inspection functions now in the several branches of state government should be transferred to the Department of Health. For instance, the health inspection of taverns now done by the Liquor Control Commission, etc.
4. The Committee concurred in several recommendations of the report as follows: That consideration be given to the problem of raising the quality of personnel in state hospitals and that a more realistic attitude be taken in regard to remuneration. That a codification of all health laws be undertaken. That the School for the Blind and the School for the Deaf remain under the Department of Education and not be transferred to any health agency.
5. The Committee specifically disapproved item No. 8 of the Commission report which would make the present Commissions on T.B., Hospital Survey and Construction, Mental Health, and Crippled and Afflicted Children, only advisory in nature. This conforms to the plan for administration as proposed by this committee in part 2 of this report.
6. This committee disapproves a proposal to amalgamate all the various health examining and licensing boards in one over-all board.

Respectfully submitted,
JACKSON E. LIVESAY, M.D., *Chairman*

O. J. JOHNSON, M.D.
J. G. MOLNER, M.D.
H. MARVIN POLLARD, M.D.
S. B. WINSLOW, M.D.

Michigan's Department of Health

Albert E. Heustis, M.D., Commissioner

With the spraying and dusting season in full swing, the danger to the home gardener of inseticides containing parathion and tetraethyl pyrophosphate is of growing concern. In the hands of trained and equipped commercial operators, these insecticides were not dangerous, but with their appearance in small packages on seed store shelves the situation changed. These materials, even in mixtures diluted for use or as ready-to-use dusts, contain poison in concentration highly toxic to man.

Doctors are urged to keep in mind the possibility of poisoning from these insecticides if there is any record of contact and if the symptoms warrant. Symptoms of poisoning may include headache, excessive sweating, giddiness, blurred vision, weakness, nausea, cramps, diarrhea and discomfort in the chest. Signs include sweating, constriction of the pupils, epiphora, excessive salivation, cyanosis, convulsions, coma, loss of reflexes and loss of sphincter control. Laboratory findings may be normal except for a lowering of the blood cholinesterase level.

* * *

Short courses to train vision and hearing technicians will be held again this summer. The courses for training locally employed persons to do vision screening will be given at Michigan State Normal College, Central Michigan College of Education and Northern Michigan College of Education and will be taught by the supervisor of the Vision Unit of the Department.

The short course to train locally employed persons to do hearing screening will be held at Michigan State Normal College, taught by Department audiologists.

* * *

The series of regional institutes for food service personnel in small hospitals, county infirmaries, child caring institutions, county homes for the aged and other institutions that proved popular and helpful last summer is being repeated this year. Featured at each institute will be the principles of general menu planning and the problems of special diets. The District Hospital Councils in co-operation with the Michigan Hospital Association, the Michigan Dietetic Association and the Michigan Department of Health are sponsoring the meetings.

* * *

Governor Williams' proclamation designating June as Ragweed Control Month in Michigan has hastened the inquiries from hay fever sufferers for information on pollen-free areas in the state.

Data gathered in the ten years from 1940 to 1950 that the Department carried on state-wide ragweed pollen surveys show that people with ragweed hay fever can find relief in the northern third of Michigan's lower peninsula and most of its upper peninsula.

"Ragweed Pollen in Michigan," a single sheet summary of the findings of the concluding five years' surveys, is available from the Department and gives facts which will help those anxious to avoid high pollen areas. A table and a map for the period 1945-49 show the sixty-two counting stations with their average number of days per year that pollen counts exceeded 100 grains per cubic yard of air in a twenty-four-hour period.

The ten years' experience showed that there is little or no change in the relative distribution of ragweed pollen in Michigan from year to year, but it should be remembered that pollen concentrations vary locally with land and water masses, degree of cultivation of soil, and elevation, and that they are influenced from day to day by wind, rain and sunshine. In Michigan, ragweed begins to pollinate about mid-July but it is not until mid-August that the concentration reaches 100 grains per cubic yard of air per day, the count at which people who are susceptible to ragweed pollen usually show symptoms.

* * *

Traverse City is the latest addition to the list of Michigan cities fluoridating their public water supplies as a preventive of tooth decay among children. This brings to twenty-two the number of cities offering this protection.

* * *

A new pamphlet that physicians may find useful is "If Your Baby is Blind," recently issued by the Department. As the title indicates, it is written for parents of blind or partially sighted babies, giving simple suggestions on care and training. It was prepared for use in the Department's vision conservation program, in answer to a definite need apparently not met by existing publications. The text was first printed in the Department's monthly bulletin and requests have been received from other states for it, one state asking to reprint it.

* * *

The Department is helping to promote the annual institute to be held at the Michigan School for the Blind in August for parents and their preschool children who are so visually handicapped that they cannot attend public schools. If the child is two years of age or older parents are asked to bring him. The only expense to parents will be transportation and any special food, medicines or equipment that cannot be provided by the school. Details may be obtained from Wallace J. Finch, Superintendent of the School for the Blind, Lansing.

* * *

An accurate diagnosis of a lump in the breast is *only* possible with the aid of a microscope.

* * *

Hormonal therapy should *not be used in undiagnosed* breast tumors.

* * *

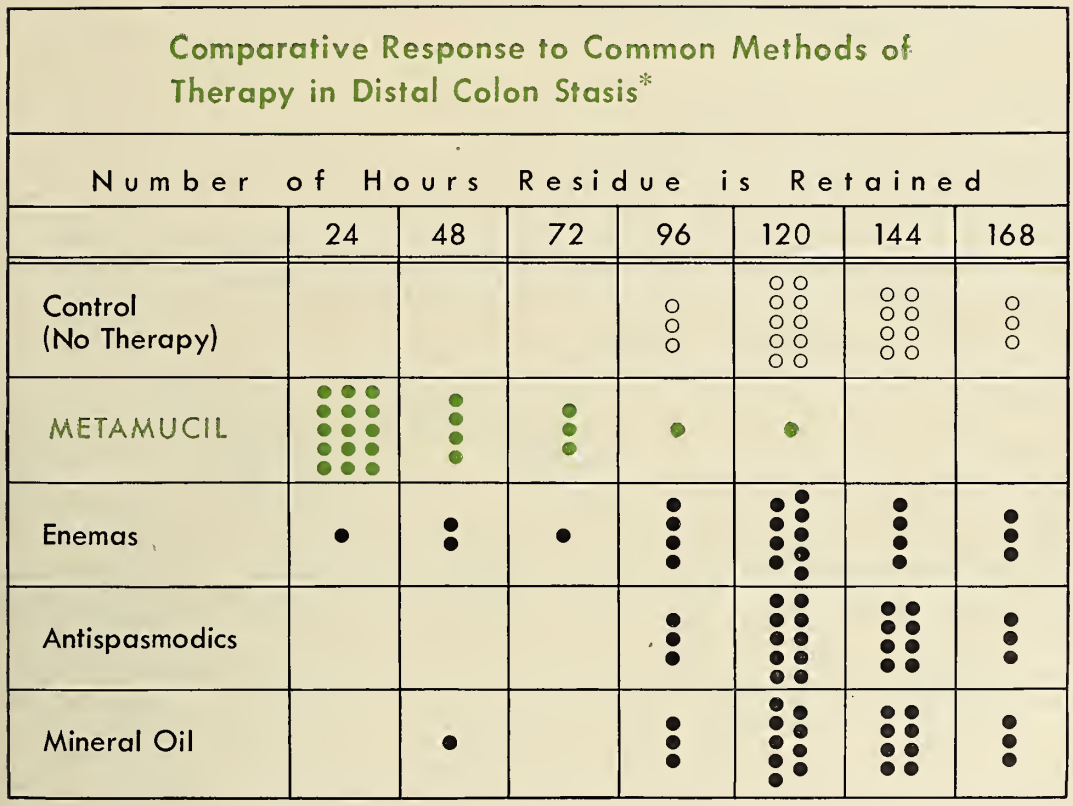
An early cancer of the breast is usually a local cancer and thereby a curable cancer, if properly managed.

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*Barowsky, H.: A Roentgenographic Evaluation of the Common Measures Employed in the Treatment of Colonic Stasis, Scientific Exhibit, National Gastroenterological Association, Chicago, Sept. 17-22, 1951.

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Correspondence

Wilfrid Haughey, M.D., Editor
610 Post Building
Battle Creek, Michigan

Dear Dr. Haughey:

I am enclosing an interesting clipping out of a recent issue of the *Spectator*. It is very encouraging to note that the British are able to make fun of themselves and of their program of government help. I thought that you might want to read this, and if you thought that it is of general interest, you might wish to put it in the MICHIGAN STATE MEDICAL JOURNAL. Unfortunately the time may come when our situation here in the United States will be so that we will not consider the verses very humorous.

Yours very sincerely,
HARTMAN A. LICHTWARDT, M.D
Medical Director

THERE WAS AN OLD WOMAN

There was once an Old Woman who lived in a Shoe;
She had so many children, she didn't know what to do—

They thronged her each morning in urgent resort
With lists far too long for a purse far too short.
There was Tommy demanding a tank and a gun,
And Phil thinking physic and spectacles fun.
Young Bert wanted trucks and new tracks for his trains
And Ralph helicopters and a—er—o—planes.
As their wants, and the chilidren, grew bigger and bigger,
She near lost her wits, the Shoe quite lost its figure.
"To keep them amused, housed, clad, shod and fed,
Is beyond my poor powers," the Old Woman said.

She went to a Cobbler, and said, "Pray, good soul,
Will you shore up my Shoe—bring it under control?"
He frapped it and lapped it and bound it around,
But your patch will not hold if your garment's unsound
Those children devised ways round, through and under
Snapped fingers at her, and the frappings asunder,
And soon, like the Shoe, were all over the place,
Still hungry, still toyless, their clothes a disgrace.

She went to a Planner, and said, "My good man,
Will you fit my affairs to a rational plan?"
He got out his forecasts, his tables, his graphs—
Some looked like sierras and some like giraffs—
But in spite of his graphs, tables, forecasts and charts
They all went on playing their several parts.

She went to a Statesman, and said, "My good sir,
You have never been known (you have said it) to err
Pray, what is the matter, and what's to be done?"
He answered, "The cure and condition are one,"
And proceeded to vent a great deal of hot air
About social equality, shares that were fair—
Till at length the Old Woman cried, "Stop, for I think
Your medicine and spectacles both are too pink."

In the end, when she found no advice would avail,
And the Shoe was as wrecked as a castaway whale,
With no loaf in the crock and no cheese on the shelf
She determined to settle her troubles herself.
"Dear children," said she, "like the Canningite Dutch
You have offered too little and asked for too much.

But now you must *work* to get out of your fix."
She set the alarm for five minutes to six—

hen she gave them some soup, without any bread,
nd whipped them all soundly, and sent them to bed.

JOHN PETRIE.

May 15, 1952

ditor,
ɔurnal, Michigan State Medical Society,
ansing, Michigan
ear Sir:

The Thirteenth Precinct Businessmen's Youth Club ɔonsors a teen-age girls club, "The Thirteeners." Its ıembers come from all precincts of Detroit and meet ı the Woodward Station Gym. All teen-age girls are elcome, regardless of race, creed or color. They are ɔt delinquents.

Realizing the urgent need for rescue ambulances for se in any emergency throughout the state, especially r crashes, forest fires, bombings, children lost in the oods, et cetera, the Thirteeners have started a drive ɔr funds for a rescue ambulance to be given to the AP. The 13th Precinct BMYC sponsors three flights.

There are no rescue ambulances in Michigan, and ol. Louis Edwards, Wing Commander, Michigan CAP, ges immediate action in this matter, as a vital emergency efense aid. The ambulance will be used in conjunction ith the airplane the BMYC presented to the CAP. It ill be equipped with two-way radio. We have Col. dwards' full co-operation in this venture. He may be ɔntacted at WO. 2-3058, David Whitney Bldg., 1553 Woodward Avenue, Detroit, Michigan.

Contributions for this project should be sent to "The Thirteeners," c/o Thirteenth Precinct BMYC, Box 214, North End Station, Detroit, Michigan.

Sincerely yours,
(Mrs. J.) ELEANOR RIGGS WELLS
Director of Girls' Activities
Thirteenth Precinct BMYC

TEAR SHEDDING DISEASE

The expression "crocodile tears" is a familiar figure of speech to describe hypocritical sorrow. The Roman writer Pliny told the story that this reptile will consume a man's body and limbs, then weep bitterly over his victim's fate. Then he will eat the head. But there is also a disease known as crocodile tears. Dr. Jerzy Chorobski writes about it in the *Archives of Neurology and Psychiatry* (Vol. 65, p. 299). Another name for it is paroxysmal lachrimation. It occurs with patients who have paralysis of the facial nerve. They weep copiously while eating. Chewing without food has no effect. Such persons do not shed tears from any emotional cause. This condition usually lasts for months or years.

Doctor, when you peruse the advertising pages of our journal, remember this: All ads are carefully screened —the items, services and messages presented are committee-accepted. Our standards are of the highest. The advertisers like our journal—that's why they selected it for use in their promotional program. They seek your patronage and your response encourages continued use of our publication. In turn, the advertisers' patronage helps us to produce a journal that is second to none in our state. When you send inquiries, tell them that you read their advertisement in THE JOURNAL of the Michigan State Medical Society.

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In Memoriam

LeROY K. ALLEN, M.D., of Roseville, died May 20 at the age of sixty-seven.

For the past thirty years he served the community of Roseville and southern Macomb County as a general practitioner and obstetrician. He was on the Board of Health in Roseville for many years. Doctor Allen was graduated from Wayne University College of Medicine in 1921.

He is survived by his wife, Mrs. Marjorie Allen, and a son, LeRoy Allen.

GEORGE BATES, M.D., of Kingston, died May 13 at the age of ninety.

Doctor Bates, an emeritus member of the Michigan State Medical Society, had practiced medicine in Tuscola County for more than sixty years until his retirement last February. Following his graduation from the University of Michigan Medical School in 1890, he began his practice in Deford. Several years later he established his practice in Kingston where he remained until his death.

Doctor Bates was on the staff of the Hubbard Memorial Hospital in Bad Axe. He is survived by his sister, Mrs. Minnie S. Maynard, of Kingston, and five nieces and nephews.

CHARLES L. BENNETT, M.D., of Kalamazoo, died April 22 at the age of seventy-six.

For the past thirty-three years he served the community of Kalamazoo as a general practitioner. Previous to that, Doctor Bennett had practiced in Gobles, Michigan, after his graduation from the University of Michigan Medical School in 1904.

He was a former president of the Kalamazoo Academy of Medicine. He was extremely active in civic affairs.

Doctor Bennett served as a member of the staff of Borgess and Bronson Hospital. He is survived by his wife, Ethel, and two sons, Keith F. Bennett, M.D., and Gordon J. Bennett of Kalamazoo. He also leaves a sister, Mrs. L. L. Cole, of Paw Paw.

LYNUS T. BRANCHEAU, M.D., of Petersburg, died April 20 at the age of forty-six.

For the past seven years he served the community of Petersburg as a general practitioner. Previous to that Dr. Brancheau had practiced in New Boston, Michigan, after his graduation from Wayne University College of Medicine in 1936.

During World War II he entered the U. S. Navy in 1942 and served for three and one-half years before he was separated from the service in 1945. In that period he served mostly in the South Pacific Theater.

He is survived by his wife, Rita, one daughter, Nanette, four sisters, and three brothers.

(Continued on Page 920)

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(Continued from Page 918)

ALEXANDER W. HARPER, M.D., of Flint, died May 3 at the age of seventy-five.

For the past thirty-two years he served the community of Flint as a general practitioner. Previous to that, Doctor Harper had practiced in Manton for seventeen years following his graduation from the Saginaw Valley Medical College, Saginaw, in 1903. He was born in Forest, Ontario.

Doctor Harper was a member of the Genesee County Medical Society and a life member of the Michigan State Medical Society.

He is survived by his wife, Mary; a daughter, Mrs. Joseph Harris, of Detroit; and Homer Harper, M.D., of Flint; two brothers and two sisters.

HUGH HARRISON, M.D., of Detroit, died April 27 at the age of eighty.

Doctor Harrison, who retired from active practice in 1948, had been a member of the staff of Harper Hospital and St. Joseph Mercy Hospital. He was graduated from Michigan College of Medicine and Surgery, Detroit, in 1896.

Doctor Harrison was an honor member of the Wayne County Medical Society and had been active in his county society work for thirty years.

He is survived by his wife, May; and a son, Wesley Harrison, M.D.

ORRIN D. HUDNUTT, M.D., of Plainwell, died April 26 at the age of seventy-one.

For the past nineteen years he served the community of Plainwell as a roentgenologist. Previous to that Doctor Hudnutt had practiced in Otsego and Kalamazoo after his graduation from the University of Michigan Medical School in 1910.

Doctor Hudnutt served his internship at Youngstown, Ohio. He was a member of the Allegan County Medical Society and a former president of the Kalamazoo Clinical Society. Doctor Hudnutt was also a member of the Radiological Society of North America, Inc.

During World War I he served in the Medical Corps.

He is survived by his wife, Ruth, and three children. They are Mrs. Helen Shipman, of Plainwell; Mrs. Jean Berg of Glencoe, Illinois, and Dean Hudnutt, a senior medical student at Western Reserve University School of Medicine.

RAY R. McCRUMB, M.D., of Lansing, died May 5 at the age of sixty-five.

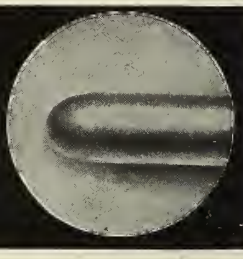
For the past thirty-three years he served the community of Lansing as a general practitioner. Dr. McCrumb was graduated from Wayne University College of Medicine in 1914.

He was a member of the Ingham County Medical Society.

Doctor McCrumb is survived by his wife, Gladys, and

(Continued on Page 922)

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Laboratory Fees in Hospital	5.00	10.00	15.00	20.00
Operating Room in Hospital	10.00	20.00	30.00	40.00
Anesthetic in Hospital	10.00	20.00	30.00	40.00
X-Ray in Hospital	10.00	20.00	30.00	40.00
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Ambulance to or from Hospital	10.00	20.00	30.00	40.00

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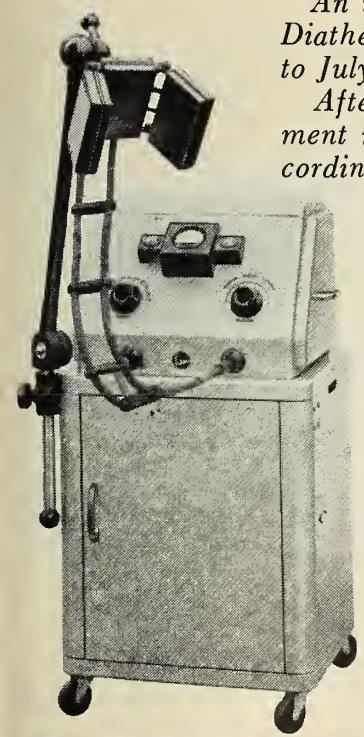
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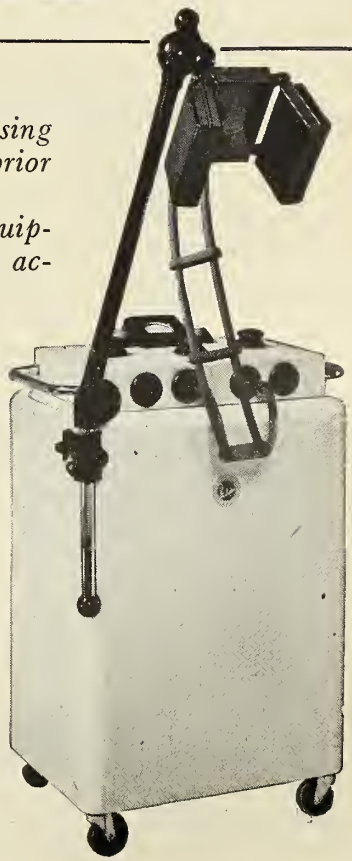


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RAY R. McCRUMB

(Continued from Page 920)

three brothers. They are Grant McCrumb, of Ypsilanti; Ross McCrumb, of Ann Arbor; and Ford McCrumb, of Eagle.

JOSEPH A. McGARVAH, M.D., of Detroit, died March 20 at the age of seventy.

Doctor McGarvah was graduated from the Detroit College of Medicine in 1905. He interned at Harper Hospital and then established his practice in Fowlerville for twelve years before coming to Detroit. He was a member of the Wayne County Medical Society.

He is survived by five children; a brother, Arthur W. McGarvah, M.D., of Detroit; and four sisters.

CLARK C. PIPER, M.D., of Highland Park, died April 22 at the age of sixty-five.

For the past thirty-two years, he had practiced medicine in Highland Park and Detroit.

Doctor Piper was graduated from Rush Medical College, Chicago, in 1915. He served his internship at Children's Memorial Hospital, Chicago. He was on the staff of the Highland Park General Hospital. Doctor Piper was a member of the Wayne County Medical Society.

He is survived by his wife, Frances, and two children. They are Mrs. Barbara Ann Wiese and Thomas Brian Piper.

CLYDE R. VAN GUNDY, M.D., of Detroit, died May 5 at the age of sixty-five.

Doctor Van Gundy was graduated from the University of Illinois College of Medicine in 1912. He practiced medicine in Peru, Indiana, until he entered the U. S. Army during World War I. After the war, he established his practice in Detroit where he was a member of the surgical staff of Lincoln Hospital. Doctor Van Gundy was a member of the Wayne County Medical Society.

W. EDWARD WOODS, M.D., of Detroit, died April 23 at the age of fifty-eight.

Doctor Woods had practiced medicine in Detroit for more than thirty years. He was one of the original staff members of the Highland Park General Hospital. Doctor Woods was graduated from the University of Toronto Faculty of Medicine in 1920. He was a member of the Wayne County Medical Society.

He is survived by his wife, Joyce; a daughter, Joycelyn; his father, John W. Woods, and a sister, Mrs. W. L. Ham.

In the fiscal year 1952, the Public Health Service will allocate $3,100,000 for cancer work among the states of which Michigan will receive $111,900.

* * *

A tumor of the breast should never be "watched."

* * *

Any lump in the breast is abnormal.

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. NEWS MEDICAL

MICHIGAN AUTHORS

D. J. Leithauser, M.D.; L. Saraf, M.D., S. Smyka, M.D., and M. Sheridan, M.D., of Detroit, are the authors of an article, "Early Ambulation in Prevention of Postoperative Thromboembolism," published in *The Journal of the American Medical Association,* May 17, 1952.

Laurence Sidney Fallis, M.D., of Detroit, read a paper on "Bilroth I. Gastrectomy" and also was moderator of a panel discussion on "Lower Abdominal Pain" at the Annual Session of the Oklahoma State Medical Association, May 20, 1952.

J. Lewis Dill, M.D., and Donald S. Bolstad, M.D., of Detroit, are the authors of an article, "Further Observations on the Local Use of Cortisone in the Nose in Allergic Rhinitis," published in *Transactions of the American Academy of Ophthalmology and Otolaryngology,* March-April, 1952.

Clifford D. Benson, M.D.; John J. Coury, Jr., M.D., and Donald R. Hagge, M.D., of Detroit, are the authors of an article, "Acute Appendicitis in Infants," published in the *American Medical Association Archives of Surgery,* May, 1952.

John Reid Brown, M.D., and John Wm. Derr, M.D., of Detroit, are the authors of an article, "Arterial Blood Supply of Human Stomach," published in the *American Medical Association Archives of Surgery,* May, 1952.

Henry K. Ransom, M.D., of Ann Arbor, is the author of an article, "Carcinoma of the Colon," published in the *American Medical Association Archives of Surgery,* May, 1952.

O. T. Mallery, Jr., M.D., of Ann Arbor, is the author of an article, "The Industrial Physician, Past, Present and Future," published in *Industrial Medicine and Surgery,* June, 1952.

John K. Ormond, M.D., and P. W. Fairey, M.D., Detroit, are authors of an original article on "Urethral Rupture at Apex of the Prostate" in the May 3, 1952 issue of *The Journal of the American Medical Association.*

Meyer O. Cantor, M.D., Bert E. McCollum, M.D., and Jason Hodges, M.D., Detroit, are authors of an article on "Intestinal Intubation for Barium Produced Bowel Obstruction," published in the *American Journal of Digestive Diseases,* May, 1952.

Meyer O. Cantor, M.D., et al, Detroit, are authors of an article on "Further Simplifying Intestinal Intubation," published in the *American Journal of Surgery,* April, 1952.

John S. DeTar, M.D., of Milan, was among the five men who received alumni awards for distinguished professional and civic service at the annual alumni reunion of Wayne University, Detroit, May 3.

The reunion, commemorating the 84th anniversary of Wayne's founding, was held in the Student Center building on campus.

Dr. DeTar, a 1931 graduate of Wayne's College of Medicine, was named Michigan's Foremost Family Physician in 1948. A general practitioner in Milan, he was recently elected vice president of the American Academy of General Practice. He is a past president of the Washtenaw County Medical Society, an American Medical Association fellow, and a board member of Michigan Medical Service.

Long active in community service, he was organizer of the Milan Boys' Club, Recreation, Community, and Veteran's Councils, and aided in founding the Milan Rotary Club. He obtained and was first president of the Milan Library and also serves as physician for Milan High School athletic teams.

Married, he has four children, John H., Jean, David, and Mary.

* * *

Michigan Health Council has employed Warren F. Tryloff, formerly of Mt. Clemens, as Field Secretary. Mr. Tryloff is a veteran of the Air Force, and a graduate of the School of Business Administration, Michigan State College. During service, he was a German war prisoner for nine months. Mr. Tryloff, who has moved his family to Lansing, will have the main responsibility of expansion of health council activities on the community level.

* * *

The Navy has announced that it will make 176 Naval Hospital Internships available to medical school students who will graduate in 1953. Students interested in a Navy Internship may obtain further information by writing the Surgeon General of the Navy, Bureau of Medicine and Surgery, Navy Department, Washington 25, D.C.

* * *

Louis J. Hirschman, M.D., Traverse City, and Edgar A. Kahn, M.D., Ann Arbor, were guest speakers at the Northern Tri-State Medical Association meeting in South Bend on April 15. Dr. Hirschman's subject was: "Proctologic Diagnosis and Treatment in Office Practice." Dr. Kahn spoke on "Mechanism of the Loss of Consciousness (Head Injuries)."

* * *

The American Congress of Physical Medicine will hold its thirtieth annual scientific and clinical session on August 25 to 29 at the Roosevelt Hotel, New York. For

ɔgram, write the Congress at 30 N. Michigan Avenue, ıicago 2, Illinois.

* * *

Great Britain's National health system is costing 50 to per cent more than had been expected and is suffering ɔm serious defects which "appear to be inherent in any ıtem of socialized medicine," according to Ralph A. ynolds, M.D., who recently returned from his second p in two years made to England for the purpose of dying its health system. Dr. Reynolds' impressions pear in the May issue of U.S.A.—The Magazine of nerican Affairs.

Diabetes Week of 1952 will mark the fifth nationwide Diabetes Detection Drive sponsored by the American Diabetes Association.

For further information on this year's drive and on Diabetes Week of November 16 to 22, write the Association at 11 W. 42nd St., New York 36, New York.

The AMA announces that Russell F. Staudacher ɔrmerly associated with the Michigan State Medical ciety in its Public Relations Department) will devote ll time to the job of Executive Secretary of the Student MA and also serve as Executive Editor of its journal. Hiram W. Jones, of Elmhurst, Illinois, has been ap-ınted Executive Secrctary of the American Medical lucation Foundation (this work formerly being handled Mr. Staudacher who went to the AMA from Lansing May, 1951).

Today the Student AMA has approximately 10,000 embers in forty-four active chapters with twelve more ovisional chapters being admitted next December.

* * *

AMEF: During the first three months of 1952, the nerican Medical Education Foundation received more dividual contributions than during the entire year of)51.

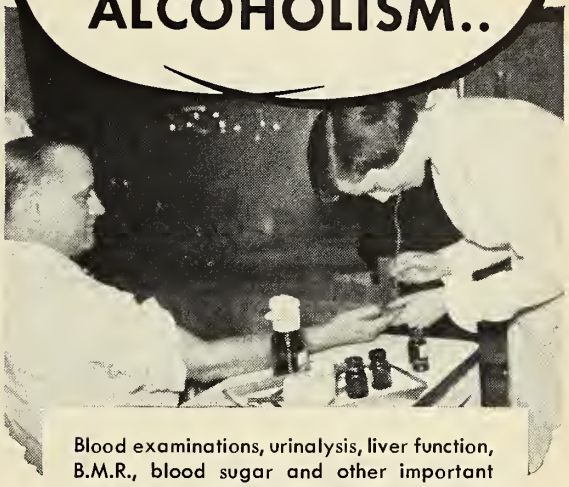
* * *

R. B. Robins, M.D., Camden, Arkansas, president of e American Academy of General Practice, recently shed out at "big government" in Washington for gimenting the lives of the American people. "The ·ople"s health has in recent years become a verbal ılitical football for public officials, legislators, ıreaucrats, economists, and a wide variety of pseudo-perts with an uncertain knowledge of the subject," ated Dr. Robins who is the elected Democratic National ɔmmitteeman for Arkansas. Dr. Robins addressed the ational Association of Chain Drug Stores at its Florida ınvention. He urged the chain druggists to take a more tive civic role in problems relating to health.

* * *

Joseph S. Lawrence, M.D., Washington, D. C., who ıs served as Director of the AMA's Washington Office ıce 1944, will retire September 1. His successor will the present Deputy Director, Frank E. Wilson, M.D. Congratulations, Dr. Lawrence, on a big job well ɔne!

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Blood examinations, urinalysis, liver function, B.M.R., blood sugar and other important diagnostic tests are performed in a modern, well-equipped laboratory.

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All patients receive the utmost consideration from our staff of full-time physicians. Restraining methods and avulsive reactors are not employed. The referring physician is constantly informed of the patient's progress.

[*This is the fourth of a series describing the successive steps in the treatment of the "Problem Drinker."*]

Complete information, including rates, will be furnished to physicians on request.

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Oregon Decision Leaves Some Questions Unanswered.—We were pleased, of course, with the seven to one decision of the U. S. Supreme Court in throwing out the government's anti-trust charges against the doctors of Oregon who set up their own medical insurance plan. But Bill Holloway, head of our Bureau of Legal Medicine, tells me that the decision still leaves unanswered a number of important basic questions.

For example, is the practice of medicine trade or commerce? Can the operation of a prepaid medical service plan constitute interstate commerce in any case? The decision, he tells me, did not answer these questions; it didn't even hold that the trial court ruled correctly. The Supreme Court merely held that the district court ruling was not "clearly erroneous" on the basis of the evidence presented.

—AMA Secretary Geo. F. Lull, M.D., May 12, 1952.

* * *

Important messages are presented in the advertisements in our journal each month. New products are announced from time to time and information is presented regarding the use of products featured. Other types of ads emphasize services rendered and commodities offered that may be used in your practice, in your office and in your home. Doctor, you can rely on the statements and facts presented. We aim to include only ethical advertisements in our journal. Please tell the advertisers that you saw their advertisements in The Journal MSMS.

"Your Doctor" Movie to be Distributed Nationwide.—Of special interest to the medical profession is the sho subject film—"Your Doctor"—now being released RKO Pathe to theaters from coast to coast. This seve teen-minute film tells the story of the American Medic Association's contribution to modern medicine in t field of rural health and medical education. It will available to all theaters through RKO Pathe distributi offices.

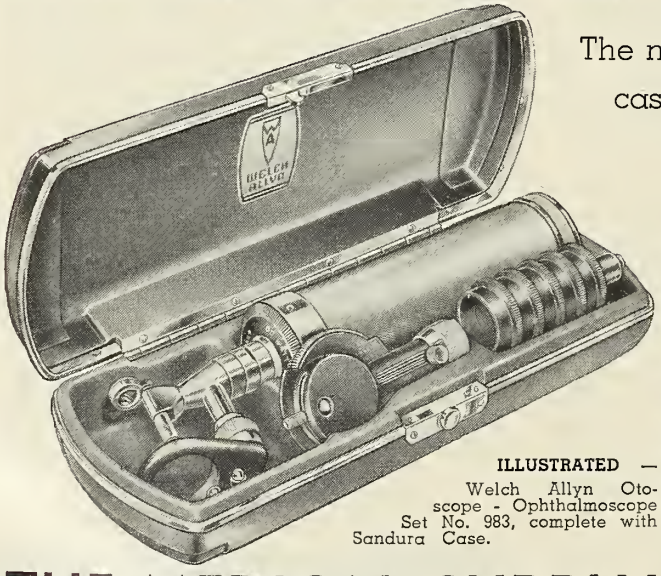
* * *

FDA Releases Isoniazid for Prescriptions.—Food a Drug Administration has given drug manufacture authority to distribute the new anti-tuberculosis dru isonicotinic acid hydrazide (isoniazid), for use und "close medical supervision." *This means all licens physicians may prescribe the drug for their patien* The FDA announcement said approval was granted the basis of clinical and pharmacological studies report by drug manufacturers. FDA emphasized that relea of the drug implies no approval or endorsement by t agency.

Packages delivered to the druggist by the manufactur must state: "for use in treatment of streptomyci resistant tuberculosis, under close supervision of phy cian," as well as carry the usual caution: "Federal l prohibits dispensing without prescription."

Medical officers of FDA said there has not be sufficient study to determine the place of the new dr in the treatment of tuberculosis. The agency add

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ome tuberculosis authorities are of the opinion that e new drug is less effective for patients who are sponding to treatment with a combination of strepto- ycin and para-aminosalicylic acid. *There is growing ncern about the possible effects of promiscuous and discriminate use . . .* there have been reports of the ergence of resistant strains of tubercle bacilli after rying periods of treatment . . . *the drug should be ed in selected cases where it may be a life-prolonging life-saving measure."*

AMA's Council on Pharmacy and Chemistry has taken tion similar to FDA's regarding various brands of the ug submitted to it for consideration.

* * *

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Who is the boss?
The Man who founded your business or profession?
The President?
The Officers?
The various Departmcnt heads?
No, none of these.
I am the reason for this business or profession.
I am the reason for its prosperity.
I am its guiding genius.
I must be served before I bestow my blessings.
I am the end-all and be-all of everything connected with my business or profession.
I am the foundation of its progress.
I am the customer, patient, or client.

Tips for the Doctor's Secretary.—Practical public relations techniques for dealing with the doctor's patients are included in two new illustrated booklets which the American Medical Association soon will make available to physicians. A twenty-page pamphlet—designed as a brief guide for secretaries—will be sent to all AMA members. Especially valuable as a training guide for girls interested in becoming medical secretaries is the sixty-page detailed manual which will be available July 1 to individual physicians through state medical society offices.

* * *

Postgraduate Study.—**Samuel H. Rutledge, M.D.**, Lansing, and **Irwin H. Zielke, M.D.**, of Traverse City, are attending postgraduate courses at the Cook County Graduate School of Medicine.

* * *

Michigan Medical Service.—Enrollment reports as of April 30, 1952, indicated a coverage of 2,478,714, or less than 22,000 from two and a half million. Michigan is the second largest now by only a little over 100,000. Another general solicitation for non-groups will be held July 1 to 25. Anyone under sixty-five may join without the necessity of belonging to a group. The conditions are a little different, but the membership is available.

Indicating the vastness of MMS public trust activities, up to March 31, 1952, it had paid for services to subscribers $71,623,994.57; to veterans $6,119,228.11, a total of $77,743,222.68, and we are now spending for services over a million and a half each month. Paid out

Cook County Graduate School of Medicine

ANNOUNCES CONTINUOUS COURSES

SURGERY—Intensive Course in Surgical Technic, two weeks, starting August 4, August 18, September 8.
Surgical Technic, Surgical Anatomy and Clinical Surgery, four weeks, starting September 8, October 20.
Surgical Anatomy and Clinical Surgery, two weeks, starting September 22, November 3.
Surgery of Colon and Rectum, one week, starting September 15.
Gallbladder Surgery, ten hours, starting October 20.
Basic Principles in General Surgery, two weeks, starting September 8.
General Surgery, two weeks, starting October 6.
General Surgery, one week, starting October 6.
Breast and Thyroid Surgery, one week, starting October 6.
Esophageal Surgery, one week, starting October 13.
Thoracic Surgery, one week, starting October 20.
Fractures and Traumatic Surgery, two weeks, starting October 6.
GYNECOLOGY—Intensive Course, two weeks, starting September 8, October 20.
Vaginal Approach to Pelvic Surgery, one week, starting September 22, November 3.
OBSTETRICS—Intensive Course, two weeks, starting September 29, November 3.
PEDIATRICS—Informal Clinical Course every two weeks.
MEDICINE—Electrocardiography and Heart Disease, two weeks, starting July 14.
Gastroscopy and Gastroenterology, two weeks, starting September 15, November 3.
UROLOGY—Intensive Course, two weeks, starting September 8.
Cystoscopy, ten days, starting every two weeks.
DERMATOLOGY—Intensive Course, two weeks, starting October 13.

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We believe our doctors have made an enviable recor in the care of the veteran. The first three months o this year the Veterans Administration authorize $353,311.20 for services, and our doctors rendere $252,264.50. They returned the unused 28 per cent o authorizations. For all of 1951 the unused portion wa 27.52 per cent.

* * *

Irving I. Edgar, M.D., of Detroit, addressed the annua conference of The Florence Crittenton Homes Associatio in Chicago, May 27. His subject was, "The Psych logical Aspects of Unmarried Motherhood." He als addressed the National Committee on Service to Un married Parents in Conjunction with the National Con ference of Social Work on May 29.

* * *

Leland E. Holly, M.D., of Ann Arbor, gave a pape on "Dust Diseases of the Lungs" at the May 27 meetin of the Industrial Division of the Greater Grand Rapid Safety Council.

One in ten tuberculosis deaths in Michigan occur in homes. Fifty per cent occur in tuberculosis hospitals. These facts are revealed in a report from the United States Public Health Service on tuberculosis deaths by place of death.

According to the report, Michigan's 1,285 tuberculosis deaths (respiratory) in 1949 occurred as follows:

Outside of institutions	132-10.3%
In general hospitals	284-22.1%
In tubercuosis hospitals	670-52.1%
In mental hospitals	96- 7.5%
In other institutions	103- 8.0%

MICHIGAN TUBERCULOSIS ASSOCIATION

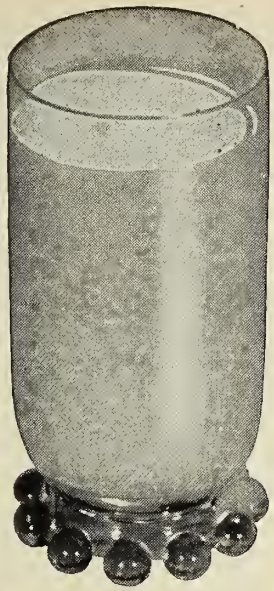
Beaver Island, Michigan, needs a practitioner of medi cine. The doctor of medicine who has served Beave Island is leaving as of September 1.

Beaver Island pays a subsidy of from $5,808 to $6,57(to its doctor. In addition, the physician in past year has had a contract with the U. S. Coast Guard whicl netted an additional $300 per annum. The Beave Island physician has the usual privilege of collectin private fees from those able to pay.

For more information, write the Michigan Departmen of Health, DeWitt Road, Lansing 4, Michigan.

* * *

Oakland County opens second Rheumatic Fever Diag nostic and Consultation Center.—A new Rheumati Fever Diagnostic and Consultation Center was formall opened May 6, 1952, at the Royal Oak Health Center Royal Oak, Michigan, to serve Southern Oakland Count and adjacent areas of Wayne and Macomb counties The center offers diagnostic and consultation service fo rheumatic fever and rheumatic heart disease on referra



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y the family physician. This center is in charge of a anel of consultants headed by J. F. Pearce, M.D., of oyal Oak, and is sponsored by the Rheumatic Fever ommittee of the Oakland County Medical Society nder the chairmanship of Donald S. Smith, M.D., of ontiac, in co-operation with the Rheumatic Fever ontrol Program of the Michigan State Medical Society. akland County's first Rheumatic Fever Diagnostic and onsultation Center is located at the Pontiac General ospital, Pontiac, Michigan.

* * *

Michigan Team Wins AMA State Golfing Trophy.—Ves G. Reid, M.D., of Detroit, with a low gross of 80; dward F. Kelly, M.D., of Grand Rapids, with 82; ichard H. Sidell, M.D., of Grand Rapids, also with an 2, and G. Donald Albers, M.D., of Grand Rapids, with n 88, bagged the Chicago Medical Society Trophy—a ew event in the 1952 American Medical Golfing Asso- iation Tournament held at Medinah Country Club in hicago on June 9 during the AMA Session.

Small replicas of the large Chicago Medical Society up were presented to Drs. Reid, Kelly, Sidell and lbers to hold in permanent possession; the trophy itself ill rest for one year at the Michigan State Medical ociety headquarters in Lansing.

The combined score of the four Michigan medical olfers was the best of any state team among the 215 egistrants at this year's AMGA Tournament.

Other Michigan participants in the tournament at Medinah were: Otto O. Beck, M.D., Birmingham; W. C. C. Cole, M.D., Detroit; Russell S. Paalman, M.D., Grand Rapids; F. A. Rice, M.D., Battle Creek; Homer H. Stryker, M.D., Kalamazoo, and Harlan Taylor, M.D., Battle Creek.

* * *

Beaumont Memorial Restoration.—As of June 20, more than $20,000 has been received for the restoration of the American Fur Company's store on Mackinac Island to make it into a permanent memorial to Dr. William Beaumont and to the medical profession of Michigan. The goal is $40,000.

Two letters have gone to all MSMS members, recommending contributions. This project is one that is exclusively the opportunity of the MSMS membership. Only Michigan's doctors of medicine are being invited to contribute to the Beaumont Memorial.

The MSMS Council requests every county medical society to certify the names of its Beaumont Memorial Committee personnel to MSMS. This information is requested by the MSMS Beaumont Memorial Committee and by President Otto O. Beck, M.D.

* * *

Dispensing Barbituric Acid Preparations.—The director of Drugs and Drug Stores, Michigan Board of Pharmacy, invites the attention of all Michigan practitioners of medicine to the dispensing of barbituric acid preparations without proper labeling and marking on the containers dispatched and without the name of the patient. The Dangerous Drug Act specifically provides for such labelling and for the patient's name.

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Postgraduate Conference on Prothrombin.—On July 31 and August 1, 1952, a conference on "Prothrombin" will be held, to include the theory of prothrombin determinations, demonstration of the test and facilities for actual performance of the tests. The conference will be held at the College of Medicine, Wayne University, Detroit, Michigan.

The members of the Wayne County Medical Society and of the Michigan State Medical Society are cordially invited to attend this conference It is the purpose of this conference to improve the performance of prothrombin determinations in medical laboratories in Michigan. There will be no charge and no tuition fee. The conference will be held under the auspices of the Michigan Pathological Society and the College of Medicine of Wayne University.

Thursday, July 31, 1952
The College of Medicine—Wayne University

Morning

9:30 Welcome
Dr. H. J. Linn

9:35 Introductory Remarks
Dr. E. R. Jennings

10:00 Review of Modern Concepts of Blood Clotting
Dr. Walter H. Seegers

11:30 Discussion Period
Dr. Walter H. Seegers

Afternoon

1:30 Theoretical Consideration of Methods of Prothrombin Determination
Dr. J. Frederic Johnson

3:00 Demonstration of the Two-Stage Method of Prothrombin Determination
Dr. J. Frederic Johnson
Dr. Edna B. Andrews
Dr. Pietro De Nicola
Dr. Shirley Johnson

Friday, August 1, 1952

Morning

9:30 Influence of Drugs on Prothrombin Time
Dr. E. R. Jennings

10:00 The One-Stage Prothrombin Time: Theoretical Aspects
Dr. V. Schelling

10:45 The One-Stage Prothrombin Time: Practical Application
Dr. Edna B. Andrews

11:30 Demonstration
Dr. Edna B. Andrews
Dr. V. Schelling

Afternoon

1:30 The One-Stage Prothrombin Time: Demonstration: Performance by Students
Dr. Edna B. Andrews
Dr. Pietro De Nicola
Dr. J. Frederic Johnson
Dr. V. Schelling



Parke-Davis President Opens Laboratory at Wayne iiversity.—Preparing the first prescription in the new 0,000 Parke-Davis Pharmacy Laboratory at Wayne iiversity, Detroit, is Harry J. Loynd, president of Parke, Davis & Company. Looking on is Dr. David D. Henry, president of Wayne University, who accepted the new lab in a brief ceremony. Completely equipped for teaching two important branches of the science—operative and dispensing pharmacy—the ultra-modern laboratory contains duplicate facilities to those found in the most modern pharmacies. It was furnished by Parke-Davis, world's largest makers of pharmaceutical products.

* * *

Group Health and Accident Insurance Studies.—MSMS has a Committee on Insurance Studies which is now making a detailed study of group health and accident insurance. The Committee is endeavoring to find the most attractive group health and accident insurance plan for MSMS members based upon a reasonable rate structure. The proposed program already has been discussed with the Executive Committee of the Council; if approved by the whole Council, it will be presented to the MSMS House of Delegates in September.

The eventual decision of the House of Delegates will be forwarded to every MSMS member following the Delegates' Session of September 22-23, 1952.

* * *

Martin J. Urist, M.D., of South Haven, is the author of an article, "Surgical Treatment of Esotropia With Bilateral Elevation In Adduction," published in the *A.M.A. Archives of Ophthalmology*, February, 1952.

* * *

J. S. DeTar, M.D., Milan, was re-elected **Speaker of** the Congress of Delegates of the American Academy of General Practice at its 1952 Atlantic City meeting.

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Wilkie M. Drake, M.D., of Breckenridge, **William E. Keane, M.D.**, of Grosse Pointe, **Earl M. McCoy, M.D.**, of Grand Ledge, and **George P. Raynale, M.D.**, of Birmingham, were awarded Golden Anniversary diplomas by Wayne University College of Medicine Alumni Association at the Sixty-Sixth Annual Clinic Day in Detroit, May 14. These four doctors of medicine are the surviving members of the class of 1902.

Principal speaker at the alumni banquet was LeMoyne Snyder, M.D., Lansing, who discussed "Medicine and Homicide Investigation." Frank A. Weiser, M.D., Detroit, was toastmaster.

* * *

John H. Schlemer, M.D., Detroit, recently was elected president of the Wayne County Academy of General Practice. The new vice president is Arthur B. Levant, M.D., Detroit.

Howard C. Rees, M.D., Detroit, is treasurer; William P. Curtiss, M.D., Detroit, is secretary, and Charles V Sellers, M.D., Detroit, is editor.

Dr. Schlemer, who is a doctor of medicine and lawyer, was chosen as official parliamentarian at th recent Congress of Delegates of the American Academ of General Practice held in Atlantic City.

* * *

A Horticultural Therapy special course is being ina gurated at Michigan State College, East Lansing, A gust 4 to 8, 1952. The purpose of this course is to pr vide practical knowledge for an enjoyable hobby whic can be pursued by patients after they leave the hospita as well as to obtain needed exercise for handicappe limbs and to enhance a patient's social rehabilitation.

Frederick C. Swartz, M.D., Lansing, is among th resource persons aiding this new course.

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THE DOCTOR'S LIBRARY

Acknowledgment of all books received will be made in this column, and this will be deemed by us as full compensation to those sending them. A selection will be made for review, as expedient.

MEDICAL BIOGRAPHIES. The Ailments of Thirty-three Famous Persons. By Philip Marshal Dale, M.D. Norman: University of Oklahoma Press. Price $4.00.

This book is a series of extremely interesting accounts of the medical side of the life and death of thirty-three personages of history: Buddha, Charlemagne, William the Conqueror, Christopher Columbus, Henry VIII, to name a few. The entire list is impressive, the analysis clear, the diagnosis and reasons given, and the last chapter of the book gives the references upon which the deductions are made. Any doctor's library should have this work, especially if he is the least bit interested in history and its relation to medical knowledge, and the influence of medical affairs on history.

EX FOR MEDICAL WRITING. A useful guide to Principle and Practice of Effective Scientific Writing and Illustration. By Edwin P. Lordan, M.D., and Willard C. Shepard. Philadelphia and London: W. B. Saunders Company, 1952. Price $2.50.

Writing about medical subjects is briefly outlined in the small volume. It tells of the choice of subject, the search for material, the first draft of the paper, the first revision, the second revision, the third revision. The opening of the subject and the end of the paper are important. Illustrations are studied, and good ones suggested. Statistics are important, and if the subject is presented by case reports, that makes very good material, much appreciated by readers. This book is a valuable guide to the young author, and the older one can also profit.

A TEXTBOOK OF PHARMACOLOGY. Principles and Application of Pharmacology to the Practice of Medicine. By William T. Salter, M.D., Professor of Pharmacology, Yale University School of Medicine. Illustrated. Philadelphia: W. B. Saunders Co., 1952. Price $15.00.

In the preface to this text Dr. Salter says, "This is a the choices of one who has spent many hours at the bedside of clinical patients as well as long nights in the laboratory." It is a personal book, and a good one. Although the book is a text and will be used mainly

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by students and as a reference, many physicians will enjoy browsing through its pages. The writing style of the author tends to lead you on to the next paragraph. The text is divided into four parts. Part I deals with general principles of pharmacology; Part II with drug action of physiological mechanisms; Part III with application of drugs in clinical medicine; Part IV with toxicology. This book is, in a way, a treatise on pathologic physiology. It is recommended to all physicians.—J.W.H.

ELEMENTARY MEDICAL STATISTICS. The Principles of Quantitative Medicine. By Donald Mainland, M.B., Ch.B., D.Sc., F.R.S.E., F.R.S.C., Professor of Medical Statistics, Division of Medical Statistics, the Department of Preventive Medicine, New York University College of Medicine. Illustrated. Philadelphia: W. B. Saunders Co., 1952. Price $5.00.

The author advises his students in one chapter to read it over rapidly, then over again, learning each definition, and then he will be able to decide. This study enters into the valuation and recording of various facts, findings, procedures; in fact, it concerns every procedure and result in the practice of medicine. The author in one place develops a plan of action with questions: who? why? what? where? when? how? how much? how many? This book is a study in a new field for students who wish to know what to expect, how to find out, why a reaction occurs, and what to do about it. The realm of statistics is not new, but as applied to medicine it is new to most of us. A valuable book, requiring some intensive study at first, but well rewarding the effort.

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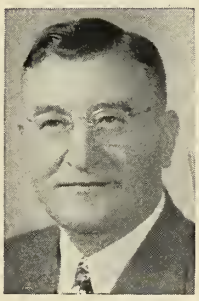
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(Continued on Page 944)

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MICHIGAN STATE MEDICAL SOCIETY ANNUAL SESSION
DETROIT—September 24-25-26, 1952

AMA PRESIDENT BAUER TO SPEAK AT MSMS ANNUAL SESSION



PRESIDENT BAUER

The 1952 MSMS Annual Session offers a bonus of entertainment and knowledge outside the realm of the purely scientific.

Speaking on the topic "The Medical Profession, Government and the Public," Louis H. Bauer, M.D., Hempstead, New York, will be a stellar attraction at Officers Night, Wednesday, September 24, 1952, in the Grand Ballroom of the Sheraton-Cadillac Hotel, Detroit. Dr. Bauer—president of the American Medical Association and secretary-treasurer of the World Medical Association—will bring a message of extreme importance to all those attending this public meeting.

Sharing the spotlight that same evening will be the 1952 Biddle Lecturer—Paul de Kruif, Ph.D., of Holland, Michigan. All Michigan doctors of medicine, their wives and friends are cordially invited to hear the talk given by this nationally famous writer.

The 1952 Annual Session is Michigan's most important medical gathering. It will be held Wednesday, Thursday and Friday—September 24, 25 and 26—in Detroit.

As indicated in the preliminary program sent to all members of the Society in July, twenty-five guest speakers will appear on the star-studded program. They include:

Gaylord W. Anderson, M.D., Minneapolis; Claude S. Beck, M.D., Cleveland; John J. Bonica, M.D., Tacoma, Washington; Spencer Braden, M.D., Cleveland; George Crile, Jr., M.D., Cleveland; Ormond S. Culp, M.D., Rochester, Minnesota; Daniel C. Darrow, M.D., New Haven, Connecticut; Edwin J. DeCosta, M.D., Chicago; Garfield G. Duncan, M.D., Philadelphia; Carl W. Eberbach, M.D., Milwaukee; Dwight E. Harken, M.D., Boston; Peter C. Kronfeld, M.D., Chicago; Milton I. Levine, M.D., New York; Roland P. MacKay, M.D., Chicago; Samuel F. Marshall, M.D., Boston; Earl R. Miller, M.D., San Francisco; Emil Novak, M.D., Baltimore; Duncan E. Reid, M.D., Boston; David A. Rytand, M.D., San Francisco; Ben H. Senturia, M.D., St. Louis, Missouri; Evan W. Thomas, M.D., Albany, New York; Philip Thorek, M.D., Chicago; Leonard F. Weber, M.D., Chicago; and Claude E. Welch, M.D., Boston.

REAPPORTIONMENT PETITIONS FILED

Two proposals to amend the Michigan Constitution to reapportion the legislature will appear on the general election ballot on November 4, 1952.

The Michigan Committee For A Balanced Legislature composed of farm, business and many professional organizations filed petitions totaling more than 290,000 signatures with the Secretary of State on July 3.

Previously, the Michigan Committee For Representative Government supported by the CIO and AFL, National Association For the Advancement of Colored People, Americans For Democratic Action, The Michigan Farmers Union and other liberal groups, had filed petitions bearing 270,205 signers. This proposal would reapportion the state on a strict population basis giving Wayne, Genesee, Macomb and Oakland counties over 51 per cent of the representatives in both the Senate and House of Representatives.

The Michigan Committee For a Balanced Legislature proposes:

1. To leave the Senate as at present on a geographical basis, with the addition of two seats —one to represent Oakland County and the other Macomb County.

2. To reapportion the House of Representatives on a basis of population but not to exceed 110 members, (present membership 100).

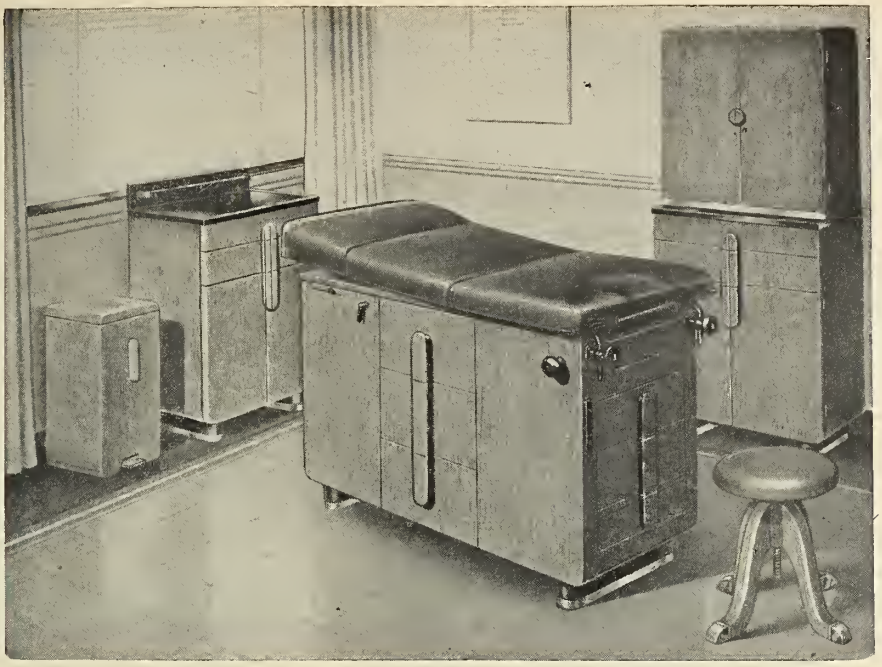
3. To continue recognition of county boundary lines.

4. To permit a representative for a county when its population is over 50 per cent of the population unit determined by the reapportionment formula.

5. To district the city of Detroit on a fair basis and eliminate the present "bedsheet ballot."

Since both proposals amend the same section of the constitution, the proposition receiving the largest number of votes will be adopted in case both receive a favorable majority.

(Continued on Page 948)



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(Continued from Page 946)

MSMS STUDIES GROUP HEALTH AND ACCIDENT INSURANCE

MSMS has a Committee on Insurance Studies which is now making a detailed study of group health and accident insurance. The committee is endeavoring to find the most attractive group health and accident insurance plan for MSMS members, based upon a reasonable rate structure.

The Committee has developed a preliminary report which will be presented to The Council at its Detroit session on September 21. If approved by The Council, it will be considered by the MSMS House of Delegates on September 22-23.

The eventual decision of the House of Delegates will be forwarded to every MSMS member, following the Detroit Annual Session.

AMA SURVEYS USE OF MDs IN MILITARY SERVICE

The AMA Council on National Emergency Medical Service is distributing questionnaires to all physicians discharged from the armed services since July 1, 1951. This survey is being conducted to evaluate the use to which doctors are being put in the service, to determine the amount of time spent in supplying medical care to others than service personnel, and to determine how the American Medical Association can better serve medical personnel in uniform.

The AMA hopes that the results of the studies will serve as a basis for recommendations concerning the "doctor-draft law," which expires July 1, 1953. It will be necessary for the AMA to recommend to Congress at that time whether such draft legislation should be extended or terminated, and if extended, the form it should take.

1953 MICHIGAN CLINICAL INSTITUTE

The dates of Wednesday, Thursday, Friday, March 11-12-13, have been selected for the 1953 Michigan Clinical Institute at the Sheraton-Cadillac Hotel, Detroit. The "block" system, so successful at the 1952 Institute, will be continued.

The Committee on Arrangements, meeting on June 25, 1952, under the chairmanship of J. M. Robb, M.D., of Detroit, decided to feature surgical subjects on Wednesday morning; miscellaneous subjects (including gynecology, obstetrics and pediatrics) on Wednesday afternoon, March 11.

Cancer will be featured Thursday morning and Trauma of the Surgical Patient on Thursday afternoon, March 12.

Heart and Rheumatic Fever will be the subject matter of Friday morning and Internal Medicine subjects will be presented Friday afternoon, March 13.

An innovation in 1953 will be the single discussion conference each day, from 12 noon to 1 p.m., with all speakers of that day seated on the platform for a "catch-as-catch-can"-audience-participation question-and-answer period. This will be the highlight of next year's Institute.

All members of the Michigan State Medical Society are cordially invited to make plans for attendance at the 1953 MCI of March 11-12-13. No registration fee.

HIGHLIGHTS OF MEETING OF EXECUTIVE COMMITTEE OF THE COUNCIL JUNE 18, 1952

Fifty-four items were presented to the Executive Committee of The Council at its June 18 meeting in Lansing. Chief in importance were:

- Monthly financial reports were presented and approved. Statement on contributions to the Beaumont Memorial Restoration Fund was presented by President Otto O. Beck, M.D. of Birmingham, who reported a total of $19,226.25 received to June 18; 23.35 per cent of MSMS members have contributed with an average contribution of $12.15.

 Bills payable were inspected and payment was authorized. A contribution of $600 to the Woman's Auxiliary for expenses of its Detroit convention in September, 1952, was authorized, together with a vote of commendation to the Woman's Auxiliary for its extraordinarily fine work and great effort in MSMS campaigns and public relations activities.
- Physician for Beaver Island. Report was given that an announcement re this opportunity for a doctor of medicine will appear in JMSMS.
- Committee reports—the following reports were considered: Maternal Health Committee, meeting of April 17; and Child Welfare Committee, meeting of June 5.
- Louis H. Bauer, M.D., of Hempstead, New York, President of the American Medical Association and Secretary-Treasurer of the World Medical

(Continued on Page 950)



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1. Silbert, N. E.: New England J. Med. 242:931, 1950.
2. Eisenstadt, W. S.: Journal Lancet 70:26. 1950.

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HIGHLIGHTS OF THE EXECUTIVE COMMITTEE

(Continued from Page 948)

Association, is to be invited as guest speaker at the MSMS Annual Session, at the public meeting of Wednesday evening, September 24, in Detroit. His talk will include a brief on the work being done by the World Medical Association.

- G. Donald Albers, M.D., Edward F. Kelly, M.D., Richard H. Sidell, M.D., of Grand Rapids, and Wesley G. Reid, M.D., Detroit, were congratulated on winning for Michigan the State Trophy at the recent American Medical Golfing Association Tournament in Chicago. The State Trophy is to be housed in the MSMS building at Lansing for the ensuing year.
- President Beck reported that Paul de Kruif, Ph.D., of Holland, would present the Biddle Lecture of 1952 at the public meeting of Wednesday evening, September 24, in Detroit.
- John R. Rodger, M.D., Bellaire, was congratulated on his excellent article "Country Practice" published in a recent number of *Journal of Student American Medical Association.*
- Temporary annual licenses to Canadian graduates who are not citizens, as authorized by the Michigan State Board of Registration in Medicine at its June 12 meeting, was reported. This is pursuant to amendments made by the 1952 Legislature to the Michigan Medical Practice Act (in S.B. 301).
- Ralph Wadley, M.D., Lansing, was appointed as medical representative on the Selective Service Appeal Board for the Eastern Federal Judicial District of Michigan.
- S. E. Gould, M.D., Eloise, was appointed as MSMS representative to the Brucellosis Conference in Saint Paul on July 7-9, 1952.
- A letter of commendation and support was authorized to be sent to the Bay County Medical Society members on their recent courageous action in connection with the Bay City General Hospital problem.
- Monthly progress reports of Rheumatic Fever Control Co-ordinator Leon DeVel, M.D., and of Cancer Control Committee Secretary Frank L. Rector, M.D., were approved.
- Legal Counsel J. Joseph Herbert presented an opinion re giving blood transfusions to a member of a religious sect without specific permission; and legal responsibilities on leaving medical practice.
- Public Relations Counsel H. W. Brenneman gave progress report on the MSMS television program "Medical Mailbox," and on the MSMS daily radio program "Tell Me, Doctor" which on July 15 will be distributed daily to seventeen stations in Michigan; a schedule of the showings of the MSMS film "To Save Your Life" was presented; the list of "Formula For Freedom" nights was given and special commendation was placed on the minutes to State Treasurer D. Hale Brake who traveled 1,506 miles to appear before nine different county medical societies and groups in the presentation of the F.F.F. program.
- Wm. A. Hyland, M.D., Grand Rapids, newly elected Chairman of Michigan's Delegation to the AMA House of Delegates, reported briefly on some of the major activities at the June 9-13 AMA Session, and praised the work of outgoing Delegation Chairman, W. D. Barrett, M.D., Detroit, "who has built up Michigan's reputation to a high degree during his tenure," stated Dr. Hyland.

1953 MICHIGAN CLINICAL INSTITUTE

	March 11	March 12	March 13
A.M.	Surgical Subjects	Cancer Control Subjects	Heart & Rheumatic Fever Subjects
P.M.	Obstetrical, Gynecological, Pediatric Subjects	Surgery of Trauma Subjects	Internal Medicine Subjects

THE "BLOCK SYSTEM" WILL SAVE YOUR TIME

CHILD WELFARE COMMITTEE

Meeting of June 5, 1952

Following roll call, and approval of the minutes of the previous meeting, of April 11, 1952, the Chairman introduced the following chief items of business:

Retro-Lental Fibroplasia.—Dr. Mason discussed this briefly and introduced Dr. Robert H. Davies who is working with the Kresge Eye Institute at Children's, Women's and Harper Hospitals in Detroit. Dr. Davies stated that they were interested in the etiology and prevention, if possible, of this disease. They are, at present,

ıdying the incidence of the disease by making a survey all birth records of premature infants that weigh less an four pounds. Dr. Davies stated the response from e parents has been very good and that the survey s been completed at Women's and Harper Hospitals t is continuing at Children's. Dr. Davies stated that ose families contacted had the children examined at e Kresge Eye Institute. He stated further that they e still studying the records and examination and no ıal figures are at present available. There are approxiıately 330 premature infants per year in the past five ars in these hospitals and between 30 and 40 were ;s than 4 lbs. at birth. Dr. Davies stated that the first ıdy of this type was made by a Dr. Susick, from St. ›uis. Indications are that a sudden withdrawal from gh concentrated oxygen produces fundus changes of e eye, while weaning the child away from this concenıated oxygen gradually does not make this change. He ıted he has found five cases of Retro-Lental Fibroplasia; ur of these have continued to a complete membrane one or both eyes. He also reported on one child who ıd 56 days of concentrated oxygen, and that one hostal indicated no cases of Retro-Lental Fibroplasia. e stated that at most hospitals, the time of withdrawal the infant from the concentrated oxygen is left to the scretion of the nurse.

Dr. Davies stated he plans to continue checking all emature infants at two of these Detroit Hospitals nce there is no definite basis for thinking that the :ygen concentrate is the guiding factor. A great deal further study is needed. In cases of prematures under lbs., the oxygen in the incubator should be checked ıd he feels that the opthalmologist should look at all rematures in all hospitals. Dr. Davies further stated ıat if the premature is over 4 lbs., the congenital cat-act replaces the Retro-Lental Fibroplasia and he felt ıat those prematures born with the weight of less than lbs., should be examined as soon as possible after irth and again after two weeks of oxygen. While those orn weighing more than 4 lbs. could be checked any me after discharge from the nursery, which in five cases aried from 12 to 52 days.

Dr. Davies invited the attention of the Committee to ıe fact that England had never had a case of Retroental Fibroplasia until 1950 since, prior to this time, ıey did not use oxygen routinely and have discontinued s use again since several cases have developed.

ACTH and Cortisone are not recommended for use in ıese cases and it was reported that the School for the lind has ⅓ of its students, kindergarten, first and secnd grades with Retro-Lental Fibroplasia.

Dr. Davies stated he desires four to six months more f study and will call on the Committee for assistance in issemination of information when he feels the Committee can be of help.

Dr. Mason thanked Dr. Davies for attending the ıeeting and providing this very interesting information, and offered the assistance of the Committee in any way they might be able to serve if Dr. Davies would notify them.

Home Care of Acute Poliomyelitis.—Dr. Nolting stated that he had attended the Regional Convention of the Academy of Pediatrics at Washington, D. C., and he read a program developed by Philip M. Stimson, M.D., (son of the former Secretary of War) which stated that the home care of the polio patient required a screening as to the home facilities as well as the condition of the patient. (A copy of this program attached).

MOTION: That each member of the Child Welfare Committee be supplied a copy of this plan and the attention of the Executive Committee of The Council of the Michigan State Medical Society be invited to this plan for consideration as a possible trend in the care of polio. Carried.

MOTION: That the definition of stillborn and live birth as defined by the World Health Organization be reaffirmed. This was outlined in the April 11, 1951, minutes. Motion carried.

Relationship Between Inoculations and Poliomyelitis

The State and Territorial Health Officers Association requested the U. S. Public Health Service to sponsor a study and issue a clarifying statement on the possible relation between various types of inoculation and poliomyelitis. Subsequently, the Public Health Service, on March 14, 1952, sponsored a meeting of forty-two poliomyelitis investigators, epidemiologists, pediatricians, allergists, and health officers. The National Foundation for Infantile Paralysis participated in the conference and helped in planning it.

The conference voted unanimously in favor of the conclusions contained in the following statement, which has been accepted by the Public Health Service and is being transmitted to official health agencies, to the medical profession, and to the public:

"There is no definite evidence that an increase in the number of cases of poliomyelitis has occurred as a result of injections of vaccine, drugs, and other medicinal agents. There is evidence that injections for the prevention of diphtheria, whooping cough and possibly tetanus, when given during an epidemic of poliomyelitis, may, on rare occasions, localize the paralysis in the inoculated arm or leg. There is no satisfactory evidence that other types of injections have any effect on the localization frequency or severity of poliomyelitic paralysis. In the small number of persons with localization of paralysis in the inoculated limb, the injections, for the most part, were given about 7 to 21 days prior to onset, which corresponds to the usual incubation period of poliomyelitis. This has raised the question as to whether or not inoculated persons have a greater chance of contracting poliomyelitis during an epidemic.

"There is as yet no final answer to this question, but

it is a fact that, even if there should be an increased chance, it is extremely small. Many thousands of poliomyelitis cases occur every year among children who have not had any injections during the preceding few months, and thousands of children have received injections for whooping cough, diphtheria and tetanus during poliomyelitis epidemics and have not developed the disease.

"Diphtheria, tetanus and whooping cough are serious diseases which can be prevented by immunization. Unchecked, these diseases present a far greater hazard than poliomyelitis. The benefits derived from immunization against these diseases far outweigh the questionably small increased chance of contracting poliomyelitis. However, even this questionable risk can be avoided by carrying out these immunizations when poliomyelitis is not epidemic in the community. There appears to be no good reason for withholding these immunizations during the summer months in communities that are not having an epidemic of poliomyelitis.

"Furthermore, poliomyelitis is at all times so rare in infants under 6 months of age, and the danger from other infectious diseases, particularly whooping cough, is so great, that it is advisable to continue the immunization procedures for this age group even during a poliomyelitis epidemic. In adults also, poliomyelitis is relatively so infrequent, that when there is a need for immunizing or therapeutic injections, such injections should not be withheld.

"Certainly no parent should object and no physician should hesitate to administer a needed antibiotic, drug or other injection for treatment of disease at any time. When there is immediate danger from diphtheria, whooping cough or tetanus, the preventive inoculations should be given to all threatened age groups even during a poliomyelitis epidemic. In the final analysis the decision as to when an immunizing or therapeutic injection shall be given to an individual patient must rest with the physician."

On the basis of this report, the Michigan Department of Health does not recommend the discontinuance of immunizations during the so-called polio season.

The Home Care of Acute Poliomyelitis

Philip M. Stimson, M.D., reported on home care of acute poliomyelitis in accordance with the following outline:

I. Introduction

II. Some Reasons for Home Care
 1. Less fatigue and less psychological disturbance.
 2. Often the preference of patient and family.
 3. Family doctor can continue with his own patient.
 4. No need to hospitalize for isolation; family already infected and not further endangered.
 5. Releases hospital beds and nurses for sicker cases.
 6. Reduce the non-polio hospital admissions.
 7. Cheaper for patient's family and assisting agencies.

III. Selection of Cases for Home Care
 A. The Patient
 1. The "suspect" including:
 a. the non-polio, and
 b. the "characteristic minor illness," especially in a polio family.
 2. The nonparalytic
 a. the diagnosis reviewed
 b. lumbar punctures—significance

 Possibly
 3. The paralytic—apparently already improving.
 4. The very mild bulbar—apparently already improving.
 B. The Home
 1. Adequacy
 a. of personnel
 b. of accommodations
 C. Availability of Services to the Home Medical Consultants, Nurses, Physical Therapists Equipment.

IV. Indications for hospitalization
 A. The Patient
 1. Increasing fever
 2. "Looks sick"—progressing
 3. Urinary difficulties
 4. Deltoid weakness
 5. Breathing difficulty
 6. Changing voice
 7. Inability to swallow
 8. Hypertension
 B. The Home
 1. Inadequate personnel
 2. Inadequate accommodations
 3. Poor emotional stability
 C. Doctor's convenience
 1. Medical and auxiliary services not easily available either in home or out-patient service.
 2. Centralization of specialized equipment in hospital.
 D. Possibility of unfavorable neighborhood reaction.

V. Treatment at Home
 1. Isolation—own room and bed, hand-washing
 2. "Set-up"—firm bed, foot board
 3. Minimum of handling, comfort, quiet, natural sleep, no sedation. Reading aloud and other diversions.
 4. Treatment of pain and tightness
 5. Reassurance
 6. Careful observation

VI. "Backing" for the family doctor
 A. Consultation panel
 B. Public Health Nursing advice
 C. Follow-up team: physician, nurse, physiotherapist

Immunization During Summer Months.—Dr. F. S. Leeder stated that at a meeting in March of the Epidemiologists regarding summer immunization, this item had been discussed and he presented a full page describing the relationship between inoculations of poliomyelitis, stating that the Health Department feels that the continued immunization program would more than compensate for any slight chance of paralytic polio. Quoting the last paragraph of the report: "On the basis of this report, the Michigan Department of Health does not recommend the discontinuance of immunizations during the so-called polio season." (Copy of this report

(Continued on Page 956)

IN FALL ALLERGIES . . .

Turn Distress into Comfort

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Neo-Antergan brings safe symptomatic relief quickly by effectively blocking the histamine receptors.

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URINARY TRACT

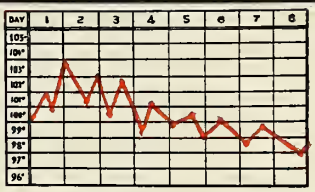
Pyelonephritis

1 Pyelonephritis occurs most often in the young child . . .



commonest in the "diaper-age" female

2 The onset is sudden, usually with a chill . . .



. . . temperature—"spiking"



. . . white cell count—high

3 Always, pus cells and bac pear in the urine



look for *clumps* of white ce in *catheterized* specimens

4 Culture determines pathogen. Mixed infection not uncommon.



in 8 out of 10 children, colon bacillus invades

5 Sometimes there is tenderness over the kidney region . . .



try the McKnight punch, or



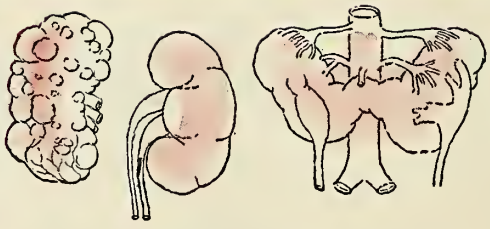
palpation in C-V a

6 . . . or abdominal pain and rigidity



suggestive of an acute abdomen

7 Look for a cause of urinary stasis.





in children, 75% have congenital malformation . . . others may have calculus, foreign body, neoplasm, ureteral spasm.

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Many urinary tract infections
as well as other infections
rapidly respond to therapy
with this well-tolerated
broad-spectrum antibiotic

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CHILD WELFARE COMMITTEE

(Continued from Page 952)

follows). Dr. R. J. Mason stated that last year the Detroit Health Department had cut inoculations during the summer and Dr. Leeder added he felt the publicity on the small hazard tends to disrupt the program of immunization and position of the public which had been built up over a period of many years, and that the hazard of whooping cough and diphtheria is much greater than paralytic polio.

MOTION: That the Child Welfare Committee of the Michigan State Medical Society recommend routine immunization procedures, including Boosters, be continued through the summer months. Carried unanimously.

Report on Hearing Testing Program.—Dr. G. B. Corneliuson reported that the Committee on hearing defects, a subcommittee of the Child Welfare Committee, has four Otologists included in its membership and the program is in its tenth year, an educational case-finding program. The State Health Department teaches public health workers the method of screening school children prior to referral to the Hearing Testing Center and about 2% need adjustment in their school work or seat location. Very few need hearing aids; most families can afford these aids when they are investigated as to financial ability. It was reported that in 1951, 150,000 children were tested in 31 counties and that since 1949 over 70 practicing Otologists participated in the program.

Report on Sight Program.—Dr. Corneliuson reported that the School for the Blind in Lansing each year holds an institute for parents of pre-school children that are blind, that 76 parents have applied for this institute this year, to assist them in raising these blind children. It was reported too that in past years this course, or institute, has had much lower attendance.

The Institute this year will be held at the Michigan School for the Blind in Lansing, Michigan, beginning August 26 through 31, 1952. Further information can be secured from Mr. W. J. Finch, Supt., of the School for the Blind. Dr. Corneliuson presented a booklet, "Is Your Baby Blind?" and stated the need of teaching parents how to raise and assist the blind child. It was further stated that visual environment can be improved with paint and proper lighting. Dr. W. S. Nolting asked at what age to start giving the Snelling Test and Dr. Davies said that many children can co-operate at age 3½ but much better co-operation is secured at 4½ years.

MOTION: That the Child Welfare Committee of the Michigan State Medical Society recommends a continuation of the Hearing and Sight Saving Program of the State Health Department. Carried.

WHERE MONEY GOES

General Foods Corporation in reporting its earnings and profits for the first quarter of the year estimated a gross sales of about two-thirds of a billion dollars. It was noted that while the stock holders receive an annual dividend of $2.40 per share the government's share is $5.52, according ot the *Wall Street Journal.*

MEDICAL MEETINGS AND CLINIC DAYS

A list of known medical meetings and clinic days, sponsored by county medical societies and other physicians' groups in Michigan, follows:

1952

Sept. 24-26	MICHIGAN STATE MEDICAL SOCIETY ANNUAL SESSION.....Detroit
Oct. 8	Clara Elizabeth Fund—Genesee County Medical Society—Lectures of 1952...Flint
Oct. 9	Fourth Michigan Cancer Conference Kellogg Center, East Lansing
Nov. 17-18	Wayne County and Michigan Academies of General Practice Kellogg Center, East Lansing
Autumn	MSMS Postgraduate Extramural Courses State-wide

1953

Jan. 16-17	Sixth Annual Michigan Rural Health Conference Kellogg Center, East Lansing
Mar. 10	MICHIGAN INDUSTRIAL HEALTH DAY..Sheraton-Cadillac Hotel, Detroit
Mar. 11-13	MICHIGAN CLINICAL INSTITUTE Sheraton-Cadillac Hotel, Detroit Complete program will be published in the December JMSMS. Plan now to attend and secure your room reservations by writing Robert M. Buckley, Secretary, Committee on Hotels, Michigan Clinical Institute, c/o Sheraton-Cadillac Hotel, Detroit.
April 9	Genesee County Medical Society 8th Annual Cancer Day.....Flint
May 13	Annual Clinic Day and Reunion of Wayne University College of Medicine Hotel Fort Shelby, Detroit

Additions to this list of meetings are invited by the Editor of JMSMS, in order to make this monthly announcement complete and accurate.

Man was created somewhat lower than the angels, but to him the Creator gave the right to plan his own life, to dare his own adventure, to earn his own reward so long as he does no harm to his fellows.

The genius of our founding fathers which preserved this republic longer than any republic in history was the concept of the limitation of powers within our government. One of their strong purposes was to protect free men by restriction of Presidential power.

If you want to see pure socialism mixed with give-away programs, take a look at socialized medicine and socialized electrical power.

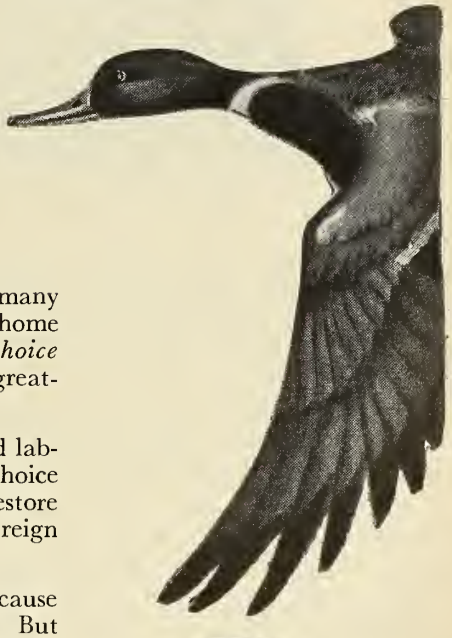
These things do not make for free men.—From Herbert Hoover's speech to the Republican Convention.





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Beaumont Memorial Contributors

The Michigan medical profession continues to be generous in its contributions to the Beaumont Memorial Restoration. Every week checks from doctors of medicine, members of the Michigan State Medical Society, are bringing closer to realization the plans of the MSMS Beaumont Memorial Restoration Committee to erect a symbol of wood and stone to mark the location of a renowned advance in medical science.



Proposed Beaumont Memorial Restoration

This symbol—restoration of the American Fur Company store on Mackinac Island—will serve as an eternal reminder to the hundreds of thousands of people who visit this historic isle, of the contributions to Medicine of Dr. William Beaumont and other medical scientists throughout the ages. The Beaumont Memorial in our state will be a constant and tangible remembrance to Michigan's doctors of medicine who made the shrine possible.

MSMS President Otto O. Beck, M.D., Birmingham, is making the Beaumont Memorial Restoration a special project during his tenure. He is devoting all his organizational ability to this important work. His many friends are wishing him well by sending generous checks to the Beaumont Memorial Committee.

Academy of Surgery Contributes $500

While individual M.D.'s are responding in increasing numbers to the invitation for contributions, organizations ancillary to Medicine are contributing sizable lump sums secured from their membership.

The Academy of Surgery of Detroit recently voted $500 for the Beaumont Memorial Restoration. This complements a like sum received from the Woman's Auxiliary to the Wayne County Medical Society, and a check for $1,864 from the Genesee County Medical Society.

The one hundred ninety-two (192) members of the Ingham County Medical Society have contributed $1,920, on the basis of ten dollars each. These and previously reported sums now swell the total received to July 10 to $20,159.

The list of contributors follows:

Academy of Surgery of Detroit; Earl R. Addison, M.D., Crystal Falls; Sidney Adler, M.D., Detroit; Lambert L. Agin, M.D., Owosso; Reuben G. Alexander, M.D., Lansing; G. Donald Albers, M.D., Grand Rapids; Ralph V. Allen, M.D., Grand Rapids; John K. Altland, M.D., Lansing; Sherman E. Andrews, M.D., Kalamazoo; David C. Asselin, M.D., Lansing; Axel U. Axelson, M.D., Detroit;

Kenneth B. Babcock, M.D., Detroit; Waldo O. Badg-

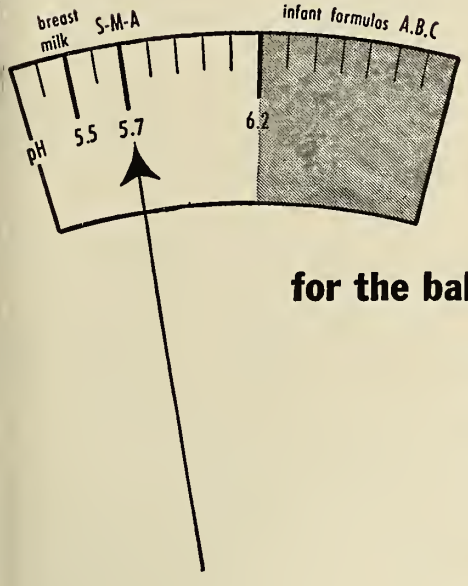
(Continued on Page 960)

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- produces a stool with a pH "practically identical" with that of the infant fed human milk. Stools of babies fed other formulas are distinctly more alkaline (6.2 to 6.7).[1]

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6. *Minimal danger of perianal dermatitis and diaper rash in the new-born.*[3]

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(Continued from Page 958)

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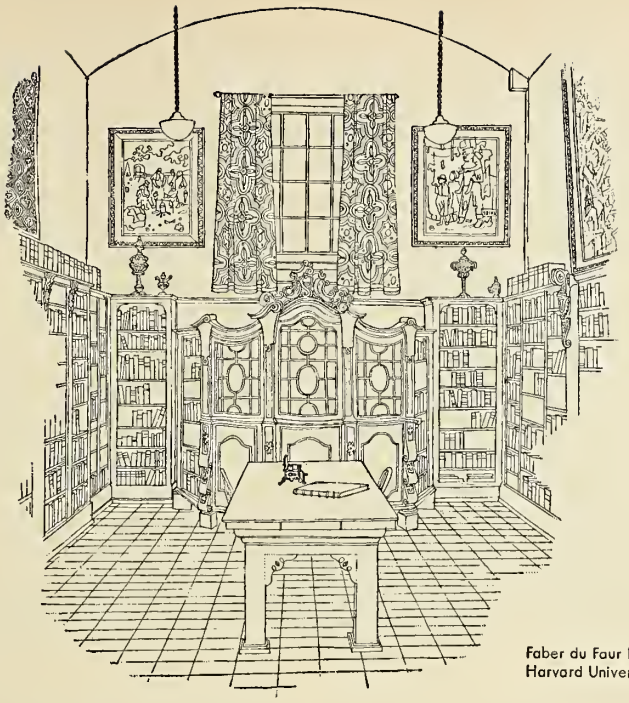
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1. Merrymon, M. P.: The Use of the Low Sodium Diet. South Dokota Jour. Med. & Phorm., 2:57, Feb., 1949.
2. Heller, E. M.: The Treotment of Essentiol Hypertension. Conod. Med. Assn. Jour., 61:293, Sept., 1949.

*Author unidentified. From Mencken, H. L.: A New Dictionory of Quototions. New York, Alfred A. Knopf, 1942, p. 1057.

Heart Beats

MHA SPONSORS HEART RESEARCH



C. E. Wilson

More than $18,800.00 in Memorial Contributions have been assigned to three exceptionally promising projects in heart research, Charles E. Wilson, Chairman of the Board of Trustees of the Michigan Heart Association, announced last month in Detroit. The money, from the Association's Memorial Fund, has been allocated to medical institutions in Michigan for the fiscal year beginning July 1, 1952.

"An ever-increasing number of persons," Mr. Wilson said, "have found deep satisfaction in making memorial contributions to the Michigan Heart Association in memory of a friend, relative or associate who has died of heart disease. The money is entirely unsolicited and has been designated by the donor to serve the highly useful purpose of scientific research in the cardiovascular field. It is these funds," Mr. Wilson continued, "which have been earmarked for research projects which are currently being conducted at Harper Hospital and the Wayne University College of Medicine in Detroit and the University of Michigan Medical School in Ann Arbor."

Mr. Wilson pointed out that the Association has given top priority to the support of research because of the urgent need for information that will reveal the still unknown causes of diseases of the heart and circulatory system which constitute America's top medical menace today. Thirty-two research, education and community service projects have already been financially supported by the Michigan Heart Association which receives the major portion of its funds from "United" fund campaigns in many Michigan communities.

"The Michigan Heart Association," Mr. Wilson concluded, "gratefully acknowledges these memorial funds which will be used as the donor intended—to support those projects which are concerned with reducing premature death and disability caused by heart disease."

The research projects which will receive financial support from the Memorial Fund are:

1. **Wayne University College of Medicine—Detroit—Department of Physiology and Pharmacology. Grant: $9,550.00**
 Investigator: Walter H. Seegers, Ph.D.

In an extensive study, by the investigator, of the fundamental nature of plasma antithrombin activity, it was discovered that a hitherto unrecognized antithrombin reaction exists. The substance of the plasma which causes this reaction has been called antithrombin-accelerator. With the funds received from the Michigan Heart Association, Dr. Seegers plans (1) To study the properties of antithrombin-accelerator, and to see whether concentrates can be prepared from plasma; (2) To study the effect of drugs on the antithrombin-accelerator concentration when the drugs are given to animals; (3) To study the possibility of devising a practical quantitative method for prothrombin analysis; and (4) To pursue any promising lead that is seen during the course of the study.

2. **Harper Hospital—Research Division—Detroit—Grant: $6,310.00**
 Investigators: Aran S. Johnson, M.D., Robert A. Gerisch, M.D., Harry C. Saltzstein, M.D., Schayel R. Scheinberg, M.D., Fred W. Girton, M.D.

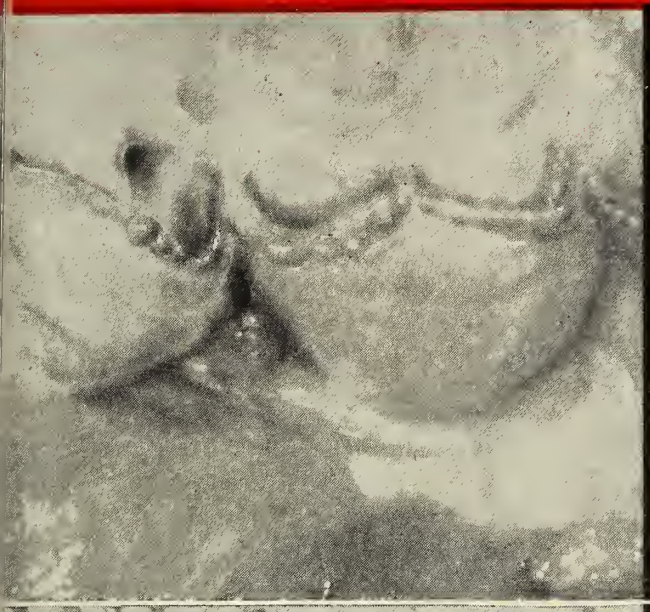
Studies completed to date on this project have shown that Cortisone was effective in reducing the size of myocardial infarcts in dogs whose coronary arteries had been previously ligated. The reduction in size of these infarcts was 85 to 95% compared to those found in the control animals. The object of further research in this field is to broaden the experiment to where it may possibly be of clinical value in patients with acute coronary occlusions.

3. **University of Michigan—Department of Internal Medicine—Ann Arbor. Grant: $3,000.00**
 Investigator: Franklin D. Johnston, M.D.

Further studies of electrocardiographic leads using fluid mappers, low frequency vibrations over

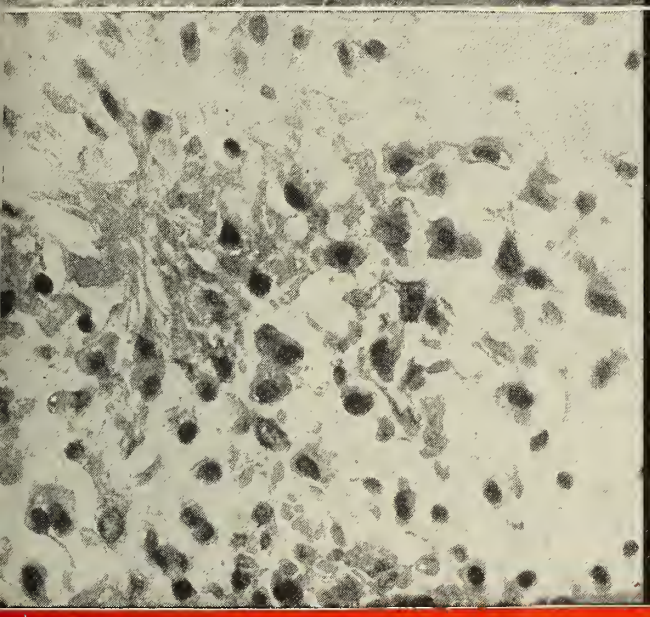
(Continued on Page 971)

response in rheumatic fever



q. Does cortisone influence the heart lesions of rheumatic fever?

a. Early cortisone administration suppresses and in some cases may even prevent serious cardiac damage.



q. What effect does cortisone have on acute rheumatic fever?

a. Often within 24 hours after cortisone therapy, the severely ill, toxic patient appears alert and comfortable; and within one to four days, temperature drops to normal, appetite increases, and polyarthritis subsides.

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AMA Annual Session-June 1952

The total registration (including physicians, guests, exhibitors) was 28,122. A near record crowd of 13,162 M.D.'s attended the Chicago session.

New officers of the AMA are:

President—Louis H. Bauer, M.D., Hempstead, Long Island, New York.

President-Elect—Edw. J. McCormick, M.D., Toledo, Ohio.

Vice-President—Leo F. Schiff, M.D., Plattsford, New York.

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New member Board of Trustees—James R. McVay, M.D., Kansas City, Mo.

House of Delegates Busy

Michigan delegates on AMA reference committees of the 1952 House of Delegates included:

1. Grover C. Penberthy, M.D., Detroit, Chairman of Sections and Section Work.

2. Wyman D. Barrett, M.D., Detroit, Chairman of Rules and Order of Business.

3. Ralph A. Johnson, M.D., Detroit, member of Committee on Legislation and Public Relations.

The House of Delegates went on record favoring amendments to the Constitution of the United States:

1. Limiting the taxing power of the federal government;

2. Providing that no treaty or executive agreement shall conflict with any provisions of the Constitution or regulate purely domestic affairs.

President's Commission Blasted

The House of Delegates resolved "that the conduct of the officers and Board of Trustees regarding the President's Commission (on Health Needs of the Nation of which Paul B. Magnusson, M.D., is Chairman) is re-affirmation of the principle subscribed to by the vast majority of the members of the AMA." President John W. Cline, M.D., of San Francisco, labeled the Commission as politically motivated and advised of the "unwarranted, intemperate attack on the AMA" because of its opposition to the Commission. "Any report emanating from the Commission must be carefully examined," stated Dr. Cline. "It will not only be based upon inadequate time and opportunity for study but may have all the misleading and dangerous attributes of a snap diagnosis." The House of Delegates also referred to the Board of Trustees a resolution urging that the AMA establish a Health Commission of its own.

The House of Delegates condemned the attempt of the International Labor Organization to socialize medicine.

The House recommended that the Board of Trustees appoint a committee to study and consult with the American Osteopathic Association concerning osteopathic education.

The House also established a single membership classification; it increased the size of the House of Delegates by making Past Trustees members of the House; it reiterated that all doctors of medicine in the United States shall be eligible for membership in the AMA without regard to race, color, or creed.

The House instructed the Constitution and By-Laws Committee to study and evaluate the present Principles of Ethics.

The following Michigan doctors of medicine registered at the AMA meeting:

Monday, June 9, 1952: A. U. Axelson, M.D., Detroit; Margaret Bell, M.D., Ann Arbor; Abraham Bloch, M.D., Detroit; Mary B. Campbell, M.D., Port Huron; Leo A. Dick; M.D., Kalamazoo; Austin I. Dodson, M.D., Ann Arbor; Hugo A. Freund, M.D., Detroit; Eugenia Gurskis, M.D., Detroit; Frederik E. Hansen, M.D., Detroit; Clyde Knapp Hasley, M.D., Detroit; Edwin S. Hoffman, M.D., Detroit; Charles G. Johnston, M.D., Detroit; James J. Lightbody, Detroit; Traian Leucutia, M.D., Detroit; Bruce C. Lockwood, M.D., Detroit; Joseph M. Markel, M.D., Dearborn; James Milton Robb, M.D., Detroit; Howard B. Rasi, M.D., Detroit.

Major Charles T. Root, M.C., Fort Custer; C. Howard Ross, M.D., Ann Arbor; Albert D. Ruedeman, M.D., Detroit; Schayel R. Scheinberg, M.D., Detroit; Charles L. Schneider, M.D., Detroit; Alexander Bryce Stearns, M.D., Detroit; William J. Steenrod, Jr., M.D., Fort Custer; Richard E. Straith, M.D., Detroit; Nelson Taylor, M.D., Grosse Pointe.

Tuesday, June 10, 1952: Hugo Aach, M.D., Kalamazoo; Ralph V. August, M.D., Muskegon; Warren W. Babcock, M.D., Detroit; Margaret F. Benjamin, M.D., Parchment; James J. Boccia, M.D., Detroit; Wilbur L. Casler, M.D., Marquette; Francis X. Claps, M.D., Battle Creek; Daniel E. Cohn, M.D., Detroit; Hodge N. Crab-

ee, M.D., Ann Arbor; Aaron A. Farbman, M.D., etroit.

Leo S. Figiel, M.D., Detroit; Robert A. Gerisch, M.D., etroit; H. R. Gilbert, M.D., Wyandotte; William Henry ordon, M.D., Detroit; Lucile R. Grant, M.D., Grand apids; Ferdinand E. Griefenstein, M.D., Dctroit; Earl . Hamilton, M.D., Traverse City; Robert W. Hartley, [.D., Detroit; F. L. Honhart, M.D., Grosse Pointe; Wil-am A. Hudson, M.D., Detroit.

Aran S. Johnson, M.D., Detroit; F. E. Kolb, M.D., alumet; P. T. Lahti, M.D., Royal Oak; Edward E. evine, M.D., Dearborn; Sydney S. Levine, M.D., Detroit.

Norman L. Lindquist, M.D., Escanaba; Stanley L. ipinski, M.D., Detroit; Wm. L. Lawrie, M.D., Detroit; furray S. Mahlin, M.D., Detroit; S. C. McArthur, [.D., Clare; Carey P. McCorth, M.D., Ann Arbor; obert C. Hoeling, M.D., Detroit; Wm. S. Murray, [.D., Detroit; John E. Orebaugh, M.D., Ann Arbor; E. 'heodore Palm, M.D., Crystal Falls; D. A. Paris, M.D.,)etroit; Charles A. Paukstis, M.D., Ludington.

Richard A. Rasmussen, M.D., Grand Rapids; Robert .. Reagan, M.D., Benton Harbor; F. A. Rice, M.D., attle Creek; Herbert F. Robb, M.D., Belleville; Saul .osenzweig, M.D., Detroit; J. Griswold Ruth, M.D., enton Harbor; Carolyn S. Salisbury, M.D., Detroit; 'eza Schinagel, M.D., Detroit; Laurence F. Segar, M.D.,)etroit; Harry C. Saltzstein, M.D., Detroit; Eugene L. poehr, M.D., Ferndale; Albert L. Steinbach, M.D.,)etroit; Henry W. Ten Pas, M.D., Hamilton; Geo. C. 'hosteson, M.D., Detroit.

Edw. T. Torwick, M.D., Jackson; Henry J. VanDuine, [.D., Grand Rapids; Wm. H. Wacek, M.D., Ironwood; .obert K. Whitely, M.D., Detroit; Weldon A. William-)n, M.D., Detroit; Charles H. Willison, M.D., Midland; Vm. G. Winters, M.D., Holland; Hackley E. Woodford, [.D., Benton Harbor; Duane R. Worgess, M.D., Battle Creek; Bernard S. Zager, M.D., Fort Custer.

Sidney Adler, M.D., Detroit; Nicholas M. Azzato, [.D., Selfridge Field; Wyman D. Barrett, M.D., Detroit; 'ranklin W. Baske, M.D., Flint; Mark S. Beaubien, M.D., Lansing; C. W. Beers, M.D., Muskegon; Albert .. Bernstein, M.D., Detroit; Alexander Blain, M.D.,)etroit; James B. Blodgett, M.D., Detroit; M. J. Brady, M.D., St. Clair Shores; J. Russell Brink, M.D., Grand Rapids; Philip H. Broudo, M.D., Detroit; Earl L. Bur-)idge, M.D., Kalamazoo; Nathaniel O. Calloway, M.D., Battle Creek; L. A. Campbell, M.D., Saginaw; George Chabut, M.D., Northville; Henry G. Chall, M.D., De-roit; Sidney E. Chapin, M.D., Dearborn; Sidney Char-ias, M.D., Detroit.

Frederick A. Coller, M.D., Ann Arbor; S. O. Cotton, M.D., Detroit; Arthur C. Curtis, M.D., Ann Arbor; Carleton Dean, M.D., Lansing; John S. DeTar, M.D., Milan; Mark W. Dick, M.D., Grand Rapids; Dwight C. Ensign, M.D., Detroit; I. E. Falk, M.D., Detroit; Leon Fill, M.D., Detroit; L. Fernald Foster, M.D., Bay City.

E. L. Garrett, M.D., Niles; W. L. Green, M.D., Kala-mazoo; Robert H. Grekin, M.D., Kalamazoo; Frank L. Groat, M.D., Grand Haven; David S. Gudes, M.D., De-roit; L. C. Harvie, M.D., Saginaw; Wilfrid Haughey, M.D., Battle Creek; Hilda Hensel, M.D., Monroe; Noel J. Hershey, M.D., Niles; John K. Hickman, M.D., Dowagiac; Fred Jenner Horges, M.D., Ann Arbor; Wil-ard B. Howes, M.D., Detroit; A. Ray Hufford, M.D., Grand Rapids; Willis H. Huron, M.D., Iron Mountain; Wm. A. Hyland, M.D., Grand Rapids; Arthur Isaacson, M.D., Detroit.

Henry T. Johnson, M.D., Lansing; Ralph A. Johnson, M.D., Detroit; Tyre K. Jones, M.D., Marshall; D. J. Kilian, M.D., Midland; J. Paul Klein, M.D., Fremont; Edmund J. Knobloch, M.D., Detroit; Wm. H. Koehler, M.D., Royal Oak; Eugene W. Lange, M.D., Muskegon; James O. Lawrence, M.D., Kalamazoo; A. D. Litsky, M.D., Detroit; F. E. Luger, M.D., Saginaw; Douglas B. McDowell, M.D., Eloise; Richard M. McKean, M.D., Detroit; Joseph A. Macksood, M.D., Flint; J. C. Malone, M.D., Kalamazoo; Daniel B. Marcus, M.D., Detroit; Arthur Campbell Miller, M.D., Detroit; Ray S. Morrish, M.D., Flint; Reinard P. Nanzig, M.D., Grand Rapids; Wm. Edw. Nesbitt, M.D., Alpena; Carl Porter O'Sonies, M.D., Saginaw; Eugene A. Osius, M.D., Detroit.

M. D. Palvich, M.D., Detroit; Hermann Pinkus, M.D., Monroe; Harold M. Podolsky, M.D., Detroit; H. Marvin Pollard, M.D., Ann Arbor; Harry Portnoy, M.D., Detroit; E. W. Prentice, M.D., Muskegon; Wm. S. Reveno, M.D., Detroit; Maurice L. Richardson, M.D., Lansing; E. M. Rotarius, M.D., Detroit; James L. Salomon, M.D., Detroit; Louise F. Schnute, M.D., Grand Rapids; Frank W. Schwarz, M.D., Battle Creek; C. D. Selby, M.D., Port Huron; Frank Schubeck, M.D., Ann Arbor; A. Clark Sibilsky, M.D., Battle Creek; Edward F. Sladek, M.D., Traverse City; Franklin W. Smith, M.D., Ovid; Edward D. Spalding, M.D., Detroit; Ellis H. Steffensen, M.D., Detroit; Charles S. Stevenson, M.D., Detroit.

Robert Stobbelaar, M..D, Grand Rapids; Titsuo Sugi-yama, M.D., Grand Rapids; Alvin J. Swingle, M.D., Benton Harbor; Harlan H. Taylor, M.D., Battle Creek; Elmer Clinton Texter, M.D., Detroit; Bert Van Ark, M.D., Eaton Rapids; Russell J. Vastine, Jr., M.D., Buchanan; Carver G. Walcott, M.D., Fenton; John A. White, M.D., Big Rapids; Alvon C. Winegar, M.D., Benton Harbor; Samson S. Wittenberg, M.D., Detroit; Melissa H. Worth, M.D., Ann Arbor.

Wednesday, June 11, 1952: G. Donald Albers, M.D., Grand Rapids; J. H. Ahronheim, M.D., Jackson; Harry Arnkoff, M.D., Pontiac; Abel J. Baker, M.D., Grand Rapids; Arthur G. Baker, M.D., Lansing; Herbert G. Barak, M.D., Kalamazoo; J. Bebin, M.D., Ann Arbor; M. Clarence Beets, M.D., Grand Rapids; Robert J. Bolt, M.D., Ann Arbor; Paul R. Boothby, M.D., Lawrence; Osborn Allen Brines, M.D., Detroit; E. T. Brunson, M.D., Ganges; M. S. Chambers, M.D., Flint; Clarence P. Chrest, M.D., Kalamazoo; Wyman C. C. Cole, M.D., Detroit; K. E. Corrigan, M.D., Detroit; Robert Cowen, M.D., Detroit; William De Kleine, M.D., Lansing; B. F. Dorinak, M.D., Detroit; Howard P. Doub, M.D., Detroit.

Edward F. Ducey, M.D., Grand Rapids; Robert M. Eaton, M.D., Grand Rapids; Edward N. Elmendorf, M.D., Vassar; Robert S. Elvidge, M.D., Detroit; August F. Fath, M.D., Kalamazoo; James A. Ferguson, M.D., Grand Rapids; Robert E. Fisher, M.D., Bay City; Mary Margaret Frazer, M.D., Detroit; E. H. Fuller, M.D., Grand Rapids; R. L. Garmire, M.D., Selfridge Field; Michael A. Gertz, M.D., Ironwood; Margaret J. Gilfillan, M.D., Battle Creek; Ira Gore, M.D., Detroit; Joseph M. Grace, M.D., Detroit; John G. Graham, Jr., M.D., Detroit; J. P. Gray, M.D., Detroit; E. S. Gurdjian, M.D., Detroit.

Hilda A. Habenicht, M.D., Jackson; E. Richard Har-rell, M.D., Ann Arbor; Henrietta S. Hayden, M.D., Detroit; L. E. Heavner, M.D., Grosse Pointe; Edw. H. Heneveld, M.D., Muskegon; W. Leonard Howard, M.D., Northville; Walter L. Howland, M.D., Pinconning; Or-len J. Johnson, M.D., Bay City; Arthur H. Joistad, Jr., M.D., Muskegon; D. H. Kaump, M.D., Detroit; Edward F. Kelly, M.D., Grand Rapids; Paul B. Kilmer, M.D., Reed City; Howard A. Klein, M.D., Detroit; Donald Koch, M.D., Port Huron; Francis S. Kucmierz, M.D., De-troit; Clare V. Lawton, M.D., Benton Harbor; Fred O. Lepley, M.D., Detroit; A. G. Liddiocoat, M.D., De-troit; Walter Irving Lillie, M.D., Grand Rapids; David Littlejohn, M.D., Eloise; L. R. McElmurry, M.D., Lans-ing; Earle D. MacKenzie, M.D., Detroit; W. G. Macker-sie, M.D., Detroit; John T. Manning, M.D., St. Joseph; F. A. Mantz, Jr., M.D., Battle Creek; Elba Molina,

M.D., Lansing; Reed M. Nesbit, M.D., Ann Arbor; Martin Patmos, M.D., Kalamazoo; Pablo Perez, M.D., Ann Arbor; Earl C. Potter, M.D., Lansing; Leo B. Rasmussen, M.D., Vicksburg.

Harold R. Reames, M.D., Kalamazoo; Frank L. Rector, M.D., Lansing; L. Reynolds, M.D., Detroit; Robert D. Risk, M.D., Muskegon; Samuel H. Rutledge, M.D., Lansing; Maurice H. Seevers, M.D., Ann Arbor; Emil M. Shebesta, M.D., Muskegon; Richard Sidell, M.D., Grand Rapids; George W. Smith, M.D., Battle Creek; Robert B. Smith, M.D., Grand Rapids; S. D. Steiner, M.D., Lansing; Charles G. Steinke, M.D., Iron Mountain; Floyd H. Steinman, M.D., Flint; Cyrus C. Sturgis, M.D., Ann Arbor; Irvin C. Susman, M.D., Selfridge Field; Francis X. Sweeney, M.D., Detroit; John C. Szejda, M.D., Detroit; D. Emerick Szilagyi, M.D., Detroit.

John F. Tannheimer, M.D., Ionia; Maurice Tatelman, M.D., Detroit; Henry Turkel, M.D., Detroit; E. Gifford Upjohn, M.D., Kalamazoo; Edward H. Wagenaar, M.D., Muskegon; Everal M. Wakeman, M.D., Dearborn; George L. Walker, M.D., Dearborn; J. Edwin Watson, M.D., Detroit; Sumner Merrill Wells, M.D., Grand Rapids; Russell F. Weyher, M.D., Detroit; Norman H. Wilex, M.D., Battle Creek; D. R. Wright, M.D., Flint; Jack Foy Wu, M.D., Battle Creek.

C. A. Alexander, M.D., Kalamazoo; Vivian G. Behrmann, M.D., Detroit; Eugene F. Bolliger, M.D., Detroit; Wm. P. Chester, M.D., Detroit; Francis C. Cretsinger, M.D., Kalamazoo; Paul L. Cusick, M.D., Detroit; Robert H. Denham, M.D., Grand Rapids; Joe DePree, M.D., Grand Rapids; Harold D. Dykhuizen, M.D., Muskegon; Lynn A. Ferguson, M.D., Grand Rapids; B. Charles Foucek, M.D., Three Oaks; M. R. French, M.D., Coldwater; F. R. Gehman, M.D., AuGres; Douglas H. Giese, M.D., Detroit; L. Grant Glickman, M.D., Menominee; Kuno Hammerberg, M.D., Clare; Curtis M. Hanson, M.D., Kalamazoo; Frank W. Hartman, M.D., Detroit; Robert E. Hayes, M.D., Lansing; M. W. Alcorn, M.D., Bay City; Roy H. Holmes, M.D., Muskegon; E. O. Jodar, M.D., Detroit; Wm. Klein, M.D., Detroit; Henry P. Kooistra, M.D., Grand Rapids; C. G. Krupp, M.D., Grand Rapids.

Leonard D. Kurtz, M.D., Detroit; Conrad R. Lam, M.D., Detroit; V. S. Laurin, M.D., Muskegon; Morton R. Lazar, M.D., Detroit; John E. Ludwick, M.D., Jackson; Harvey D. Lynn, M.D., Detroit; Clarice L. McDougall, M.D., Grand Rapids; Howard H. McNeill, M.D., Pontiac; R. E. Michmerhuizen, M.D., Grand Haven; Albert F. Milford, M.D., Ypsilanti; Edward A. Miller, M.D., Berrien Springs; Marlin K. Morris, M.D., Lansing.

Hugh F. Mullenmeister, M.D., Battle Creek; Jean M. Holdredge, M.D., Wyandotte; P. B. Northouse, M.D., Grand Rapids; James A. Olson, M.D., Detroit; Russell J. Paalman, M.D., Grand Rapids; Kenneth C. Pierce, M.D., Dowagiac; Junius Mott Rawlings, M.D., Flint; A. S. Rogoff, M.D., Detroit; Max Ronald Burnell, M.D., Detroit; Bernard Rose, M.D., Detroit; Ivan B. Taylor, M.D., Detroit; R. A. Tearnan, M.D., Munising; Rita B. Tower, M.D., Flint; Otto von Renner, M.D., Vassar; John C. Watts, M.D., Detroit; Joseph P. Webb, M.D., Kalamazoo; Martha Wells, M.D., Detroit; T. P. Wickville, M.D., Calumet; Warren K. Wilner, Jr., M.D., Ann Arbor.

Thursday, June 12, 1952: A. F. Bliesmer, M.D., St. Joseph; Robin C. Buerki, M.D., Detroit; Claire H. Clausen, M.D., Sault Ste. Marie; Warren B. Cooksey, M.D., Detroit; Edmond L. Cooper, M.D., Detroit; Robert Duane Danforth, M.D., Grosse Pointe; Stella M. Delani, M.D., Detroit; Frank Diskin, M.D., Muskegon; James C. Droste, M.D., Grand Rapids; John A. Freel, M.D., Bay City; Sidney Friedlaender, M.D., Detroit; Martha H. Goltz, M.D., Montague; Brenton M. Haigil, M.D., Detroit; B. E. Henig, M.D., Grayling; R. J. Himmelberger, M.D., Lansing; David B. Johnson, M.D., Detroit; William Harry Johnson, M.D., St. Joseph; G. H. Kaven, M.D., Unionville; Jack Lapides, M.D., Ann Arbor; A. F. Lecklider, M.D., Detroit; E. C. Long, M.D., Monroe; James M. Louisell, M.D., Bridgman; Kenneth Moore, M.D., Ypsilanti; Victor A. Notier, M.D., Grand Rapids, John J. Prendergast, M.D., Detroit; David J. Sandweiss, M.D., Detroit; George Sewell, M.D., Detroit; Maynard N. Southworth, M.D., Schoolcraft.

B. R. Springborn, M.D., Detroit; W. J. Stapleton, M.D., Detroit; David L. Sugar, M.D., Detroit; Edward C. Thompson, M.D., Grand Rapids; Carl W. Uthoff, M.D., Grand Rapids; O. van der Velde, M.D., Holland; Peter P. Werle, M.D., Detroit; C. J. Williams, M.D., Grosse Pointe.

Harvey C. Bodmer, M.D., Kalamazoo; Clifford C. Corkill, M.D., Douglas; Maynard M. Conrad, M.D., Kalamazoo; Lolita Goodhue, M.D., Kalamazoo; Burton R. Corbus, M.D., Grand Rapids; Harold J. Damstra, M.D., Grand Rapids; A. Jackson Day, M.D., Detroit; Clayton S. Emery, M.D., Niles; George T. R. Fahlund, M.D., Grand Rapids; Fred C. Garlock, M.D., Grand Ledge; W. C. Huyser, M.D., Kalamazoo.

James M. Kennary, M.D., Detroit; James T. Keyes, M.D., Birch Run; Ezra Lipkin, M.D., Detroit; Sherman L. Loupee, M.D., Dowagiac; Wm. G. McEvitt, M.D., Detroit; G. Thomas McKean, M.D., Detroit; Lorenzo Nelson, M.D., Baldwin; Constantine L. A. Oden, M.D., Muskegon; Dayton O'Donnell, M.D., Detroit; C. Allen Payne, M.D., Grand Rapids; J. P. Pratt, M.D., Detroit; Jacob Roth Rupp, M.D., Detroit; Alexander W. Sanders, M.D., Detroit; John M. Sheldon, M.D., Ann Arbor; Louis E. Sigler, Jr., M.D., Pontiac; Claire L. Straith, M.D., Detroit; Marvin H. Strick, M.D., Benton Harbor.

C. K. Stroup, M.D., Flint; Harold C. Swenson, M.D., Grand Rapids; Edward J. Tallant, M.D., Detroit; Charles A. Teifer, M.D., Muskegon; W. R. Vaughn, M.D., Plainwell; Udo J. Wile, M.D., Ann Arbor; Ruth Zeman, M.D., Ann Arbor; Alphonse J. Zujko, M.D., Pontiac.

Friday, June 13, 1952: Earl R. Addison, M.D., Crystal Falls; Kenneth Babcock, M.D., Detroit; Paul S. Barker, M.D., Ann Arbor; George M. Childs, M.D., Detroit; Lewis Cohen, M.D., Detroit; L. David Comstock, Jr., M.D., Dowagiac; W. B. Crane, M.D., Kalamazoo; J. Colin Elliott; M.D., Buchanan; R. D. Ettinger, M.D., Fenton; Michael Faber, M.D., Benton Harbor; Fordus V. Hand, M.D., Detroit; S. W. Hartwell, M.D., Muskegon; Roscoe C. Hildreth, M.D., Kalamazoo; Archie E. Humphrey, M.D., Marshall; Benjamin Juliar, M.D., Detroit; Fanny Helen Kenyon, M.D., Lansing; A. T. Kibzey, M.D., Detroit; Harry Lieffers, M.D., Grand Rapids; Oliver W. Lohr, M.D., Saginaw; James H. Lyons, M.D., Dearborn; John R. MacGregor, M.D., Parchment; Don Marshall, M.D., Kalamazoo.

L. L. Marston, M.D., Lakeview; V. P. Moisdes, M.D., Detroit; Dirk Mouw, M.D., Grand Rapids; George S. Olmstead, M.D., Detroit; Philip S. Peven, M.D., Detroit; Carol Platz, M.D., Detroit; Harold L. Riner, M.D., Dearborn; L. Eugene Robertson, M.D., Detroit; Max Rulney, M.D., Flint; Richard H. Schaftenaar, M.D., Holland; William A. Scott, M.D., Kalamazoo; J. S. Sluyter, M.D., Grand Rapids; Clarence M. Smith, M.D., Detroit; Fred R. Smith, M.D., Lake City; M. Luther Smith, M.D., Muskegon; R. W. Spalding, M.D., Gobles; Heinz Robert Weisheit, M.D., Sturgis; Ralph Worthington, M.D., Lansing.

R. E. Dawson, M.D., Flint; Russell N. DeJong, M.D., Ann Arbor; Kent A. Dewey, M.D., Grand Rapids; H. B. Elliott, M.D., Flint; G. R. Fattic, Jr., M.D., Niles; Wm. Fiedling, M.D., Norway; T. B. Gitzpatrick, M.D., Ann Arbor; Fred H. Mowray, M.D., Battle Creek; John M. Hammer, M.D., Kalamazoo; Winfred B. Harm, M.D., Detroit; Thos. J. Heldt, M.D., Detroit; E. G. Hester,

(Continued on Page 970)

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(Continued from Page 968)

M.D., Saginaw; W. Kaye Locklin, M.D., Kalamazoo; Dugald S. MacIntyre, M.D., Grand Rapids.

Paul E. Medema, M.D., Muskegon; John K. Ormond, M.D., Detroit; Paul A. Paden, M.D., Battle Creek; George Ritter, M.D., Detroit; Herbert Rosenbaum, M.D., Detroit; Emil D. Rothman, M.D., Detroit; James M. Ryan, M.D., Detroit; Geo. W. Sippola, M.D., Detroit; John D. Snider, M.D., Ionia; Geo. L. Waldbott, M.D., Detroit; Robert G. Wetterstroem, M.D., Northville; James L. Wilson, M.D., Ann Arbor; I. H. Zielke, M.D., Traverse City.

Comments, quotations, accomplishments are presented in an attempt to bring some of the intimate impressions to our members.

Clarence Manion, Dean of Law, Notre Dame, Chicago, June 8, 1952, Conference of Presidents:

"Many people; most of my students believe the government is a sacred cow, with its head and tail in the stratosphere, getting sustenance therefrom, and provided with innumerable big teats for everyone who wishes to suckle."

Walter Judd, M.D., M.C., Chicago, June 8, Conference of Presidents:

"No foreign government deserves, or has the right to a cent of our money."

The following from the address of retiring President John W. Cline, M.D., San Francisco:

"Medical care has increased in quantity as well as in standards. The American people enjoy more abundant and better medical care than ever before."

"Plans for protection against the costs of illness have grown and improved during the past year. More than 85,000,000 Americans now have Blue Cross or other hospital coverage, 65,000,000 have surgical and 28,000,000 medical and surgical protection."

"Over the country one finds variation in the interest of the profession and the backing it gives to the voluntary insuurance program. On the whole it is good and is improving. The voluntary plans fill a great need and render a great service to our people. On this basis alone they deserve our full support. Unquestionably they are far from perfect and defects exist in some plans. Where changes are needed let us strive to bring them about in a constructive fashion."

"Destructive criticism and withholding support and co-operation interfere with proper development and damage the entire program. Injury to the voluntary movement would jeopardize our future freedom."

"Opinion is almost unanimous that a strong and successful voluntary insurance program is our greatest bulwark against the socialization of medicine. This opinion is held by many of our friends in other fields of endeavor and in public life. It is shared by those who would destroy the high standards of American medicine by placing it under bureaucratic domination."

"Certain hospitals continue to engage in the practice of medicine in defiance of established principles and in contravention of the law in most states. There is, I believe, widening recognition by hospitals that the practice of medicine is the practice of medicine whether performed within or without the hospital. We recognize the right and the necessity for hospitals to derive income from certain departments staffed by physicians and ethical arrangements have been worked out whereby the rights of all concerned are respected. The hospital must not become dominant in the practice of medicine. This appears to be the objective of a small minority of administrators and trustees."

"We have long recognized and subscribed to the dual obligation of the physician to his patient: To render to the patient the best possible medical care and to deal fairly with him in all ways. Unfortunately there are a few of our colleagues who do not respect these obligations. When these are encountered they must be thrust from the company of gentlemen. There can be no compromise with dishonesty or unethical conduct. We owe forthright action not only to the public but to ourselves. Respect, to be maintained, must be deserved."

"Our Code of Ethics is not a body of law but is a pattern for conduct. In a sense it is the code of the gentleman in the practice of medicine. Even if it did not exist it would not be violated by many because the vast majority of our members are gentlemen."

"We recognize that our medical schools are in financial distress and we are making an effort to alleviate this situation through the American Medical Education Foundation and the National Fund for Medical Education. The results to date, this year, are more encouraging than in the first year. Every one of us owes a great debt to medical education and it must have our fullest support. Medical education is every doctor's business."

"Let us not be misled by the apparent quiet of the moment. Our battle is not yet won. Complacency could well be a fatal error. I recall clearly the false security of 1946 at which time it was said that socialized medicine was "as dead as a dodo." Two years later American medicine confronted the gravest crisis of its history."

"Few persons realize the distance we have traveled, as a nation, down the road to socialism. As physicians we know that in the course of many diseases a point is reached where the changes of structure in the tissues become irreversible and restitution of normal function becomes impossible. The disease of socialism which affects our body politic is at the present time not far from that point."

"This may well be *the* year of decision. Unless the trend toward an all powerful government progressively extending its influence into our daily lives, limiting our horizons and sapping our initiative is halted, the changes in our political, economic and social structure will soon have reached the state of irreversibility. If this occurs we will have sacrificed the most precious heritage any nation ever had, and for a mess of socialistic pottage."

AMA Committee to Meet with Osteopaths

The House of Delegates refused to modify its interpretation of the status of osteopaths. A resolution which would have permitted physicians to teach in osteopathic schools was turned down by the House. It did recommend, however, that the Board of Trustees appoint a committee to meet with osteopathic leaders to discuss osteopathic education.

President's Commission Called Political Tool

The House of Delegates endorsed the stand taken previously by its officers in criticizing the political motives of the President's Commission on the Health Needs of the Nation at its June meeting in Chicago. The Association believes that the commission was appointed in

an adroit move to pull the question of socialized medicine out of the elections this fall.

Committee Report on Federal Medical Services

A progress report summarizing extensive research which is being conducted on federal medical services to dependents of servicemen and to veterans with non-service-connected disabilities, and the processing of patients between armed forces and veterans hospitals was submitted to the House of Delegates. The special subcommittee expects to make a complete report, with specific recommendations, in December.

Fellowship Abolished

The House of Delegates officially abolished fellowship in the Association. Provision has been made for service, affiliate and honorary fellowships to be incorporated in the membership classification. All candidates for membership in the Association will be screened by the Judicial Council prior to acceptance.

Manion Says Swollen State Shrinks People

The only way to cut down the power of burgeoning government is to reduce its spending money, Clarence Manion, dean of the law school of the University of Notre Dame, told the conference of presidents and other officers of state medical associations.

"Americans, under the swelling government of the United States, have become morally sick."

"While the state has been swelling, the people have been shrinking in proportion. Big government now looks after its little people who have lost their desire for personal liberty along with their faith in themselves.

"A swelling is always evidence of sickness underneath. Only when the people's faith in God is restored to proportions described in the Declaration of Independence will government be reduced to the simple tasks marked out for it when the Republic was born.

"To avoid the rule of tyrants, people must accept the governance of God and the personal responsibility described for each man in the 10 commandments.

"Every citizen has a responsibility in this matter which is serious in the extreme. Those who work on the walls, roof, and inside the structure of American freedom have long taken the foundation of that structure for granted. They can no longer do so. The foundation of America is being undermined.

"Particularly those Americans in positions of leadership must take immediate action to revive wide popular understanding of the American Declaration of Independence. They will learn from that document that the American government has very narrow and restricted objectives and purposes.

"To torture our government into an all-purpose instrument for the relief and regulation of all mankind is to pervert its nature and destroy its effectiveness. Now stretched far beyond its constitutional framework, American government has become thoroughly corrupt, completely confused, and frequently ridiculous.

"In such a state, it is a setup for those who frankly wish to replace it with tyranny.

"America cannot defeat despotism in Russia by establishing despotism in Washington."

The speaker laid down a three-point formula for cutting government down to manageable size. The first is to demand that governmental deficit spending be outlawed. The second is to demand a permanent ceiling on federal taxes. The third is to "resist and reduce every federal appropriation for any and every purpose."

Retiring President John W. Cline, San Francisco, set the pace early Monday morning when he told the House of Delegates:

"During the last three and a half years, American medicine has changed from an ideal whipping boy for any demagogue who wished to make a rabble-rousing speech into a strong body able to respond with sufficient vigor and effectiveness to make the profession an unwise object to attack."

Dr. Louis H. Bauer, Hempstead, N. Y., in his statesman-like inaugural address, asked one pertinent question:

"Some of medicine's critics have said, raither naïvely, that politics is a dirty hands business, and physicians, who belong to a clean hands profession, should not enter it. How, I ask you, can politics be anything but dirty if those with clean hands stay out?"

HEART BEATS

(Continued from Page 964)

the precordium, direct electrocardiographic studies on the human heart during surgical procedures, and an investigation of the value of the QT interval of the electrocardiogram in the diagnosis of acute rheumatic fever. In connection with the latter problem, Taran and others have stated that the interval mentioned is of specific diagnostic value in this disease, while other investigators have denied this claim. Since the diagnosis of acute rheumatic infection, especially when it occurs as a low grade smoldering myocarditis without other important symptoms, is often difficult, it is clear that the controversy relative to the value of the QT interval should be settled if possible.

LESSON FROM THE OYSTER

"After all, most of us can afford to take a lesson from the oyster. The most extraordinary thing about the oyster is this: Irritants get into his shell. He does not like them; he tries to get rid of them. But when he cannot get rid of them, he settles down to make of them one of the most beautiful things in the world. He uses an irritation to do the loveliest thing an oyster ever has a chance to do. If there are irritations in our lives today, there is only one prescription; make a pearl. It takes faith and love to do it."—*Kiwanis Letter*

Upper Peninsula Day in Detroit — September 24



W. S. Jones, M.D.
Menominee, Michigan

"Upper Peninsula Day" will be featured at the 1952 Michigan State Medical Society Annual Session. Some forty medical practitioners of the Upper Peninsula already have indicated that they will descend on Detroit on Wednesday, September 24 and hold a 6:00 p.m. reception and dinner to which all former Upper Peninsula men who now practice medicine in upper and lower Michigan and in other parts of the United States are invited.

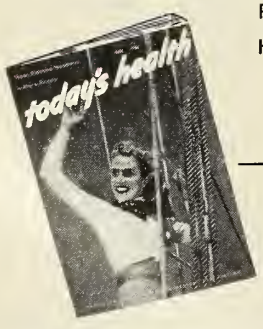
W. S. Jones, M.D., Menominee, organizer of "Upper Peninsula Day," promises all who attend a most enjoyable celebration. "We'll have everything but speeches" stated Dr. Jones. "This jolly affair at the Sheraton-Cadillac Hotel in Detroit on September 24 will be a long-remembered event!"

Among those who already have indicated they will be in Detroit for "Upper Peninsula Day" are:

E. R. Addison, M.D., Crystal Falls; S. G. Albert, M.D., Ironwood; A. B. Aldrich, M.D., Hancock; C. A. Cooper, M.D., Stambaugh; Moses Cooperstock, M.D., Marquette; J. R. Dehlin, M.D., Gladstone; J. H. Dewane, M.D., Menominee; D. C. Eisele, M.D., Ironwood; James H. Fyvie, M.D., Manistique; H. M. Harrington, M.D., Sault Ste. Marie; J. R. Heidenreich, M.D., Daggett; R. P. Hicks, M.D., Newberry; Lloyd W. Howe, M.D., Marquette; W. H. Huron, M.D., Iron Mountain; L. E. Irvine, M.D., Iron River; W. S. Jones, M.D., Menominee; Alfred La Bine, M.D., Houghton; W. A. LeMire, M.D., Escanaba; N. L. Lindquist, M.D., Escanaba; H. D. McEachern, M.D., Iron Mountain; L. M. McBryde, M.D., Sault Ste. Marie; A. H. Miller, M.D., Gladstone; B. T. Montgomery, M.D., Sault Ste. Marie; A. S. Narotzky, M.D., Ishpeming; Grover C. Penberthy, M.D., Detroit; R. C. Retallack, M.D., Iron River; A. M. Roche, M.D., Calumet; W. F. Strong, M.D., Ontonagon; J. W. Towey, M.D., Powers; R. A. Tearnan, M.D., Munising; John J. Walch, M.D., Escanaba; M. E. Wehner, M.D., Manistique; T. P. Wickliffe, M.D., Calumet; Clayton Willison, M.D., Sault Ste. Marie.

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(Continued from Page 962)

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Cancer Comment

CYTOLOGY EXAMINATIONS OF INCREASING WORTH

The vaginal cell smear (Papanicolaou) technique is continuing to prove its worth as a procedure for finding cancer in early stages. Information received recently about the cytology examination program of the Toledo and Lucas County (Ohio) Academy of Medicine reveals that more than 13,000 women in that area have had some 26,000 examinations within the past five years.

Among this group of women, 157 uterine carcinomas have been discovered, a prevalence of 1.2 per cent of those examined. On the basis of the 26,000 examinations made, this percentage falls to 0.6. This percentage of positive findings is in keeping with reports of similar examinations elsewhere.

In these examinations, there were thirty-six false positive smears (1.4 per cent) and twenty-eight false negative (1 per cent). These figures show a high degree of accuracy in the use of this method for the early diagnosis of cervical cancer. In this series, the cytological examination gave the first indication of the disease in forty, or approximately one-fourth of the cancers discovered.

Except in cases of indigency, the patient pays the physician's regular examination fee plus a small fee for the pathologist's service in examining the slides.

Approximately 70 per cent of the members of the Toledo Academy are participating in this examination program. Excluding specialists in other fields of medical practice, it is seen that a high percentage of the medical profession in the Toledo area is co-operating.

A vaginal cytology program of wider application than the one just described is getting under way in Memphis and Shelby County, Tennesse. For a three-year period, an effort will be made to get all women in that county twenty years of age and older to have a uterine cytology examination at annual intervals. This is a co-operative pilot study by the county medical society, county health department, the Department of Obstetrics and Gynecology and the Institute of Pathology, University of Tennessee College of Medicine, and the Public Health Service.

In addition to determining prevalence and incidence rates for uterine cancer in the population studied, the program will seek answers to such questions as: What is the relation between carcinoma-in-situ and cervical cancer? What is the mean duration of carcinoma-in-situ? Does all cervical cancer begin with carcinoma-in-situ? Does all carcinoma-in-situ advance to cervical cancer?

Where competent personnel is available, the cell smear method of detecting early cancer, especially in the cervix, is becoming a permanent part of diagnostic procedures in cancer-detection examinations. As more pathologists become trained and experienced in this diagnostic method, there will be fewer false positive and/or negative results. It is still sound practice to confirm all positive cell smear findings by biopsy of suspected areas. This gives the patient every advantage of the best scientific means yet developed for the accurate diagnosis of malignant growths.

In the light of present knowledge, the control of cancer, especially of cancer in readily available sites, can best be brought about by periodic examination of which the cytological examination is an important part. Cancer of the cervix, a site easily examined, should be detected in such early stages of development that not more than 10 per cent should be in the incurable class when first discovered. Today, the over-all salvage of cervical cancer is considerably below 50 per cent. In cancer of no other site, with exception of skin, are conditions so favorable for early diagnosis as in cancer of the cervix.

More women now accept pelvic examinations than ever before. With the increasing use of cell smear examinations, the salvage of cervical cancer should increase to a point where deaths from this form of malignant disease would approach a minimum.

A solitary lump in a woman's breast may be the initial sign of lymphosarcoma, rather than a mammary cyst, fibroadenoma, or carcinoma.



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Editorial Comment

MICHIGAN STATE MEDICAL SOCIETY ANNUAL SESSION
SHERATON-CADILLAC HOTEL—DETROIT
September 24-25-26, 1952

A GOOD DOCTOR IS A GOOD CITIZEN

The physician who consistently fails to attend hospital staff meetings, or who takes no active part in the affairs of his Medical Society, is hardly in a good position to criticize either the hospital or the Medical Society. By failing to make his voice heard, he must share the blame for any faults, failures, or deficiencies.

Likewise, the physician who fails to *register* and *vote* is not in a good position to complain about corruption, taxes or Governmental policies which he finds obnoxious. By failing to fulfill one of the vital duties of citizenship, he must share the blame for any black spots in the affairs of the community, the State or the Nation.

The right to *register* and *vote* which is both a privilege and a duty in a Nation of free men, was never more important than it is right now. Fundamental issues which transcend the usual party politics, and which will affect the future of every American, call for a clear-cut decision by the entire voting population. Be sure that you play your rightful part in that historic American decision.

To be a good doctor—first be a good citizen. *Register* and then *Vote*. And of equal importance, see that your family does likewise.—*The Bulletin, Saginaw County Medical Society,* May, 1952.

LET THEM EARN!

John B. Martin, Jr., auditor general of Michigan, a Republican candidate for United States senator, does not believe that earnings of beneficiaries of social security payments should be limited as they now are.

The law provides that a person receiving social security benefits forfeits them if he earns more than $50 a month to supplement his social security payments.

"We ought to encourage them to work as far as they are able, not penalize productivity and force them into idleness," Mr. Martin said in a speech in Iron Mountain.

"Today we need all the production we can get."

Furthermore, the beneficiaries of social security are entitled to benefits they receive—regardless of other income.

They and their employers have paid for those benefits—just as an individual buys an endowment insurance policy.

They should cash in on their social security endowment policies just as they would cash in on such a policy taken out with a privately owned insurance company.—The *Port Huron Times Herald.*

WHY RETIREMENT AT SIXTY-FIVE?

Dr. William Haber, professor of economics at the University of Michigan, sees no sense in compelling men and women to retire at the arbitrarily fixed age of 65.

The combination of compulsory retirement and the increasing life span in the United States creates a serious condition, Dr. Haber believes.

In 1967, he said, we can expect to have in our population twice as many men and women more than 65 years old as we have today—and if we make them all quit work at 65, we will have to spend at least twice as much tax money as we are now spending to support those over 65.

We agree with Dr. Haber. We believe that a man or woman who has given satisfactory service to an employer for years should be permitted to go on working as long as he continues to give satisfactory service.—*Port Huran Times Herald.*

DOCTORS DIAGNOSE SOCIETY

Chicago is honored by the presence of some 14,000 physicians here to attend the 101st convention of the American Medical Association.

A notable aspect of the meeting is the fact that the doctors are not confining their interest strictly to the technical side of their profession. As educated men of wide experience, they are also taking a sharp look at the society in which we live, diagnosing its shortcomings and prescribing remedies in the field of politics and economics.

The AMA particularly resents the intrusion of government into their professional affairs. For this, the association has been the target of left-wing attacks which has led some people to conclude, without considering the evidence, that the "medical trust" is trying to bar the road to progress.

The most casual reflection on the spectacular improvement in the national health refutes this charge. The convention itself will be one long recital of new refinements and discoveries leading to quicker, surer and cheaper cure of disease.

It is, of course, on the question of how the

(Continued on Page 978)

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DOCTORS DIAGNOSE SOCIETY

(Continued from Page 976)

benefit of these discoveries can be brought to the greatest number of people that controversy rages. The quack prescription is socialization of medical care that would lower, rather than increase, average standards.

We might agree that the doctors themselves should not have the last word on all matters of medical economics. They have been wrong, as when they objected initially to hospital insurance plans.

But as vitally interested parties, they are entitled to a major voice in such matters. It is encouraging to note that they are giving them an important place in the convention proceedings.—*Chicago Daily News,* June 9, 1952.

THEY KNOW WHAT THEY GET

Advocates of national health insurance or socialized medicine will find little comfort in the fact that 86 million American are now covered by voluntary hospital insurance, and another 67 million have some kind of medical protection.

In other words, more than half the population is covered by some voluntary plan and the number is increasing at the rate of about 12 per cent a year. Gradually, as new voluntary plans are made available to public participation, most people who want protection will be able to have it.

And how about the cost? The attractive feature of a voluntary plan is that the participant knows exactly how much it will cost him and exactly what benefits he can expect.

If prepaid health is taken over by a bureaucratic agency of the Government, the individual never will know what his bill, represented by taxes and assessments, will amount to, or what benefits he can claim when those decisions are reserved to the politicians.—*Detroit Free Press,* July 2, 1952.

REGARDLESS OF POLITICS HOUSE ACTION IS SOUND

No doubt politics figured in the lopsided 360-22 house vote Tuesday for increased social security pensions. The vote-conscious congressmen were deluged with protesting mail after they failed to pass the bill a month ago.

But whatever their reason for passing it in the second time up, they had a good one in the actuarial and economic soundness of the measure.

Social security payments are not government "benefits" as they often are labeled. They are pensions earned and paid for by workers and their employers. The social security setup operates just like most other pension programs, except that it is run by the government instead of a private company.

The pension insurance premiums are paid on a percentage basis. As wages and salaries go up in dollars, so do the premiums paid in. Actuarially, the percentage is the ruling factor of soundness for both the premiums and the payments. The increased pensions voted by the house merely carry the percentage of inflation over from income to outgo—the ratio is restored to balance.

The house retained in the bill a discrimination against persons who have the desire and ability to keep on working after reaching the pension age of 65. The bill deprives them of their full pension if they earn more than $70 a month. Yet the premiums are set up to provide full pensions at age 65. The working older persons thus are shortchanged, and in some cases at least the nation is sure to suffer the loss of production it might as well have had from workers over 65. The senate would do well to lift this uneconomic discrimination from the bill before passing it.—*Battle Creek Enquirer News,* June 19, 1952.

SOCIAL SECURITY

There is joker in the law, unnecessary, cruel and basically dishonest, which should be eliminated promptly by the Congress. The Social Security pension recipient cannot earn more than fifty dollars per month without forfeiting his allotment check, although he may receive and retain any amount of income from investments without being subject to such forfeiture.

The Social Security law has been criticized on the ground that it tends to inculcate in the individual the feeling that "The Government" should support him after retirement. Admitting such criticism for the sake of argument, the overall results of the law, in our judgment, definitely are beneficient. Certainly, Social Security is here to stay and injustices and inequities in the law should be ironed out promptly.

We described as "dishonest" that feature of the law limiting the earnings of the ex-employe after his removal from the payroll of his former employer. We hold such limitation basically dishonest because the retiree and his employer have actually purchased this retirement income and paid for it in good hard cash. To say that the Social Security tax (and it is a tax) is paid by the individual and his employer with knowledge of its legal limitations is to beg the question. We maintain that the state has no moral right to impose upon an individual a compulsory retirement system without actually furnishing in return a quid pro quo in the form of a pension check he has purchased and actually paid for with the collaboration of his employer. —Editorial, *The West Virginia Medical Journal,* July, 1952.

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Federal Medicine

SOCIAL SECURITY BILL PASSES: DISABILITY SECTION REQUIRES ACTION NEXT YEAR

On Saturday, July 5, Congress enacted *H.R. 7800,* the social security bill, after Senate-House conferees had written into it a new section on disability *which in effect postpones final decision on this controversial question until next year.* This section is designed to waive payment of old age and survivors insurance premiums by persons who are totally and permanently disabled. The House bill gave the Federal Security Administrator unusual control over medical examinations for the purpose of determining disability. *American Medical Association had objected to this as an unwarranted grant of power, but had not objected to other parts of the bill.* The Senate bill had no provision at all for waiver of premiums.

Now only the President's expected signature is needed to make law the following compromise, worked out by conferees and approved by both houses:

1. A new disability section, giving states rather than the Federal Security Administrator control over medical examinations for the purpose of determining total and permanent disability. It is understood the procedure would be similar to that now in effect for medical examinations of needy permanently and totally disabled persons who wish to be certified for Public Assistance grants. BUT—

2. The section can't go into effect until Congress again has acted on it. This section (but not others) will terminate on June 30, 1953—one day before the date set for filing of the first claims. This self-contradictory arrangement was worked out to insure that full hearings could be held next year before the disability section could become operative. Chairman George had demanded that his Senate Finance Committee have this opportunity.

3. Other provisions, not subject to termination with the disability section, include monthly increases of $5 (12:5 per cent) whichever is the larger, for O.A.S.I. beneficiaries; the right of a retirement age worker to earn $75 per month without sacrifice of pension (present law is $50, House asked $70, Senate $100); persons temporarily in military service to receive social security credit at the rate of $160 per month earnings; U. S. payments to states for aid to needy aged, blind and disabled raised $5 per month, payments for dependent children $3, but states are not required to pass these payments along; these Public Assistance increases terminate September 30, 1954.

The bill's only provisions dealing with medical matters, known as Section 3, were revised to retain waiver of premiums and to provide medical determinations of permanent and total disability at the State rather than the Federal level. However, this section is wholly inoperative as it expires June 30, 1953, the day before applications for benefits could be received. Several of the conferees were quoted in the press as saying that the effective and cut-off dates being nearly simultaneous would make it possible for the new Congress to hold hearings next year and draft amendments, if found desirable, before the effective date.

Congressman Reed (R.-N. Y.)), who opposed the original wording of Section 3, advocated the adoption of the conferees' report "because it eliminates the objectionable socialized medical feature of the bill as it passed the House. . . . The House permanent and total disability provision is retained in name in the conference report, but it is completely inoperative. . . . The whole section will automatically expire on July 1, 1953, unless affirmative action by the Congress to re-enact this provision is adopted. In substance the whole permanent and total disability section which was vigorously opposed by those of us who are interested in preserving the integrity of the medical profession in this country and who are opposed to the extension of federal authority over the medical profession, has been effectively eliminated."

S. 3314 DEPARTMENT OF HEALTH

By Mr. O'Conor, of Maryland, June 11. *To establish a Federal Board of Hospitalization.* Referred to the Committee on Government Operations.

Comment: After the Senate Armed Services Committee refused to favorably report S.1140, to create a Department of Health, this bill was introduced as a substitute. It would establish a 10-member Federal Board of Hospitalization. Four members would be appointed by the President from private life who are persons learned in the medical arts, and six from the government, being the Secretaries of Defense and Interior, the Administrators of Veterans' Affairs and General Services Administration, the Director of the Bureau of the Budget and the Surgeon General of the Public Health Service.

It would be the duty of the Board to make recommendations to the President respecting improvements in and better utilization of federal hospital facilities and personnel. They would seek to prevent overlapping and duplication of services and overbuilding of facilities. Such questions as need for existing or additional facilities and the location of them would also be fields in which recommendations would be made. The Board would promulgate rules and regulations for efficient utilization of doctors, nurses and related personnel for all federal facilities except that such rules would not interfere with established policies and practices of the Veterans Administration in the operation of VA facilities nor involving transfer of medical and hospital personnel from such agency unless such transfer has been approved by the reference committees of the Senate and House.

H.R. 8148 MEDICAL EXPENSE DEDUCTIONS FROM INCOME FOR TAX PURPOSES

By Mr. Clemente, of New York, June 10. *To increase the amount of deduction allowed, for income-tax purposes, for medical and dental expenses.* Referred to the Committee on Ways and Means.

Comment: Present Internal Revenue laws provide that deduction may be made for medical expenses which exceed 5% of adjusted gross income. This bill would seek to increase such allowable deductions by removing any reference to the 5%, thus permitting taxpayers to begin deductions of the first dollar of medical expense each taxable year.

S. 2552

Providing for the appointment of women physicians to the Medical Corps of the Armed Services. The House June 16 voted approval of a conference report in which the osteopathy amendment was deleted. The provisions of the bill as passed by the Senate were, therefore, agreeable to the House. The Senate June 17 approved the conference report, thereby clearing the legislation for Presidential action. The conferees agreed with the military that employment of osteopaths is not satisfactory because an osteopath is not qualified for the entire field of medical practice. It was cited that a lone medical officer's work aboard ship or at an outpost includes every phase of medical practice. Existing law authorizes the appointment of osteopaths in the *Medical Service Corps* of the Army and Navy—S.2552 would authorize their apointment in the Medical Corps.

H. CON. RES. 19

Physical Fitness Program. The House Committee on Interstate and Foreign Commerce June 9 held a one-day hearing on this bill which would authorize the establishment of a physical fitness and training program in the interest of national security. Urging its passage were Representative Hedrick (D.-W. Va.) and Mrs. Hedrick, Mr. and Mrs. Bernarr Macfadden of New York City, and John Core of Huntington, West Virginia. A statement was filed by General Hershey, Director of the Selective Service System, in which he pointed out that the total rejection rate since June 28, 1948, approximated 45%. At one point in his statement General Hershey said, "I believe the explanation lies not so much in deteriorated health of the youth of the nation as it does in the failure on the part of those charged with the use of manpower to use the manpower of the nation to full advantage within each individual's physical and mental capabilities."

BRICKER'S S. J. RES. 130

This piece of legislation deserves active support by all organizations and individuals interested in preserving our Constitution and thwarting those who seek to control and dictate our domestice legislation through international treaties.

Bricker's resolution is as follows:

"*Constitutional Amendment*—No treaty or executive agreement shall be made respecting the rights of citizens of the United States protected by this Constitution; nor shall any treaty or executive agreement vest in any international organization or foreign power, any of the legislative, judicial, or executive powers of the United States. No treaty or executive agreement shall abridge the laws of the United States or of the several States unless Congress by act shall so provide. Executive agreements, unless sooner terminated or expressly authorized by Congress, shall automatically expire 6 months after the end of the term of office for which the President making the agreement shall have been elected. On request of the succeeding President, Congress may extend the life of any such agreement for the duration of the term of such President."

This extremely important amendment if passed and if ratified by three-fourths of the States, would save this country from control by alien-thinking Nations and by Presidents who seek to rule through Executive Orders and through secret agreements with foreign powers.

Constitutional amendments are ordinarily slow to pass. This one could be speeded if:

(1) Organizations and individuals would communicate their views at once to the members of the Senate Judiciary Committee headed by Senator Pat McCarran (D., Nev.).

(2) Organizations in each State would propose State legislation to ratify the Bricker amendment, if and when passed by Congress. Speed is essential.

(3) Civic organizations throughout the Nation would publicize S. J. Res. 130.—Margaret Shearon, June 5, 1952.

SENATOR MURRAY AT GENEVA ILO CONFERENCE; BRICKER'S S. CON. RESOLUTION 83

There is now before the Senate Committee on Labor and Public Welfare a resolution of the utmost importance to every American and especially to those who oppose State Socialism. On June 5 Senator Bricker introduced S. Con. Res. 83 which deals with the International Labor Organization and should be acted upon by Congress *immediately* to prevent Senator James A. Murray and Philip Kaiser, Assistant Secretary of Labor, who are now representing the United States in Geneva at the ILO Conference, from voting favorably on the Convention for Minimum Standards of Social Security (including socialized medicine for the entire world). The Resolution states:

"Whereas the delegates appointed to represent the Government of the United States at conferences of the International Labor Organization have from time to time voted for the adoption of conventions which may prejudice the Federal-State character of our constitutional Government; and

"Whereas such delegates have also voted for conventions designed to promote a collectivist state and a controlled economy in place of our system of free competitive enterprise; and

"Whereas certain conventions which are supported by the United States Government delegates are inconsistent with legislation enacted by the Congress and by the several States, or are in conflict with clear legislative intent evidenced by rejection of proposals of the kind contained in such conventions; and

"Whereas there is a convention to be voted on in June, 1952, designed to impose binding international standards for programs affecting the purely domestic affairs of our citizens, including old-age and survivors'

(Continued on Page 1094)

AMA ASKS MEDICAL STUDENT DEFERMENT FROM DRAFT AND RESERVE SERVICE

The American Medical Association, in a statement filed with the Senate Armed Services Committee, requests that the reserve reorganization bill (H.R. 5426) include a section deferring medical students from the draft and reserve service until they complete their medical training. Such deferment, AMA said, would apply also in the event Congress puts a universal military training program into operation.

The AMA also asked the committee to insure that (a) no undue advantage accrue to armed forces hospitals by allowing internships and residency service in these installations to count against total reserve obligation, and (2) authority be vested in a *national civilian board* to insure proper distribution of medical and other health reserves between civilian and military needs under a UMT program. The reserve act, which has passed the house, reorganizes the reserve components of the three military services.

The National Guard Association reversed its position and gave detailed testimony objecting to the bill. A spokesman said the association had supported the bill in the House in anticipation of enactment of a UMT law. Among those testifying in favor of H.R. 5426 were the Reserve Officers Association, the Secretary of Labor, the director of Selective Service, Defense Department and and military officials, the American Federation of Labor, Marine Corps Reserve Officers Association and Air Reserve Association.

ARMY MEDICAL SERVICE OFFERS POSTGRADUATE COURSES

The Army Medical Service will conduct 17 short postgraduate courses in surgery, psychiatry and other subjects of major medical importance during the last six months of 1952, the Department of the Army announced today.

The instruction is open to both military and civilian physicians and is the broadest program of postgraduate professional training of this type ever sponsored by the Army Medical Service, according to Major General George E. Armstrong, MC, Army Surgeon General. The courses will be given at six large Army teaching hospitals and the Armed Forces Institute of Pathology in Washington, D. C.

Postgraduate training is designed to ensure that all Army personnel continue to receive the finest professional medical care obtainable. The courses are an integral part of the Army's career plan for medical officers under which physicians are encouraged to continue their professional education. The instruction also serves to keep medical officers in outlying installations abreast of new developments and to foster the growth of teachers in the Army Medical Service.

The largest number of spaces in each course is reserved for Army Medical Corps officers on active duty. Smaller quotas have been established also for Army Reserve and National Guard medical officers and Air Force medical officers. Civilian physicians serving in other Federal agencies or in private practice will be enrolled on a space-available basis.

Eligible applicants must have attained one of two qualification levels. Those considered to be at Level I are board-certified or board-qualified physicians, chiefs or assistant chiefs of services in hospitals and other officers well advanced in the study of their specialty. Applicants with Level II qualifications include officers partially qualified in a specialty, those with a special interest in the subject or ward officers or unit surgeons responsible for medical treatment in the specialty concerned.

Instruction will be offered in the following subjects:

Arthritis and allied diseases at Army and Navy Hospital, Hot Springs, Ark., 1-5 December. Open to 35 Level I physicians from all Army areas. This course will cover the history.

Current trends in internal medicine at Letterman Army Hospital, San Francisco, 20-24 October. Open to 50 Level II physicians from the Fourth, Fifth and Sixth Army areas.

Internal medicine at Walter Reed Army Hospital, Washington, D.C., 3-8 November.

Clinical electrocardiography and conference on heart disease at Fitzsimons Army Hospital, Denver, 10-15 November.

Pathology of ionizing radiation injuries at the Armed Forces Institute of Pathology 20-24 October.

Forensic pathology at the Institute 1-5 December.

Clinical pathology at Walter Reed 8-12 December.

Exfoliative cytology and cancer detection at Walter Reed 22-26 September.

Physical medicine at Walter Reed 1-3 October.

Psychotherapeutic medicine at Fitzsimons, Letterman and Walter Reed 25 August-6 September.

Pulmonary diseases at Fitzsimons 22-26 September.

Radiology at Walter Reed 14-16 October.

Tumor surgery at Brooke Army Hospital, Fort Sam Houston, Tex., 13-17 October.

Physiological considerations in general surgery at Fitzsimons 1-3 December.

Surgery at Walter Reed 17-21 November.

Reserve medical officers should apply to their Army area commander, while National Guard physicians should write the National Guard Bureau in Washington. Civilian physicians in the Federal service or in private practice should apply to the appropriate hospital or installation commander.

POPULARITY OF EGGS

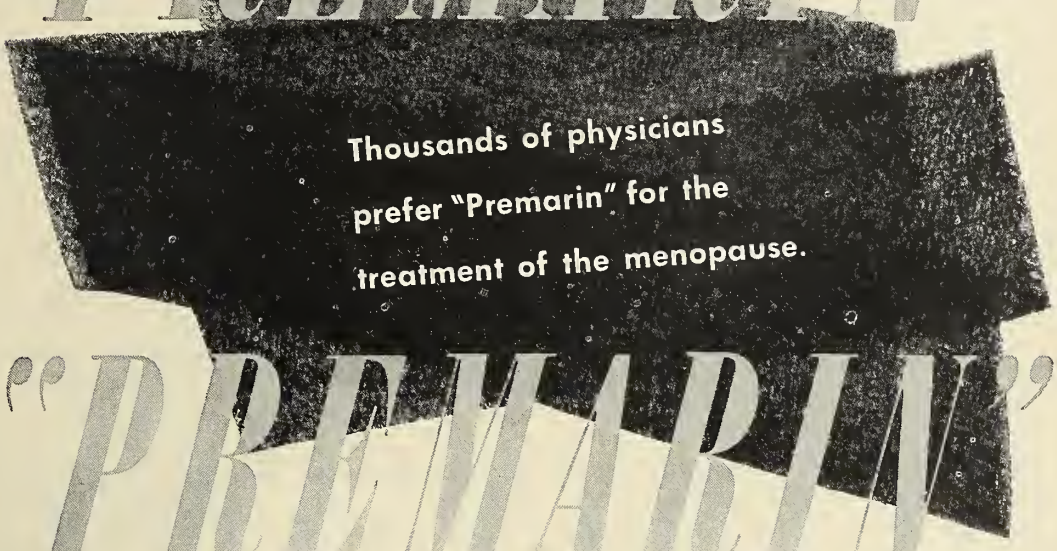
The per capita consumption of eggs in this country is now 376 per year. This is an increase of twenty-six per cent from 1935-1939. This food contains twelve amino acids and may approximate a biologic value of a hundred per cent. In addition to supplying protein of high quality, the egg is the source of vitamins of the B group, A, D, E, biotin, pantothenic acid and choline, as well as iron, phosphorus, calcium and copper. With meat prices continually advancing, it seems likely that the product of the humble hen will gain further in favor.—*Good Health*, January, 1952.

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MINERALS		VITAMINS	
*CALCIUM	1.12 Gm.	*ASCORBIC ACID	37 mg.
CHLORINE	900 mg.	BIOTIN	0.03 mg.
COBALT	0.006 mg.	CHOLINE	200 mg.
*COPPER	0.7 mg.	FOLIC ACID	0.05 mg.
FLUORINE	3.0 mg.	*NIACIN	6.7 mg.
*IODINE	0.7 mg.	PANTOTHENIC ACID	3.0 mg.
*IRON	12 mg.	PYRIDOXINE	0.6 mg.
MAGNESIUM	120 mg.	*RIBOFLAVIN	2.0 mg.
MANGANESE	0.4 mg.	*THIAMINE	1.2 mg.
*PHOSPHORUS	940 mg.	*VITAMIN A	3200 I.U.
POTASSIUM	1300 mg.	VITAMIN B_{12}	0.005 mg.
SODIUM	560 mg.	*VITAMIN D	420 I.U
ZINC	2.6 mg.		

*PROTEIN (biologically complete)	32 Gm.
*CARBOHYDRATE	65 Gm.
*FAT	30 Gm.

*Nutrients for which daily dietary allowances are recommended by the National Research Council.

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Goiter Prevention in Michigan

Results of Thirty Years' Voluntary Use of Iodized Salt

By J. K. Altland, M.D., and Brock E. Brush, M.D.

Lansing, Michigan

THE STATE OF MICHIGAN, situated as it is in the Great Lakes endemic goiter belt, offers an unusual opportunity for the study of the disease and the effects on its incidence of iodized salt used as a prophylactic measure. This challenge was accepted by the Michigan State Medical Society and the Michigan Department of Health thirty years ago, and the story of their accomplishments in goiter prophylaxis since that time is comparable to the classical discoveries of preventive medicine in many other fields. A review of their experience clearly shows that endemic goiter is truly one of the easiest known diseases to prevent.

Iodine was used unknowingly in the form of sea weed and sea sponge by the ancient Chinese and Greeks. Rogers[18] of Palermo in the year 480 A.D. observed that sea sponges were of benefit for goiter, and Pericles in the 16th century believed that goiter was due to a deficiency of minerals in the drinking water.

In 1812, Courtois of France isolated the element iodine and described its unusual color and vapors. It was soon recommended for the treatment of goiter and Switzerland used iodized salt as a prophylactic measure as early as 1840. Chatin, in 1850, showed the iodine content of the soil and water to be low in goiter areas and noted also that goiter was improved by sea sponge ash, and in 1896 Bauman[1] discovered that iodine was concentrated in the thyroid gland.

The work of Marine[12] and his associates begun in the year 1907 in the study of goiter and its relation to iodine marks the beginning of the newer and more practical knowledge of this relationship. They showed that when brook trout were maintained without iodine, goiter invariably developed and that the addition of a small amount of iodine to the water caused the goiters to decrease in size. This was shown to be true also in the case of cattle, sheep, pigs and other animals. The results of a deficiency of iodine were soon recognized in the field of animal husbandry and Hart[4] described the malady of "hairlessness in newborn pigs," and Kalkus the "weakness" and "big neck" in newborn lambs and colts. Iodine was soon added to the rock salt in these areas and later other minerals such as manganese, iron, cobalt and copper. It is difficult to believe, but true, that the animals have received better therapy than the people in many goiter areas.

In 1916 Marine and Kimball[12] studied the incidence of goiter in the school children of Akron, Ohio. This study of 10,000 children continued for four years and showed that only 0.2 per cent of those who added a small amount of iodine to their diet developed any enlargement of the thyroid gland, whereas 27.6 per cent of those who did not add iodine exhibited recognizable overgrowth of the gland. Of the group that showed increase in size on first inspection, 79.7 per cent showed a decrease when the iodine deficiency was corrected.

Marine[11] (1928) as a result of his studies believed that goiter is a compensatory hypertrophy of the thyroid gland resulting from a relative or absolute deficiency of iodine. This deficiency of iodine may be due to: (1) factors which bring about an abnormally low intake of iodine; (2) factors which interfere with absorption or utilization of an otherwise adequate intake; (3) factors which increase the needs of the body for the iodine containing hormone. The chief factor



Fig. 1. Four counties chosen for survey.



Fig. 2. Examination of school children by field medical staff of Michigan Department of Health.

under 1 is the lack of iodine in the food and water supply. Factors under 2 are becoming better known as the complex inter-relationship of the glands of internal secretion is becoming better understood. Under 3, it is well known that the thyroid is prone to enlarge at puberty, during menstruation, during pregnancies and with certain infections. Enlargement in these instances may demonstrate the need for more thyroxin when an inadequate supply of iodine for its manufacture is available.

Endemic Goiter Studies in Michigan

The studies of endemic goiter in Michigan[17] begun in 1923, have been a co-operative effort of the Michigan State Medical Society and the Michigan Department of Health with the guidance of Dr. O. P. Kimball and the co-operation of salt manufacturers and wholesale and retail grocers. The Medical Society has had an iodized salt committee for the purpose of continuous study of the problem and the early work of Drs. D. M. Cowie, Roy D. McClure, O. P. Kimball, C. C. Slemons, R. M. Olin and H. Towsley is noteworthy.

In 1923, a survey of ground water supplies in Michigan was made to determine their iodine content. On the basis of the findings of this survey, four counties were chosen for study. These counties showed the greatest differences in iodine content of their ground waters and were considered representative of a cross-section of the population of the state. They were Houghton, Wexford, Midland and Macomb Counties, located on a line running diagonally from the northwest to the southeast corners of the state.

All of the school children in these four counties were included in a goiter survey. They were examined for thyroid enlargement by members of the field medical staff of the Michigan Department of Health consisting of four clinicians and two medical inspectors. The examining group was trained by Dr. O. P. Kimball, using Lansing school children, to make sure that criteria and decisions were as uniform as possible. Dr. Kimball's classification included only visible enlargements of the thyroid, divided into three classes, 1, 2 and 3, depending upon the extent of enlargement. Exophthalmic goiters were considered separately and none were found in the survey. An organizer made all arrangements with the schools and a nurse accompanied each physician.

The total number of boys and girls examined in the four counties was 31,612. Of these, 14,914 (47.2 per cent) showed goiter[17] (Table I). While the incidence was high in all counties, it was greatest in Houghton County (64.4 per 100

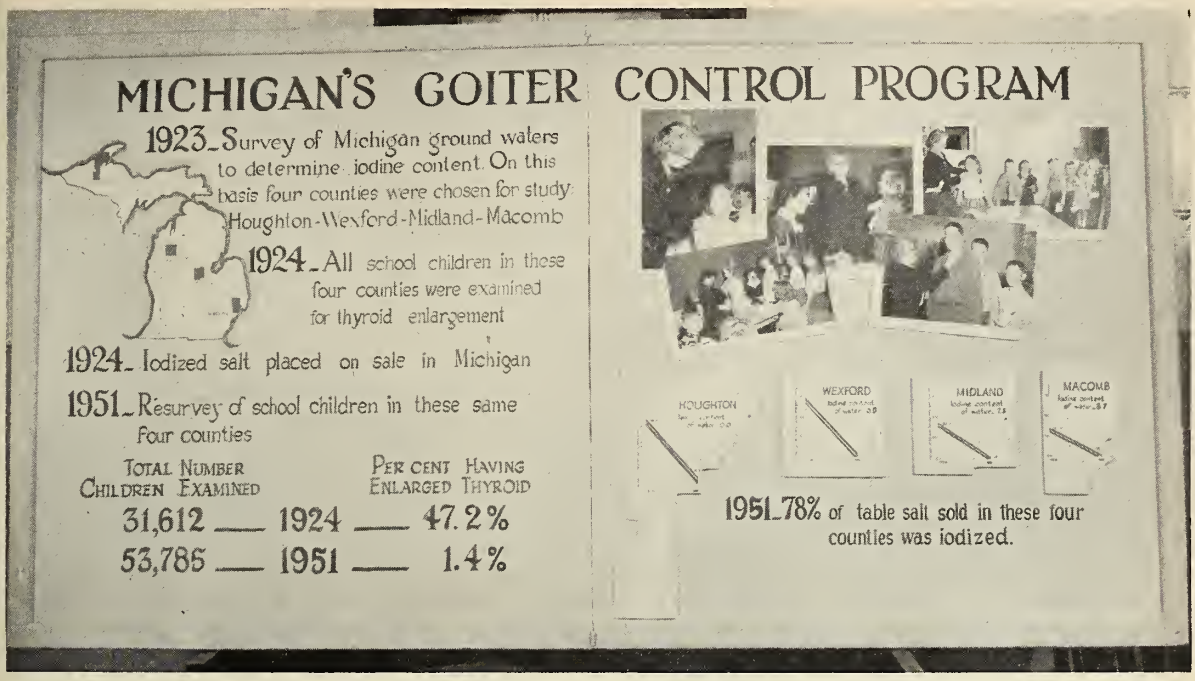


Fig. 3. Results of surveys in 1924 and 1951.

TABLE I. THYROID AND SALT SURVEYS
Houghton, Wexford, Midland and Macomb Counties
1924 and 1951

County	Thyroid Survey						Salt Survey
	Total Examined		Abnormal Thyroids				Per Cent Iodized Salt Sold (pkg. 10 lb. or less)
			1924		1951		
	1924	1951	No.	%	No.	%	1951
Houghton	13,723	6,930	8,835	64.4	575	8.3	55%
Wexford	3,984	3,811	2,216	55.6	13	0.3	53%
Midland	3,645	8,751	1,191	32.7	17	0.2	66%
Macomb	10,258	34,293	2,672	26.0	182	0.5	58%
Total (4 counties)	31,612	53,785	14,914	47.2	787	1.4	58%

examined) and least in Macomb County (26 per 100 examined).

The results of the survey showed beyond a doubt that there was a correlation between a lack of food iodine and the incidence of simple goiter, as the goiter incidence was inversely proportional to the iodine content of the ground water supply in the areas studied.

At the completion of the survey, a program of goiter prevention was undertaken by the State Medical Society and the State Department of Health. Iodized salt was selected as the medium of correcting the iodine deficiency because it was felt that a household necessity like salt would solve the problem for both urban and rural areas. The co-operation of the Salt Manufacturers Association was enlisted and the iodized salt committee of the State Medical Society worked with them on the many technical problems involved in manufacturing an iodized salt acceptable from the standpoints of content, stability and cost.

The use of iodized salt has always been on a voluntary basis in Michigan. At no time has there been a law requiring that all salt sold in the state be iodized. A statewide educational campaign accompanied the introduction of iodized salt and this has continued ever since, with sporadic intensification.

At the resurveys in 1928, 1935 and 1951, information was also obtained as to whether the children had been using iodized salt regularly, irregularly or not at all.

The resurveys in 1928 and 1935 showed a remarkable reduction in goiter among those using

iodized salt with an over-all reduction of the incidence from 38.6 per cent to 8.2 per cent. In those who had used iodized salt the incidence was reduced to between 2 and 3 per cent, while in the group who had not used it the incidence remained at from 25 to 35 per cent. A valuable study was possible in the mining town of Calumet where in 1932-35 during the depression two-thirds of the families were on relief and used non-iodized bag salt. There was an increase of 43 per cent in the number of goiters.

In 1951, the school children in the same four counties (Houghton, Wexford, Midland and Macomb) were examined for abnormal enlargement of the thyroid gland. This was a co-operative activity between the goiter committee of the Michigan State Medical Society and the Michigan Department of Health. Six physicians, again using standardized criteria, examined 53,785 pupils. The results of these examinations showed 1.4 per cent (787) with abnormal enlargement of the thyroid. This varied from 8.3 per cent in Houghton County to 0.2 per cent in Midland County.

At the same time, a survey of retail and wholesale grocery outlets in the four counties was carried on by a member of the staff of the Michigan Department of Health to determine what proportion of the salt sold was iodized, and the availability of iodized salt in the normal channels of trade. Results indicate that over half of the salt sold in packages of 10 pounds or less (presumably for human consumption) was iodized. In the individual counties the range was from 53 per cent to 66 per cent with an average of 58 per cent for all four counties.

Table I shows the results of the examination of school children in 1924 and in 1951 and the 1951 survey of the sale of iodized salt.

Summary of Findings in Four Counties

It will be noted that comparison of the 1924 and 1951 survey findings show the following:

The prevalence of abnormal thyroids was 47.2 cases per 100 examined in 1924 and 1.4 in 1951. In other words, there were approximately thirty-five times as many abnormal thyroids found in 1924 as in 1951.

Houghton County—The incidence of abnormal thyroids was 64.4 per 100 examined in 1924 and 8.3 in 1951. There were approximately eight times as many abnormal thyroids in 1924 as in 1951.

Wexford County—The incidence of abnormal thyroids was 57 per 100 examined in 1924 and 0.3 per 100 in 1951. There were approximately 190 times as many abnormal thyroids in 1924 as in 1951.

Midland County—The incidence of abnormal thyroids was 33 per 100 examined in 1924 and 0.2 per 100 in 1951. There were approximately 165 times as many abnormal thyroids in 1924 as in 1951.

Macomb County—The incidence of abnormal thyroids was 26 per 100 examined in 1924 and 0.5 in 1951. There were approximately fifty-two times as many abnormal thyroids found in 1924 as in 1951.

Discussion

The fact should be emphasized that at no time has there been a law in Michigan requiring that all salt sold be iodized. The Michigan Department of Health and the Michigan State Medical Society have carried on a program of education and advice in the form of news articles, radio programs, placards, pamphlets and health talks. Experience has shown that unless this problem is kept continually before the people there is a great tendency for the sale of iodized salt to decrease. The survey of grocery stores indicated that iodized salt is not always displayed prominently and in some instances has to be especially ordered. This problem has been met in Switzerland and Canada by having all table salt enriched with iodine. The report of J. F. McClendon[13] showed the remarkable results of goiter prophylaxis with iodized salt in Switzerland.

Curtis and Firtman[3] have performed iodine balance studies and as a result of these the Food and Nutrition Board of the National Research Council gives the daily requirement of iodine for an adult as 0.15 to 0.30 milligrams. Iodized salt meets this requirement and is especially important in adolescence and during pregnancy.

No ill effects have been noted from the use of iodized salt. The small amount of iodine used has not, according to the American Dermatological Society, caused any difficulty in those with a tendency to acne, an objection which was once raised. The stabilizers used by the manufacturers insure a uniform mixing of the iodine, and the Canners' Association has stated that there is no disadvantage in using iodized salt in all types of

food canning. DiMone of the Division of Syphilis at Johns Hopkins Hospital reported that 10,000 patients were treated with large doses of iodides with no case developing iodine hyperthyroidism.

Levin,[10] using draft board statistics, has shown that the incidence of exophthalmic goiter throughout the United States is proportional in every locality to the incidence of endemic goiter. McClure[15] reported that since the introduction of iodized salt in Michigan coincident with the great dropping off in the number of enlarged thyroids there has been a dropping off in the number of operations for hyperplasia and adenomata of the thyroid in seven large Michigan hospitals.

Among the interesting findings of the 1924 study was the tremendous difference in incidence of goiter in areas only a few miles apart. At Mount Clemens, 26 per cent of the children had enlarged thyroid, while at Romeo only twelve miles distant 75 per cent of the children had goiter. The water supply at Mount Clemens contained twenty-five parts of iodine per billion while at Romeo there was not a trace of iodine in fifty liters.

The wide use of an enriched block salt by stock farmers has undoubtedly been a factor in some of these essential elements finding their way into the food and thus has helped reduce the incidence of endemic goiter.

Conclusions

1. Endemic goiter has become practically nonexistent in Michigan since iodized salt was put on sale in 1924.

2. Salt can be iodized accurately, efficiently and inexpensively.

3. Experience in Michigan indicates that no ill effects result from the use of iodized salt.

4. Experience in Michigan also indicates that toxic nodular goiter and diffuse goiter are less apt to occur when there has been no previous enlargement of the gland as occurs in endemic goiter.

5. If the use of iodized salt is voluntary, departments of health and medical societies must carry on a continuous campaign of public education reiterating the importance of buying and using iodized salt as a preventive of endemic goiter.

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MSMS

CIVIL DEFENSE

The MSMS Committee on Emergency Medical Service urges Miehigan county medical societies to have the staffs of hospitals in their counties appoint a member of the staff to develop a plan for staff participation in civil defense aetivities.

The role of hospitals in civil defense is a most important one. By appointing a member of the staff of a hospital to assist in the development of a civil defense plan, the function of staff members in an attack would be ascertained. Such a plan of individual responsibility among staff members could fit into similar plans of other hospitals and would facilitate the proeurement of necessary and specific medieal personnel for disaster areas.

Send the name of the staff member(s) of your hospital(s), who will develop the civil defense staff participation program, to William Henry Gordon, M.D., Chairman, MSMS Emergency Medical Service Committee, P.O. Box 539, Lansing, Michigan. Dr. Gordon's committee is available for any assistance to county society emergency medical serviee committees.

Three Cases of Cerebral Palsy

Electroencephalographic and Pathologic Correlation

By H. R. Prentice, M.D.,
H. Sidney Heersma, M.D., and
John M. Hammer, M.D.

Kalamazoo, Michigan

THIS PAPER was stimulated because of the observation within a single year of three children, each presenting a clinical picture suggestive of cerebral palsy but each having a different underlying pathologic change.

Case Reports

Case 1.—R.F., a boy aged fourteen months, was the first child of a healthy seventeen-year-old mother, and the birth history was normal.

When first seen on September 29, 1950, he was rigid, unable to sit up, and unresponsive beyond crying when handled. His only activity consisted in jumping movements, with straightening out of the body and blinking. He had no actual convulsive seizures. The head was large. The eyes failed to follow or react to light. By all possible criteria, he was blind. All reflexes were hyperactive.

An electroencephalogram October 2 (Fig. 1, a and b) showed extremely slow activity with a spike focus in the right occipital area. Bipolar recordings showed extreme flattening of the pattern on the left side and in both fronto-parietal leads, with persistence of higher voltage activity and spiky components in the right parieto-occipital and occipito-temporal leads.

A pneumoencephalogram (Fig. 2) was interpreted as showing failure of filling of the ventricular system and excessive air in the subarachnoid spaces and basilar cisternae. An x-ray diagnosis of severe brain atrophy was made.

An arteriovenous fistula in the neck had been made on September 28, and the jugular vein had been found to be only about one-sixth its expected size. No improvement followed, as the fistula closed spontaneously forty-eight hours after the operation, and on October 3 a bone flap was turned down to hunt for a possible sub-dural hematoma. At this time 650 cc. of fluid were removed from the cranial cavity, under the impression that a large hematoma or cyst was being dealt with. At operation it was noted that a thin, shiny membrane just inside the dura enclosed this fluid and that only a little brain tissue could be seen, along the base of the skull and on the opposite side from the bone flap.

The next day there were spells of cyanosis. A few days later fever developed and the operative site bulged. Rigidity became worse. After a stormy course, the child expired on October 15, 1950. At autopsy, the appearance of a moderately hydrocephalic head contour was noted. An accumulation of about 300 cc. of fluid was found between the dura and the brain. The latter filled only about one-third of the cranial cavity. There was almost complete agenesia of both parietal lobes.

The cerebral hemispheres were almost replaced (Fig. 3) by a great cavity, open on both sides, having a roof formed by a thinned corpus callosum and a floor formed by the basal nuclei and brain stem, with rudimentary anterior and posterior lateral ventricle horns. The frontal and occipital tips and cerebellum were present. It appeared that the lepto-meninges and dura had been complete over both sides. The optic nerves were 2 mm. in diameter. Other cranial nerves and the pituitary gland appeared normal. The other organs of the body were essentially normal.

This was a case of spasticity based on maldevelopment.

Case 2.—R.A., a boy, born on February 12, 1948, was delivered by forceps and revived with difficulty. He was cyanotic and received oxygen for three weeks. A hematoma was tapped some time in the early weeks of life.

Electroencephalograms were done at intervals. The first one was on February 26, 1948, at the age of fourteen days (Fig. 4a) and showed only somewhat low amplitude.

A second record was done at twenty-one days of age (Fig. 4b). This record showed a definite asymmetry, the right side being of lower amplitude.

A third record was taken at six months of age (Fig. 4c). The waking record showed the right side to be of lower voltage and somewhat slower in frequency. There was also some slowing on the left, possibly due to increased intracranial pressure. It was noted that during sleep there were no 14-per-second spindles on the right side.

The last record was taken at fifteen months of age (Fig. 4d). The waking record showed frequency modulation normal for age but failure of frequency response on the right side. This record did not show marked variation from the last previous study.

Both monopolar and bipolar methods were employed at the time of each examination.

A recent pneumoencephalogram had shown cortical atrophy.

Up to the time the child was admitted to the hospital on March 22, 1950, for an arteriovenous fistula, in the hope of improving cerebral circulation, he had failed to develop ability to sit alone and did not even turn over alone. All extremities were somewhat stiff; stretch reflexes were present—also bilateral Babinski reflex and ankle clonus. Knee and ankle jerks were over-active. Nutrition was good.

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Presented at the meeting of the Central Association of Electroencephalographers, Ann Arbor, Michigan, April 12, 1951.

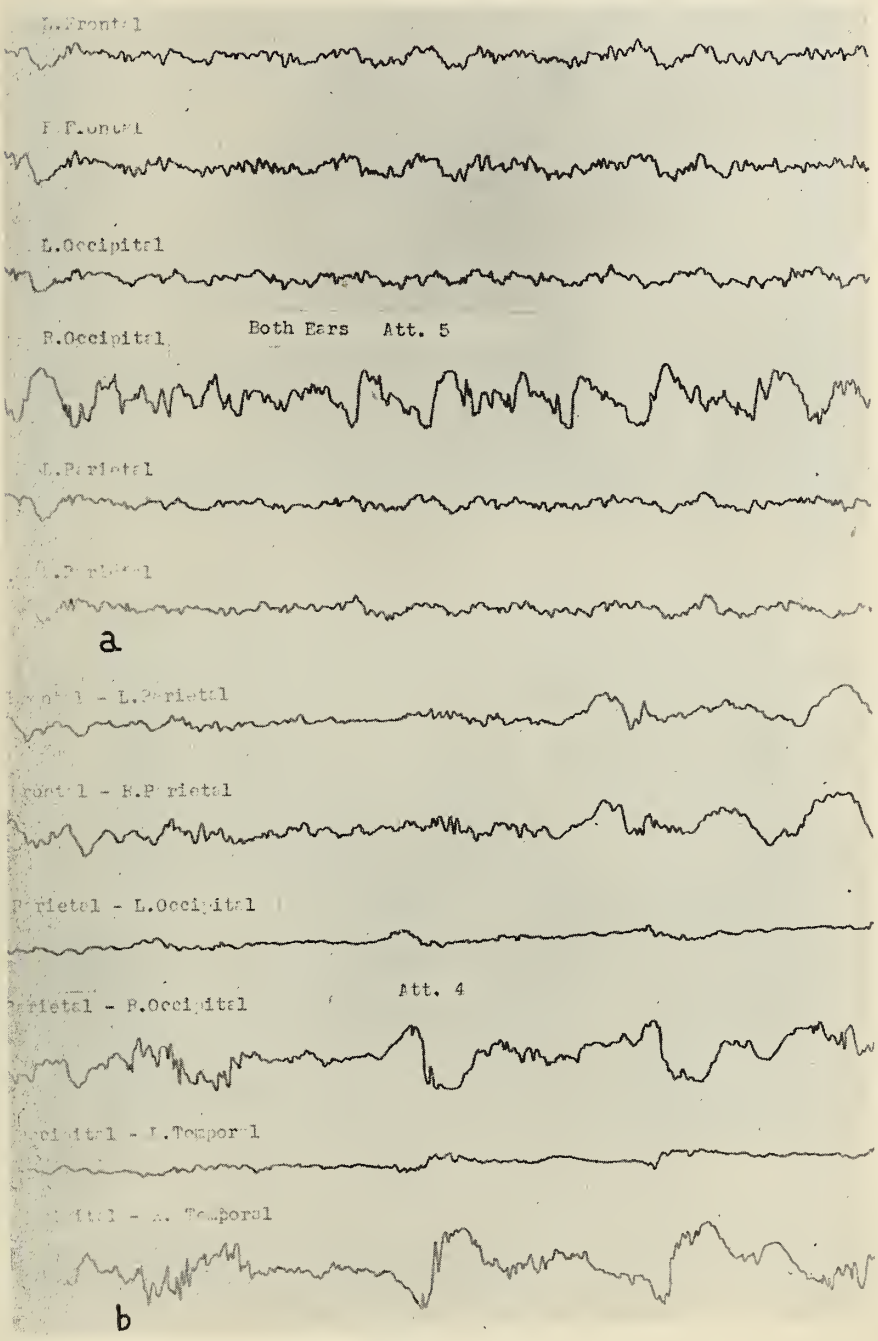


Fig.1, a and b.

A right carotid-jugular fistula was done on March 23. A day later, it was recorded that the spasticity seemed less, especially on the left side. The left Babinski reflex was less marked; clonus had disappeared, and knee jerks were considered normal. It was felt that there was improvement in the legs by the time he left the hospital on April 2, 1950, to the degree that he was trying to crawl and would try to support his own weight and attempt steps when held on his feet. He would also play with objects with his right hand, but the left was not used. He remained apparently well, attending a local school for children having cerebral palsy, but had several bouts of dyspnea, accompanying upper respiratory infections. On October 10, 1950, he suddenly expired at school. The only significant finding as a probable cause of death was marked dilatation of the right side of the heart (which is one of the recognized dangers following arteriovenous fistulas), together with a degree of chronic passive congestion of the lungs such as is seen in prolonged cardiac decompensation of adults.



Fig. 2.



Fig. 3.

The head showed an accumulation of about 15 cc. of yellow fluid in a membrane-lined space on the right side, extending over nearly the whole hemisphere.

The dura on this side was about twice the normal thickness (Fig. 5). The right cerebral hemisphere was no more than two-thirds the bulk of the left, and only the tips of its temporal and frontal lobes were spared in the atrophic process. In the occipital area, the atrophic convolutions extended onto the base. Over nearly all the atrophic area was the golden-brown pigmentation of old hemorrhage. The venous sinuses of the

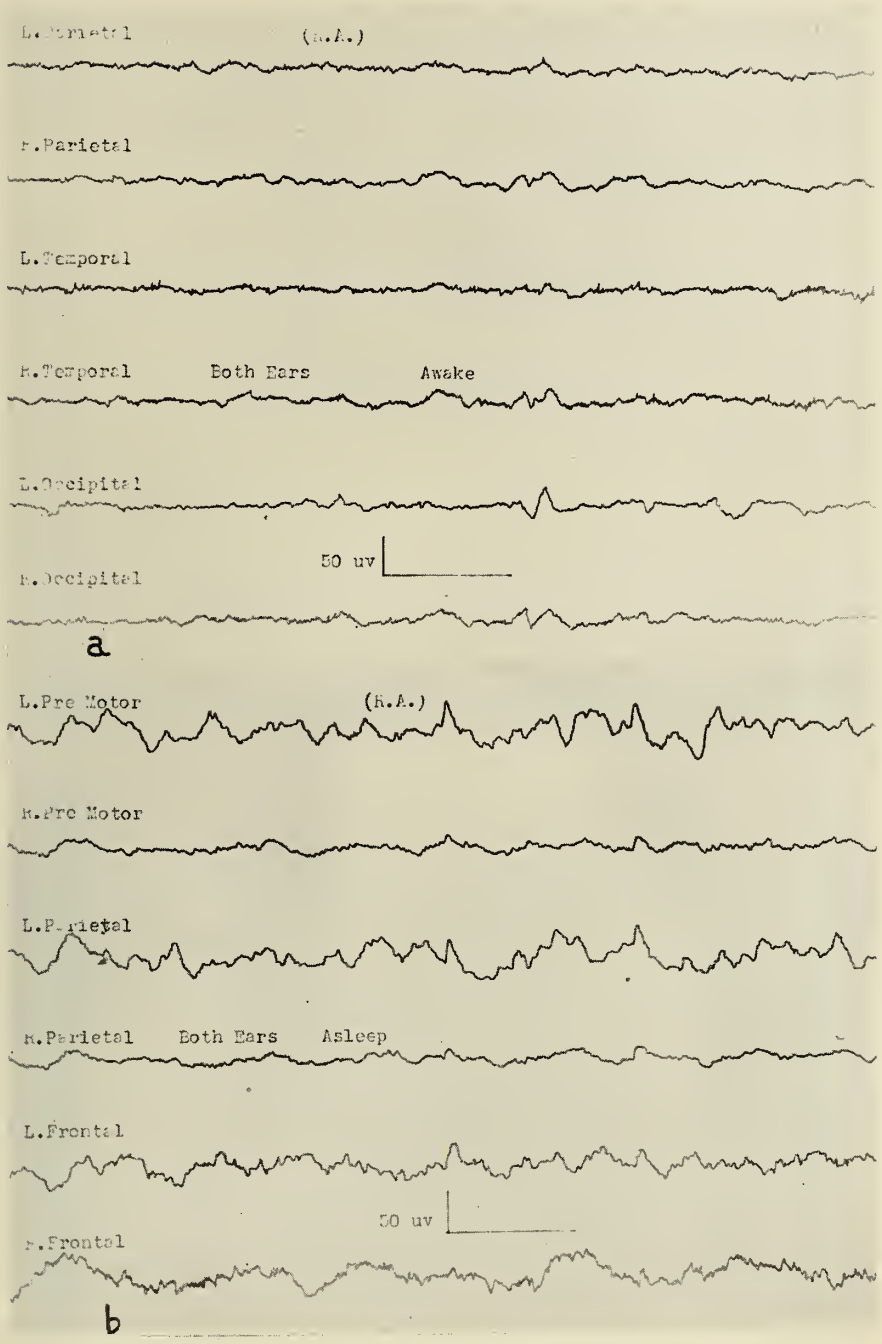

L.Parietal
(E.A.)
R.Parietal
L.Temporal
R.Temporal
Both Ears
Awake
L.Occipital
50 uv
R.Occipital
a
L.Pre Motor
(E.A.)
R.Pre Motor
L.Parietal
R.Parietal
Both Ears
Asleep
L.Frontal
50 uv
R.Frontal
b

Fig. 4, a and b.

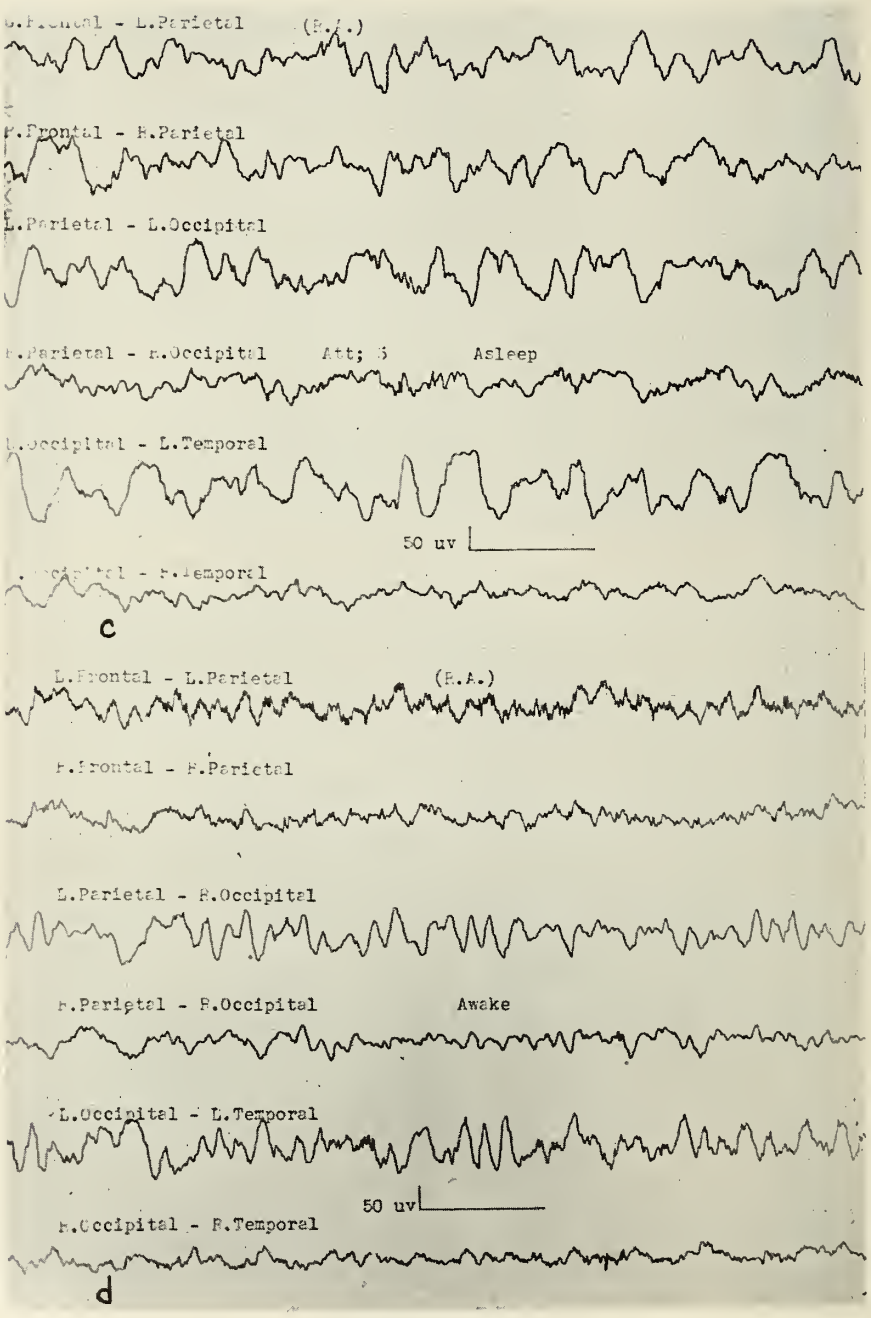

L.Parietal - L.Occipital
Asleep
50 uv
L.Frontal - L.Parietal
R.Frontal - R.Parietal
L.Parietal - R.Occipital
Awake
L.Occipital - L.Temporal
50 uv
R.Occipital - R.Temporal
c
d

Fig. 4, c and d.

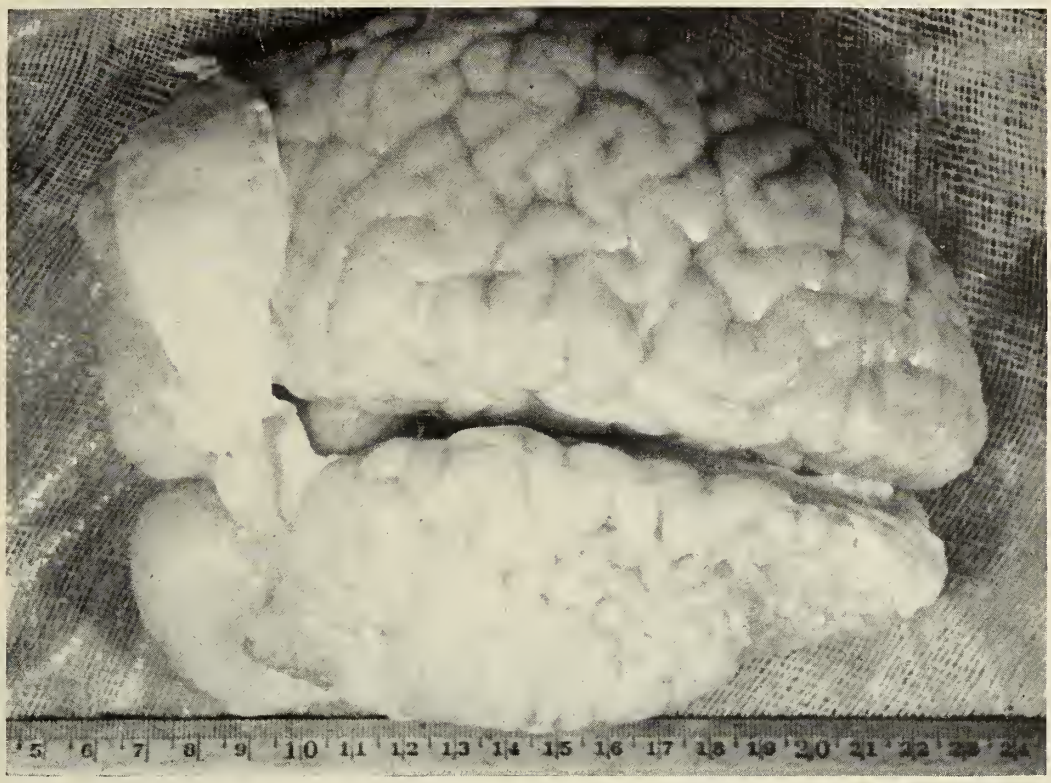


Fig. 5.



Fig. 6.

dura were congested, probably a secondary effect of the arteriovenous fistula.

This was a case of cerebral palsy due to a subdural hematoma occurring at the time of birth.

A pneumoencephalogram on August 11 showed internal hydrocephalus and cortical atrophy (Fig. 6).

An electroencephalogram on August 2, at the age of eight and a half months, showed an extremely slow

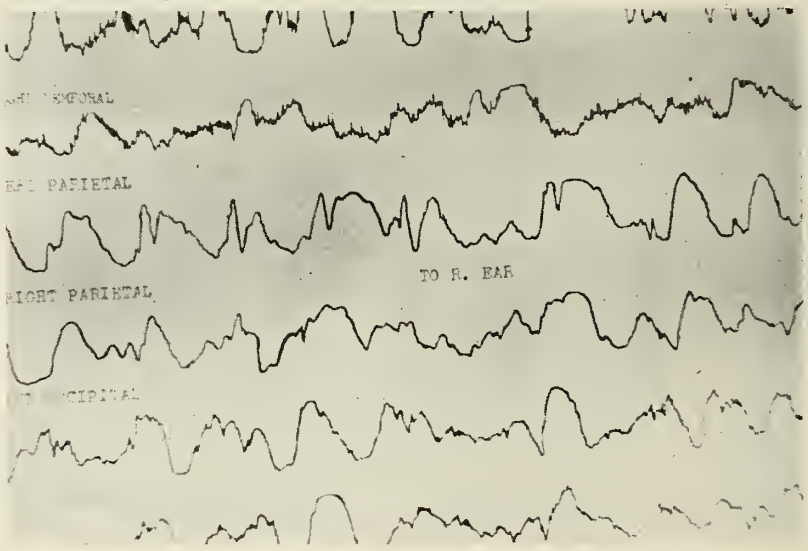


Fig. 7.



Fig. 8.

Case 3.—H.W., a boy, aged one year, had been born normally in November, 1949, but had been subject to convulsions since birth. He was known to have been seen at the University Hospital in Ann Arbor in February, 1950, with a diagnosis of convulsive disorder. At first, phenobarbital had been helpful in controlling the seizures, but by July, 1950, when first seen at the local hospital, he was either drowsy, or, when awake, having frequent convulsions.

record, with spikes occurring irregularly in all leads while awake. During the time of the record there occurred seizures, consisting of jerking of the whole body, more marked on the right side. The eyes were open and rolling slightly. Bursts of 1 to 3 per second waves were seen, and spiking accompanied the jerks. The spikes were most marked in the left parietal area. The sleeping record varied little from the waking pattern. There was still spike activity from the left frontal,

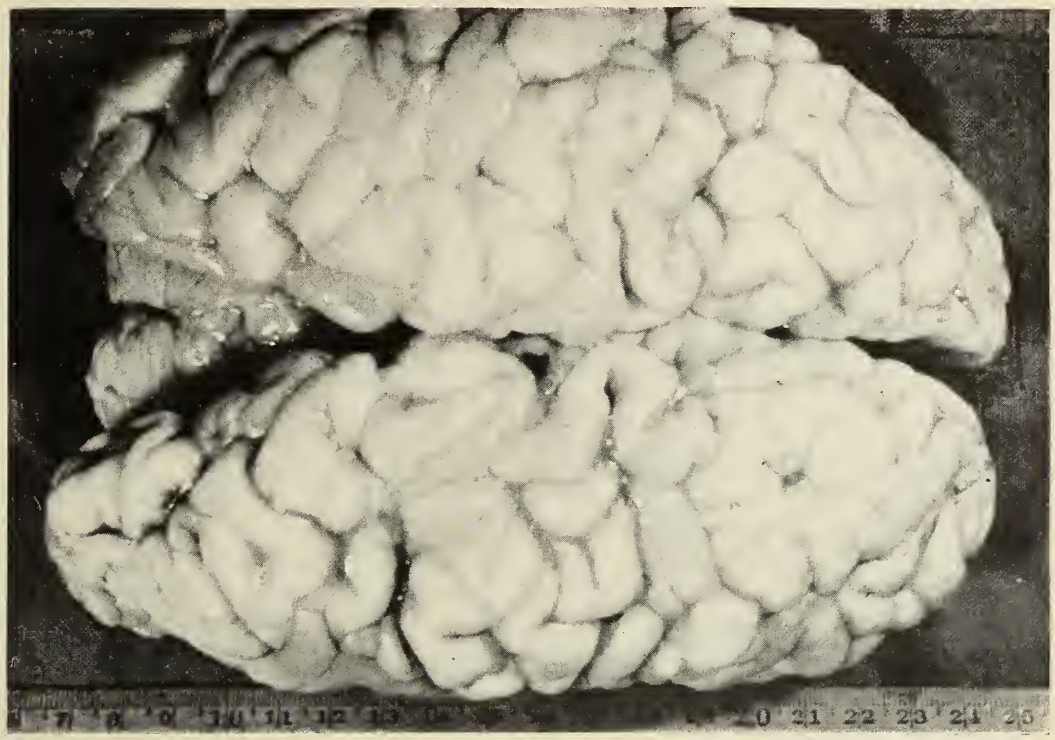


Fig. 9a.



Fig. 9b.

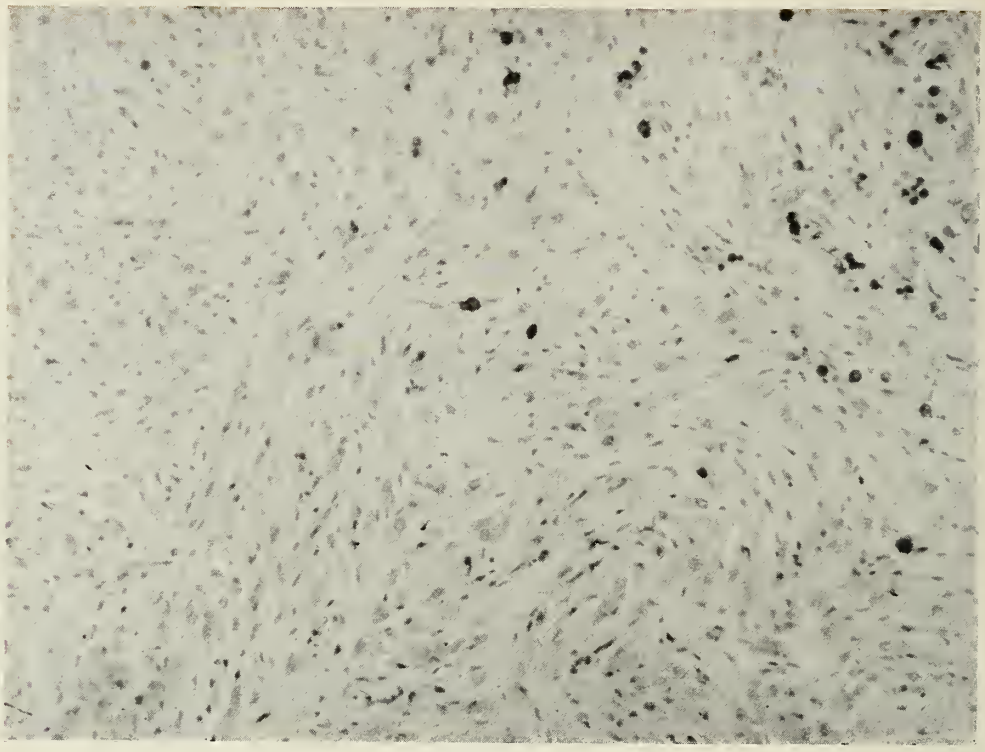


Fig. 10a.

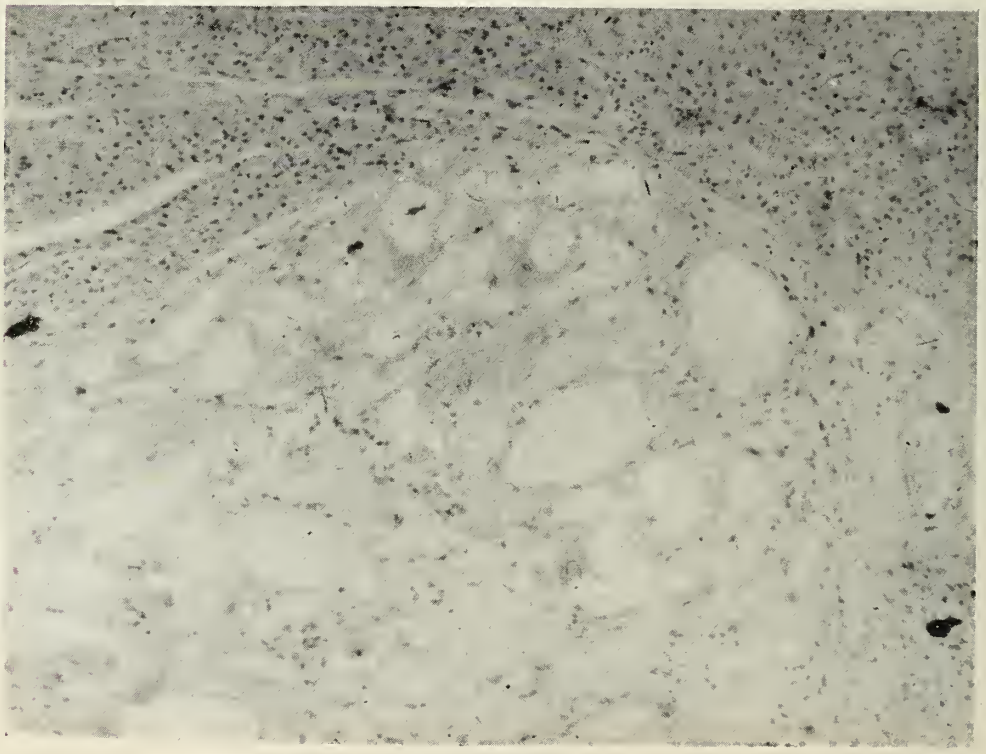


Fig. 10b.

parietal and occipital areas, unaccompanied by clinical seizures (Fig. 7).

On August 17, 1950, a common carotid-internal jugular fistula was made on the right side. Following this procedure, the child continued to have seizures, unaffected by sedation. He was re-admitted to the hospital with an upper respiratory infection on December 8, 1950. The arteriovenous fistula was functioning; the scalp veins and retrobulbar veins were dilated, and there was a right proptosis. Spinal fluid pressure was 300 mm. of water.

A retrograde angiogram (Fig. 8) showed the dye shunting across the torcular Herophili and down the opposite jujular vein. A lateral view also showed an intracranial shunt through the inferior petrosal and cavernous sinuses to the retrobulbar veins of the right eye. On January 4, 1951, an occipital craniotomy was done. During this procedure, the torcular was opened and the patient expired.

At autopsy, on opening the skull, the walls of the sinuses were found abnormally thickened, and the shunt at the torcular was confirmed.

The pattern of the cerebral convolutions was abnormal, showing umbilication in some areas (Fig. 9, a and b). The consistency of the cerebral tissue, except for small portions of the temporal and occipital tips, was firm and nodular to feel. The cerebellum was normal to feel. The lateral ventricles were dilated. From their floors and roofs arose numerous firm, semi-translucent, yellowish white structures; round or nubby in form; a few of which formed finger-like bridges between roof and floor of ventricle. The cut surface of the hemispheres felt finely nodular, and sub-miliary, firm, opaque white nodules stood out from the softer tissue. The third and fourth ventricles were not dilated.

The heart showed right-sided dilation and weighed 66 grams (normal for age: 45 grams). The endocardium looked white, and the lining of the left ventricle showed a nest of white lesions resembling those on the cut surface of the cerebral white matter. The lungs showed chronic passive congestion.

Microscopically, the firm areas of the brain showed masses of plump astrocytes; scattered small round cells and some hyalin bodies (Fig. 10a). The picture varied from section to section, but was consistent with a diagnosis of tuberous sclerosis. The heart showed rhabdomyomatous foci which are characteristic in this disease (Fig. 10b). No tumors were found in other organs and no skin lesions had developed in this very young patient.

The family history of this child revealed that one brother died at the age of five months with a thyroid tumor; one sister, aged six, was a cretin, and the mother had hypothyroidism, which during the course of this child's life had required 3 grains of thyroid extract daily for maintenance.

This is an instance of a familial disease of the brain producing the clinical picture of cerebral palsy.

(Continued on Page 1003)

The Clinical Management of Axillary Tumors

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TUMORS OF THE axilla, although not common, are certainly not rare. Recent clinical experiences at St. Joseph's Mercy Hospital, Ann Arbor, Michigan, have brought to our attention problems in the diagnosis and treatment of these tumors of which we were quite unaware. To improve our own knowledge of the subject and to evaluate the problem, the literature was reviewed and the clinical material seen in the last ten years studied.

There has been relatively little written in the English language literature concerning axillary tumors. The European and South American literature has many articles, the majority of which are case reports only. Almost every type of lesion has been reported as occurring in the axilla. These reports vary from the single instance of axillary menstruation in the male[21] to the rare occurrence of echinococcus cyst of the axilla,[6] to the not uncommon primary tumors which may arise from any of the components of the axilla, to the rather common problem of axillary carcinoma in the female without a clinically demonstrable primary. A summary of the literature, somewhat handicapped by the lack of foreign periodicals, has allowed us to compile a clinical experience which has clarified the incidence of the various types of tumors and brought out certain principles of treatment which we feel are worth repeating. It is not the purpose of this paper to present a tabulation of all axillary tumors collected from the literature but rather to consider the problem of the clinical management of these tumors. Our own case reports are relatively few. They do illustrate the commoner types of tumors not so frequently reported and also point out some of the errors in treatment.

For the purpose of this paper those cases were eliminated from consideration in which the axillary tumor was only one part of a general disease or lymphadenopathy. On a clinical basis axillary tumors were classified as (1) inflammatory,

(2) primary, (3) metastatic, primary either known or unknown.

The axillary adenopathy seen with infections of the upper extremities or shoulder girdle are seldom a problem in either diagnosis or treatment. However, when there is no history of a primary infection or when an axillary tumor persists after the primary lesion has healed, doubts begin to trouble the mind of the responsible clinician. One wonders if this is not some rare specific infection which would be quickly cured if only the correct diagnosis could be remembered. Actually there is little cause for worry. Of the fungus infections, those that do invade the axilla tend to go by fairly obvious direct extension and probably never show a healed primary lesion with a residual axillary tumor. Of the specific infections tularemia is the only one which commonly leaves an axillary mass after the primary is healed. In fact, it is said that 50 per cent of the ulceroglandular type of tularemia may never show a primary, the bacteria having entered through the intact skin. The primary, when present, will heal in a few weeks but the glands may persist for months or years. The history and blood studies will very frequently confirm the diagnosis.[38] The indications for drainage of suppurating tularemic glands are not clear cut. Drainage will shorten the clinical course and relieve the patient from discomfort of the axillary mass. Unfortunately, too frequently the diagnosis is not considered preoperatively, and the material taken at operation will be described by the pathologist as very suggestive but not diagnostic of tuberculosis. This report will start a train of investigation, expensive to the patient and resulting in an indefinite diagnosis but nevertheless marking the patient for life as a suspect for tuberculosis. In our limited experience with axillary tumors over one-third, or thirteen, were shown to be on an inflammatory basis. Twelve of the thirteen were nonspecific; the thirteenth was considered to be on the basis of tularemia. This diagnosis was reached, however, after surgical drainage and after the pathologist had reported tuberculosis. Of the thirteen cases, seven had no history of a primary lesion and in four others the primary had long since been healed. If any conclusions can be drawn concerning axillary tumors that are shown to be on an inflammatory basis, it would be that the majority will be nonspecific in etiology but that tularemia must always be considered. We are aware that axillary adenopathy secondary to a chancre of the hand and unilateral tuberculous axillary adenopathy have not been mentioned. That is because both are now extremely rare.

Primary tumors of the axilla have been reported as arising from all the possible constituents of the axilla. For clinical consideration there can be placed in one group the following solid tumors: lipomas, fibromas,[34] fibrosarcomas, [7,8,28] sarcomas, [35,37,39] rhabdomyosarcoma,[7] and tumors of neurogenic origin.[20,30] In reviewing the literature of case reports, the outstanding fact is the very bad prognosis for the malignant tumors of this group, which are all of a sarcomatous type. This prognosis is directly related to the adequacy of the surgery at the first operation.[7,8,30] Inadequate surgery has been the rule, due both to the limited ability of the first surgeon and to the operation, limited to a local excision. All axillary tumors should be considered malignant until proven otherwise. Simple removal of the tumor should be done only when frozen section has shown the tumor to be benign. Finochietti[15] of the Argentine emphasized this in 1938 with an article on the technique of radical axillary dissection. Unfortunately the great majority of these cases are seen by a competent surgeon only after continued growth of the tumor has made further surgery impossible. Leriche[30] of Lyon, France, and his colleagues for many years have advocated complete forequarter amputations for these seemingly hopeless tumors. The indications for and the results of such radical surgery may be questioned but one cannot question the necessity of an accurate diagnosis by frozen section that will lead to radical axillary dissection at the first operation.

In a second group of primary axillary tumors we have placed the cystic tumors. Axillary hygroma or lymphangioma has been frequently reported. Dowd[13] in 1913 reported ninety-one hygromas of the neck and 35 of the axilla. Goetch[19] in 1938 reported 10 of the neck and two of the axilla. There have been many other reports.[4,5,11,15,22,23,36] These tumors are usually noticed shortly after birth but may remain quiescent for years. Attention is usually called to them by a sudden increase in size associated with tenderness and a temperature elevation. On this basis over one-half of these tumors reported were considered to be inflammatory, and so incision and drainage was done. The sera-sanguineous fluid found and

the prompt recurrence indicated the correct diagnosis. Unfortunately the second operator was then faced with an infected wound to complicate a long and tedious operation. Excision of an axillary hygroma should not be attempted unless the operator is able to do and the patient prepared for radical axillary dissection.

Occasionally Hodgkins disease may be localized to the glands of the axilla. This has been reported and a remission gained by surgery.[7,15]

Our own experience with primary tumors of the axilla has been meager. Other than benign tumors, one sarcoma was excised locally because the operator felt that the tumor was well encapsulated. In five months continued growth of the tumor was evident but no further surgery could then be done. This brought to our attention the need for radical surgery at the first operation. In one instance Hodgkins disease was localized to the axilla and the patient has remained well for over one year after axillary gland dissection. In two other cases the axillary tumor was the most prominent adenopathy of this disease. We have had no experience during the period studied with axillary hygroma, although seven cases of lymphangioma elsewhere in the body were seen.

The impression to be gained is that primary malignant tumors of the axilla are not uncommon. The bad prognosis of these tumors has been associated with inadequate surgery. A frozen section diagnosis to be followed immediately by a radical axillary dissection is necessary. Axillary hygroma or lymphangioma is a relatively common tumor, frequently misdiagnosed as inflammatory and requiring the equivalent of a radical axillary dissection to remove the tumor.

Metastatic neoplasm to the axilla is seen clinically both when the primary is known and when a primary is unsuspected. Theoretically metastasis may come to the axilla from any part of the body but actually it is rare for the primary to be from other than the upper extremity or shoulder girdle. Carcinoma of the skin of the upper extremity is well known to metastasize to the axilla[31] and needs little comment. Melanoblastoma of the shoulder girdle may appear in the axilla months or years after the primary lesion was excised.[14] In the absence of other metastasis radical axillary dissection is indicated as a satisfactory remission may be gained. This has occurred twice in our experience.

The problem of this subject most frequently met is that of axillary carcinoma in the female without a primary that can be demonstrated clinically. American literature is meager on this subject, although recently there have been several articles published under the general title of "Hidden Carcinoma of the Breast."[12,25,27] European and South American literature contain many case reports and several series of such cases. There are controversial points which unfortunately cannot be settled by these reports but do point to a definite plan of treatment which should be better understood.

The existence of supernumerary nipples and occasionally a small or even fully developed breast is well known to exist along the milk line. Carcinoma has been reported in such a third breast.[2] The existence of aberrant breast tissue outside the milk line and without an identifying nipple is not so well known. Aberrant breast tissue with carcinomatous change has been reported at the zypoid process, at the clavicle and lateral chest wall[3] but most commonly in the axilla. Activity of this breast tissue during pregnancy may be a source of much discomfort to the patient.[1] There are many earlier reports of tumors said to have arisen in axillary breast tissue.[9,24,26,29,32,33,40] The largest series is that of Razeman and Bizard, who reported in 1929 seventy-six cases, of which twenty-six were benign and fifty malignant. Fitzwilliams[16] in 1945 refers to thirty cases of carcinoma, of which six are reported in detail. Razeman and Bizard, in discussing the treatment of this condition, found that of thirteen patients who had axillary dissection only, ten demonstrated recurrence within six weeks to two years. Of the ten with recurrence, seven later demonstrated a primary in the breast, much to the author's surprise as none had been found on clinical examination. They then advocated radical mastectomy because a thorough axillary dissection could not be done otherwise, and because they realized the possibility of an unsuspected primary. Of the nineteen cases adequately followed, all were dead within two years. Since that time (1929) there have been many reports.[10,12,17,18,27,31,42] Unfortunately in the majority of the cases reported, the authors at the time of operation were unacquainted with this condition. Therefore only a local exision of the axillary tumor was done. Subsequently either a continuing growth in the axilla occurred or a primary in the breast became evident. Unfortunately by this time distant metastases

were well established. A remarkable exception to these previous reports is that of Weinberger and Stetten.[41] They describe five cases of axillary tumor in which no primary was clinically found in the breast. Nevertheless in all cases radical mastectomy was done after the pathologist reported metastatic carcinoma instead of a primary axillary neoplasm. Careful examination of the gross specimen showed the primary in each case, although very small. To date the course in each of these cases has been satisfactory, in contrast to the report of Fitzwilliams, who found only one possible cure in thirty cases and that after a forequarter amputation done as a secondary operation. He attributes this miserable result to inaccurate diagnosis leading to inadequate surgery.

From this review of the literature and our own experience we are still not certain what per cent of the cases presenting axillary carcinoma have a "hidden primary" in the breast and what per cent arose in aberrant axillary tissue. One would think that the report of the pathologist on the axillary contents would indicate breast tissue in which carcinoma had developed or lymph nodes replaced by metastatic carcinoma and so settle the question. Unfortunately in many of the case summaries a detailed pathologist's report is not included. "Hidden primary carcinoma of the breast" is not a bad term inasmuch as the primary may be so small as to require multiple thin slices of the breast to demonstrate it. Undoubtedly many such primaries, as in our two cases, were missed because only routine sections of the breast were examined. There are, however, well-documented cases in which the primary definitely did arise in aberrant breast tissue.[3,10]

From the standpoint of clinical management of axillary carcinoma the disastrous results reported with inadequate surgery clearly show that radical mastectomy must be done at the first operation and not when further growth has demonstrated a breast primary or an axilla widely invaded. An adequate axillary dissection in the female cannot be done without a radical mastectomy. So, be the primary in the axilla or in the breast, radical mastectomy after frozen section diagnosis must be done.

In our own experience there were four benign tumors in aberrant axillary breast tissue seen during the ten years studied. In two additional cases the diagnosis was carcinoma and radical mastectomy was done, but no primary found in the sections of the breast. However, the pathologist's report would indicate metastatic carcinoma. The search for the primary in the breast would have been much more thorough had we been aware of the possibilities. Both patients are alive and well three and six years, respectively, postoperatively so that the primary could hardly have been from elsewhere in the body. The possibility of metastatic neoplasm to the axilla from organs other than the breast must be considered. In one instance in our series the first clinical metastasis from a known carcinoma of the stomach was to the axilla. However, one can certainly rely on a routine history and physical examination to eliminate this possibility before undertaking surgery for an axillary tumor.

Summary

The diagnosis and treatment of axillary tumors present certain problems which have been discussed. An axillary mass on an inflammatory basis may persist long after the primary lesion of the extremity has healed or there may be no history of a primary lesion. The etiology of the vast majority will be nonspecific. Of the specific infections, tularemia is the most common. All patients suspected of an inflammatory mass in the axilla should have serological studies before operation because biopsy material in cases of tularemia is often reported as tuberculosis, thus starting an unnecessary trend of investigation and branding the patient as a suspect of tuberculosis.

Primary tumors of the axilla may arise from any of the constituents of the axilla. The prognosis of the malignant tumors depends on the adequacy of the first surgery. Surgery has been inadequate in the vast majority of the cases reported, which accounts for the bad prognosis. A frozen section diagnosis must be made on all axillary tumors. If malignant, a radical axillary dissection must be done at the first operation. Hygroma is the commonest cystic axillary tumor. Because of the frequent sudden increase in size associated with tenderness and a temperature elevation, many of these tumors are drained with a mistaken diagnosis of abscess. The resulting draining wound greatly complicates excision which is a long, difficult operation at best.

Metastatic carcinoma to the axilla almost certainly from the upper extremity or shoulder girdle is given little comment. Carcinoma arising in

aberrant axillary breast tissue or metastatic from a breast primary not found clinically is discussed. Radical mastectomy after frozen section diagnosis must be done regardless of the origin of the axillary tumor as this is the only hope for improving the present bad prognosis. Many thin sections of the breast must be examined to find the "hidden carcinoma."

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MSMS

THREE CASES OF CEREBRAL PALSY

(Continued from Page 999)

Summary

There have been presented three cases of clinical cerebral palsy with different pathologic backgrounds and different electroencephalographic findings.

Acknowledgment

Acknowledgment is made to Miss Dorothy Wagner, of Honolulu, and Mr. Charles McAlpine, of Kalamazoo, technicians who produced the records and photographs.

Osteitis Deformans

Familial Constitutional Heredity Background as Etiological Factors

By Robert C. Moehlig, M.D.

Detroit, Michigan

OSTEITIS DEFORMANS, commonly called Paget's disease, was named after Sir James Paget, who described it in 1876. The eponym, Paget's disease, may be confused with Paget's disease of the nipple, so osteitis deformans would seem preferable.

The concept previously advanced,[12,15,16,18-21,23-25] that it is a constitutional disease with hereditary factors playing a major role, has been strengthened by further studies. The disease has localized manifestations in the osseous system. It was shown that there is a high incidence of familial diabetes mellitus, tallness and obesity in osteitis deformans. In a previous report[20] on forty cases it was found that thirteen gave a familial history of diabetes mellitus. There were thirty-five patients who had one or more members in their immediate families who were 71 inches (180 cm.) or more in height. Thirty of the group had one or more members in their immediate families who weighed 200 pounds (90.9 kg.) or more. Glucose tolerance tests were made in thirty-one of the cases; in twenty-seven there was a diabetic type of curve, and in four it was normal. The familial diabetes mellitus, tallness and obesity suggests the possibility that the pituitary gland may be a factor in the production of the disease, since carbohydrate metabolism, the development and state of the osseous system and obesity are related to pituitary function. The familial factors could be on a constitutional hereditary pituitary background.

The close relationship between carbohydrate metabolism and osteitis deformans was brought home to me when I investigated a family of two sisters and a brother who had osteitis deformans. The father and mother of these siblings had diabetes mellitus. The brother had diabetes and a renal calculus; one of the sisters also had a renal calculus and the other sister had a calcified fibroid. In my original report[16] of this family, only one of the sisters had osteitis deformans but subsequently the other sister with the calcified fibroid developed osteitis deformans, and an elevated serum phosphatase preceded the x-ray diagnosis of osteitis deformans. At present the osteitis deformans is extensive with multiple bone involvement.

Both sisters had a diabetic type of glucose tolerance curve. We have therefore, parents who both suffered from diabetes mellitus, and all three siblings of these parents had osteitis deformans, one of whom had diabetes mellitus and the other two a diabetic type of glucose tolerance curve. This immediately suggested a connection between carbohydrate metabolism and osteitis deformans. Subsequent studies were then undertaken with the above-mentioned findings of familial diabetes, tallness and obesity. Abbott and I[19] reported a patient whose father, three brothers and a sister who had diabetes mellitus; a niece of the patient also had diabetes.

Crumpacker and Lipscomb[2] reported osteitis deformans occurring in three siblings. They thought the disease was probably present in the mother and at least one additional sibling but could not confirm it in these two cases. Their second case, a sister of the first, had diabetes.

Dr. L. A. Schwartz[27] reported osteitis deformans in three male siblings. I saw one of these cases in consultation. One of the siblings has developed diabetes.

Koller[7] in 1946 reviewed the literature and found twenty-eight instances of osteitis deformans in more than one member of a family. Only five instances of three siblings with osteitis deformans were reported. Schwartz's three cases plus Crumpacker and Lipscomb's and our three cases bring the reported instances to eight.

It has been shown that osteitis deformans is almost always associated with arteriosclerosis, and since diabetes is characterized by a high incidence of this condition, a close analogy between osteitis deformans and diabetes seems to exist. Furthermore since obesity is a common finding in diabetes and since there is familial obesity in osteitis deformans, another link between carbohydrate metabolism and osteitis deformans is formed.

Another factor in the chain of evidence is familial tallness. As is so well known, the pituitary is linked to the development of the osseous system. Acromegaly and gigantism are due to hyperpituitarism. In these diseases there is usually a

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lowering of the sugar tolerance even to the point of frank diabetes mellitus.

In pituitary basophilism one of the characteristic findings is osteoporosis and a lowered sugar tolerance, so much so that diabetes may be present. In both acromegaly and pituitary basophilism, osteoporosis is present, which frequently results in kyphosis. Thyrotoxicosis is usually associated with a lowered sugar tolerance and at times, diabetes mellitus. This condition frequently produces osteoporosis (Hunter,[6] Snapper,[28] Moehlig and Adler[12,15,20,21]). In osteoarthritis the sugar tolerance is reduced.

Hyperparathyroidism is another disease in which phosphorus and phosphatase metabolism is disturbed. In an article[25] on carbohydrate metabolism in osteitis deformans we said, "Hyperparathyroidism is another disease associated with a calcium metabolic disturbance and pathologic changes in the bones. The metabolic manifestations of this disease are: hypercalcemia, hypophosphatemia, increased urinary excretion of calcium, and increased serum phosphatase activity.

"Ferrannini found that in normal subjects parathyroid extract lowers the glycemic rate during fasting and increases carbohydrate tolerance. The action of the parathyroid extract on the glycemic curve, when compared with that of epinephrine, is almost like that of insulin. In diabetes the parathyroid extract lowers the glycemic curve and the glycosuria on fasting. He says there is no doubt about the insulin-like action of parathyroid extract in normal subjects and in diabetic patients."

The fact that phosphorus metabolism is involved in metabolic bone diseases is important. As Hunter[6] said, "Phosphorus compounds take part in at least four important metabolic processes. They are in some way essential to the *storage or utilization of carbohydrate,* they enter into the chemical changes which precede the contraction of muscle, they are concerned with the acid-base equilibrium and they are *essential to the deposition of bone.*" The level of serum phosphorus is an indication of pituitary activity—it is elevated when the pituitary is overactive. Injections of growth hormone increase the serum phosphorus.

The serum phosphatase is elevated in osteitis deformans in the greatest amount of any bone disease. The phosphatase enzyme is related to bone activity, being found in largest amounts where bone activity or growth is greatest. This enzyme hydrolyzes phosphoric esters and is concerned with carbohydrate metabolism. The links between carbohydrate metabolism and bone activity are closely interwoven. During the growing period of childhood with great bone activity the carbohydrate intake reaches relatively its greatest height. Dempsey, Greep and Deane[3] reported that phosphatase located in the blood vessels of certain target organs disappears after hypophysectomy and reappears after replacement therapy.

This close relationship of the pituitary and phosphatase is an important step in understanding bone disturbances associated with phosphatase changes. It strengthens the argument that the pituitary is etiologically related to osteitis deformans with its greatest increase in serum phosphatase.

Schneeberg,[26] in studying eleven patients, found no significant statistical difference in both oral and intravenous tests between their glucose tolerance curve and those obtained from a control series of patients over fifty years of age. In other unpublished experiments, however, the influence of elevated serum alkaline phosphatase on carbohydrate metabolism of dogs was studied. Both oral and intravenous glucose tolerance tests were made with a potent phosphatase solution. During these tests the experimental hyperphosphatemia produced a grossly elevated and prolonged glucose curve as compared to control tests prior to injection of phosphatase. Schneeberg said, "The discrepancy between the clinical and experimental results remains unexplained. This brief presentation of our findings in Paget's disease does not, of course, alter the significance of the symptomatic response described by Moehlig and it is our purpose to investigate its effect in our own patients." He was referring to the suggestion I made that insulin relieved the pains of osteitis deformans. Two of my patients have taken insulin for twelve and thirteen years without a return of pain. Insulin of course does not cure the disease but may affect the bone activity by its action on phosphatase. It must be acknowledged that the disease may and often does exist without pain, but I have relieved the pain with insulin without any other form of therapy. Since the original report on osteitis deformans I have seen many more cases, and the original impression that a disturbance in carbohydrate metabolism is found in the majority of cases has been strengthened. The same holds true for the hereditary constitutional background of familial diabetes, tallness and obesity. Apperly

and Cary[1] found a reduced sugar tolerance in eight cases of osteitis deformans.

An interesting finding in osteitis deformans is the increased temperature of the skin over the

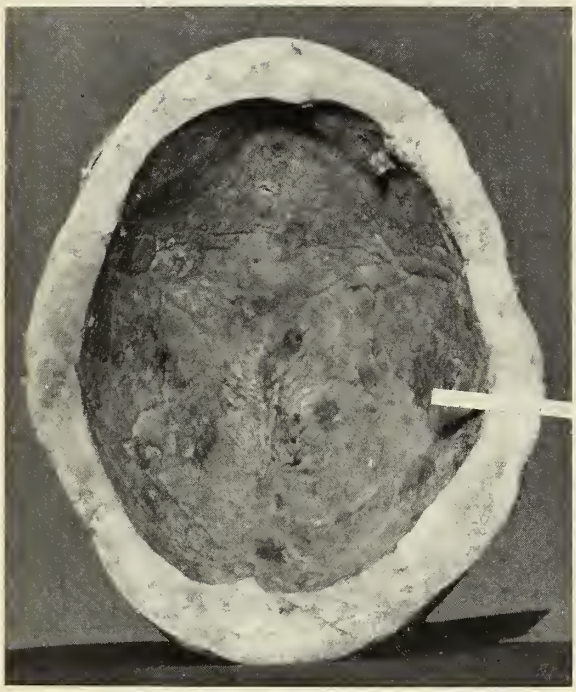


Fig. 1. Photograph of skull showing great increase in width and prominent vascular markings.

affected bone as compared to the rest of the body. Edholm, Howarth and McMichael[4] showed that there was an increased blood flow in the affected bones up to twenty times the normal: "When the disease is generalized, the circulation as a whole is greatly increased, and in such cases the signs of heart failure may develop."

The authors compare the increased blood flow in the bones to that of free arteriovenous communications. Naturally hyperemia of the bone marrow results with bone resorption and osteoid formation. The skull becomes very large, and deafness is a common symptom. Figure 1 shows a skull which reached a great width. This sixty-seven-year-old man developed bulbar symptoms which finally led to respiratory death. Two parathyroids had been removed, which were reported as normal, and the operation was without influence on the disease. It is quite evident from the photograph that the blood vessel markings are very prominent, and great vascularity must have been present to produce such an increase in the size of the skull.

The increased vascularity of the bone may lead to polycythemia, which is understandable in view of the bone marrow hyperemia and the increased blood volume. Since acromegaly and pituitary basophilism are frequently associated with polycythemia, the possibility exists that the pituitary may be a factor in its production, which would be in line with the foregoing data. Sometime ago Bates and I[22] showed that the pituitary is an important factor in erythrocyte formation. We reviewed the literature at that time (1933) and concluded from the evidence and our own experimental work that the pituitary played a large role in erythrocyte formation. The relationship of the pituitary to osseous development and function would, through this, influence hemopoiesis. It is also quite well established that this gland has an effect on the lymphatic structures of the body.[29]

For many years I have attempted to show that the pituitary has a selective action on mesodermal tissues.[8] Besides the mesodermal tissues already mentioned, that is, fat, bone, lymphatic system and blood, the mesodermal blood vessels are intimately related to pituitary function. Elsewhere I[8] called attention to the fact that a congenitally defective pituitary results in defective capillary development and the hemopoietic system is defective in this state as is the mesodermal adrenal cortex and other mesodermal structures. Dodrill and I[23] showed that when a bronchus of a dog is plugged there results an increase of the red cells and hemoglobin values. The pituitary gland of these dogs showed marked basophil hyperplasia and intense hyperemia. This work was done on a small series of dogs and should be repeated on a larger series. It was concluded that there is a reciprocal relation between the lungs and the pituitary. Apparently where the lung is injured by disease or trauma, the natural forces attempt to maintain a normal amount of oxygen by increasing the hemoglobin and red cells as a compensatory measure. Not all humans can respond to lung disease or trauma by pituitary hyperplasia since they are constitutionally endowed with a small pituitary and unresponsive, such as we see in the asthenic tuberculous individual whose entire mesodermal structures are underdeveloped. The mesodermal connective supportive tissue, the osseous system, muscular system, vascular system are poorly developed so that their resistance to disease is poor. The immune mechanism is mainly a mesodermal derivative.

The clubbing of the fingers in pulmonary osteoarthropathy is of interest in regard to the reciprocal relationship between lung function and the pituitary.[18] That there is a close association between acromegaly and hypertrophic pulmonary osteoarthropathy has been recognized for many years. Fried[5] reported four cases of pulmonary osteoarthropathy associated with bronchiogenic cancer in which evidence was presented to show that the condition is in all likelihood caused by an endocrine imbalance (dyspituitarism). All four patients had bronchiogenic cancer and symptoms of acromegaly. Three came to autopsy and revealed hyperplasia of the eosinophil cells of the pituitary. The fourth case was not autopsied but had acromegaly.

The increased circulating blood volume of affected bones in osteitis deformans and increased bone growth suggests another analogy, that is, an arteriovenous fistula of the extremities. As an example may be cited the arteriovenous fistula of the hand. Growth in the affected hand takes place by virtue of an increase in the number of blood vessels and an increase in the blood supply. This growth is accomplished without the presence of a pituitary eosinophil adenoma or hyperplasia and without a generalized increase of the anterior pituitary hormone.

The fact that arteriosclerosis of the nutrient artery to the bone leads to osteoporosis is all the more remarkable in osteitis deformans in which arteriosclerosis is so pronounced. This could be explained on the basis of Edholm and associates'[4] work showing the tremendous increase in the circulating blood volume resembling an arteriovenous communication so that even in the presence of arteriosclerosis there is such a tremendous increase in vascularity that osteoid formation takes place.

Summary

In the article it has been stressed that in osteitis deformans there is a familial constitutional hereditary background. The etiology seems to suggest that the disease is a constitutional one with localized manifestations in the osseous system. In previous papers it was found that there is a high incidence of familial diabetes mellitus, tallness and obesity in this disease. It was suggested that the pituitary gland may possibly play a leading role in the constitutional hereditary background of the disease. This is based partly on the fact that this gland is a factor in carbohydrate metabolism, in the development and function of the osseous system and is also a factor in fat metabolism. A family in which both parents had diabetes mellitus and all three siblings had osteitis deformans led to a study of carbohydrate metabolism in this disease, as previously reported. One of the siblings had diabetes and the other two had a diabetic type of glucose tolerance curve.

Other bone diseases associated with a disturbance in carbohydrate metabolism are acromegaly, gigantism, pituitary basophilism, thyrotoxicosis, osteoarthritis and hyperparathyroidism.

Phosphorus and phosphatase are important links in carbohydrate metabolism and bone activity. The pituitary gland influences both phosphorus and phosphatase and in this way may be a factor in certain bone diseases.

It was pointed out that there is a reciprocal relationship between the pituitary and lung function. This has to do with oxygen consumption and erythrocyte formation. Chronic pulmonary osteoarthropathy may be due to a pituitary disturbance.

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(Continued on Page 1027)

Drug Therapy of Hypertension

By S. W. Hoobler, M.D.
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THE TREATMENT of severe essential or malignant hypertension remains one of the commonest and most difficult problems in medical practice. In most clinics sympathectomy and dietary treatment are considered to be the best means of controlling the disease, but while dramatic results are occasionally achieved, a large number of patients remain who are unacceptable for such treatment or whose disease advances despite it. The treatment of such severe hypertensive patients with thiocyanates, veratrum viride derivatives and nitrites has in the past resulted in little improvement since the unpleasant side effects and the development of tolerance have prevented satisfactory long-term management.

It is my intention to discuss three new drugs which I believe offer considerable promise in meeting this difficult problem of drug therapy of the hypertensive patient refractory to other forms of treatment.

The first drug, hexamethonium, is presented as a technique for producing an acute and sustained blood pressure lowering for a brief period of time, usually in hospitalized patients where the mechanical effects of the elevated blood pressure may threaten life. This drug was first studied by Paton and Zaimis[7] and used clinically by Smirk[10] and later by Freis et al.[1] It has a ganglionic blocking action similar to tetraethylammonium but is superior in that it may be given subcutaneously and has a sufficiently long action span so as to permit more or less continuous blood pressure reduction when given three to four times daily. The action is summarized in Figures 1 and 2. The starting dosage of 10 mg. may have to be increased as tolerance develops, but owing to individual sensitivity, particularly in the elderly and arteriosclerotic patient, it is well to proceed cautiously at first. When a significant reduction is achieved in the supine position, the drug is given every eight

HEXAMETHONIUM ("C-6"; "Bistrium")

Ganglionic Blocking Agent
Rx: Begin at 10 mg. s. c. q 8 hrs.

Use for period of temporary BP reduction in hospital.
Watch for orthostatic syncope; ileus, bladder paralysis

Cautions: Elderly; Angina; Uremia

Fig. 1. Summary of hexamethonium.

hours subcutaneously, and the patient is urged to void or attempt defecation just prior to the next injection when orthostatic hypotensive effects are at a minimum. The parasympathetic blocking effects are a source of great inconvenience in some patients and not in others. Where prostatic hypertrophy or a tendency to distention pre-exist, the drug should not be used. The effects may be partially antagonized by urecholine.

The postural hypotension is, likewise, a difficult problem and may be serious in a patient with asthma or pulmonary edema. It is possible to reduce the dosage to such a point that blood pressure lowering occurs only in the sitting or erect posture. This, it is true, may relieve the blood pressure, but probably at the expense of pooling of blood in the legs and viscera and decreased cardiac output. The patients feel weak and dizzy in the upright posture, and their orthostasis waxes and wanes with each dose. Angina, if present, is usually unimproved, and cerebral thrombosis and advancing uremia represent calculated risks which must be accepted if this treatment be pursued. Smirk has recommended the use of the drug for ambulatory treatment of hypertensives, but in view of our difficulty with side effects, I think this method of management should be left, at present, to the clinical investigator. The oral administration of the drug has also been recommended to avoid the necessity of the patient's injecting it, but the report of deaths from paralytic ileus following such usage urges me not to recommend this technique of administration. Gastrointestinal absorption is very poor, and sudden increases in the percentage of a standard oral dose which reaches the blood stream may prove a fatal overdose.

This drug is now on the open market. It is a dangerous medication unless very carefully given. Paralytic ileus and circulatory collapse are the

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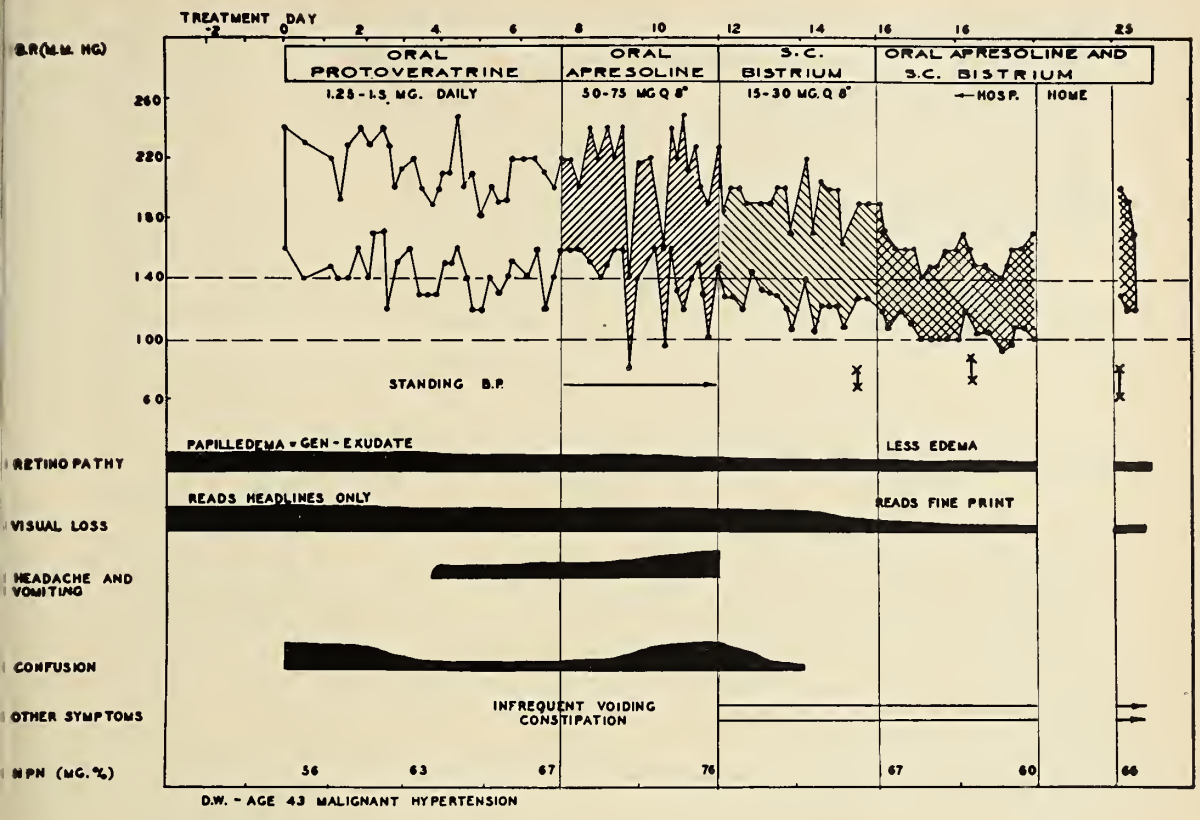


Fig. 2. Effects of protoveratrine, hydrazinophthalazine (Apresoline) and hexamethonium (Bistrium) in a severe case of malignant hypertension with encephalopathy.

It will be seen that protoveratrine and apresoline alone had little effect on the course of the disease, perhaps partly because vomiting interfered with adequate therapy. The administration of hexamethonium provided striking relief, but orthostatic hypotension and difficulty with voiding and defecation were noted. Clinical improvement was prompt, and the concomitant administration of apresoline appeared to improve the patient further.

Since the chart was prepared, further improvement has occurred, and the nonprotein nitrogen has fallen below 50 mg. per cent.

(We are indebted to Dr. Alexander Gotz of Ann Arbor for referral of this patient and to Dr. Joseph McHale for assistance in making the observations recorded above.)

gravest risks encountered. The standard treatment of paralytic ileus, including prostigmine or urecholine, should be applied when necessary. Vasoconstrictors in the treatment of circulatory collapse should be given carefully, since in the absence of the buffering action of the sympathetic nervous system great rises in pressure may ensue. The drug is probably not metabolized; it should not be given to the anuric patient.

One may rightly inquire what indication there is for such rigorous treatment. My experience in seeing two malignant hypertensives, blind, uremic and in congestive failure, leave the hospital able to see and greatly relieved symptomatically justifies some optimism in recommending this treatment under such desperate circumstances. It is our practice at present to give the drug at 7:00 a.m., 3:00 p.m. and 11:00 p.m. daily with frequent determinations of blood pressure, except when the patient is asleep. The dose is increased 5 mg. each day until a reduction of systolic blood pressure to about 160 mm. is achieved, and it is then kept at this dosage so long as continuous reduction of blood pressure is maintained. After satisfactory control has been established, the injections may be spaced more widely, and other agents, such as Apresoline, may be used in keeping the pressure reduced. If this therapy be kept up for two to three weeks, clinical improvement usually is observed, and the decision as to the type of ambulatory treatment in the home can then be made.

The second new drug for hypertension, hydra-

HYDRAZINOPHTHALAZINE
("C5968"; "Apresoline")

Renal and Peripheral Vasodilator; Increase from 50 to 200 mg. orally q.i.d. Use in severe hypertension.

N.B.: BP reduction often slight; wide individual variation; tolerance occurs; combination with hexamethonium possible.

Nausea; Headaches; Nervousness may occur.

Fig. 3. Summary of hydrazinophthalazine.

Experimentally it is of interest in that it blocks the action of several pressor substances which may be implicated in experimental hypertension.[9,11] It also reduces the blood pressure of neurogenic hypertensive dogs to normal,[3] presumably by a central action.

Clinically the most striking effects are reduction in diastolic blood pressure with widening of the pulse pressure, great variation in individual responsiveness and brief duration of action. Thus, one patient experienced a fall from 186/120 mm. Hg to 164/76 mm. Hg in one hour after a 25 mg. dose orally and had recovered to the pre-treatment blood pressure one and one-half hours later,

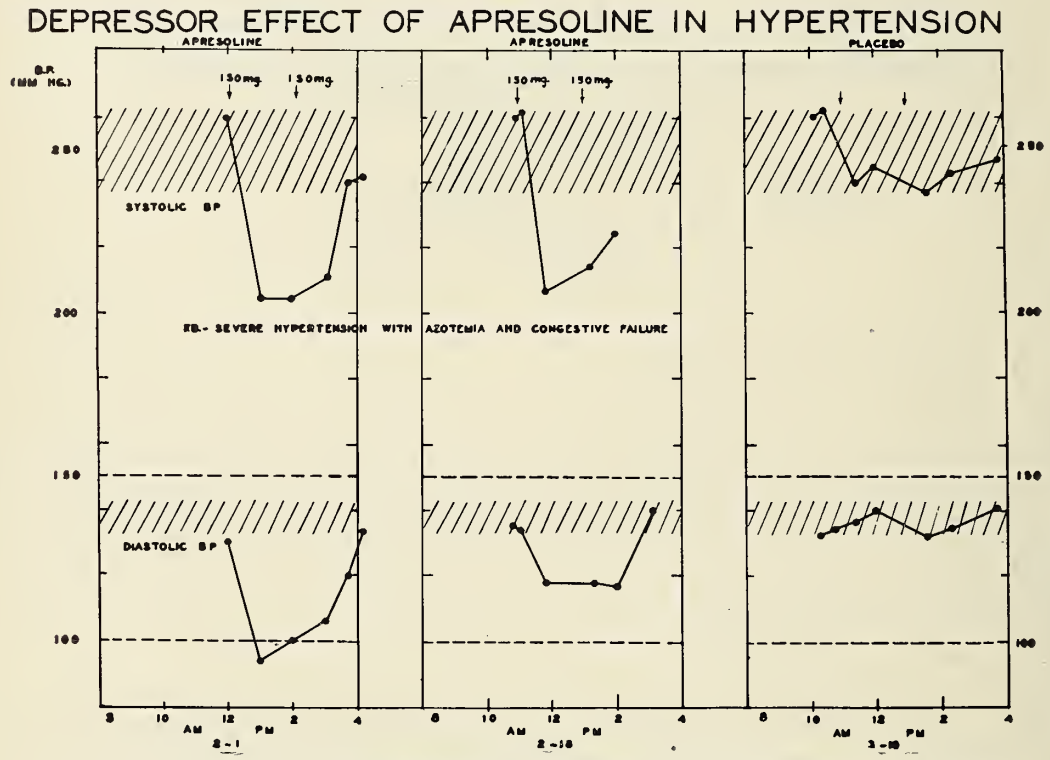


Fig. 4. Effects of hydrazinophthalazine (Apresoline) on blood pressure in an ambulatory patient with hypertensive heart disease observed in the Hypertension Clinic of University Hospital on the dates specified. The last panel on the right indicates the effect of placebo medication on the blood pressure.

Patient had been taking the drug for over two months at a dosage level of 150 mg. four times daily without significant side effects or development of tolerance. Congestive failure had improved slightly, but patient still required diuretic therapy.

zinophthalazine, is reviewed in Figures 3 and 4. It is of great interest to the clinical investigator but is of less certain value in the treatment of hypertension because of its inconstant action and side effects. It is by far the most effective agent we now have in increasing renal blood flow, and it also has a marked peripheral vasodilator action as manifested by the flushing of the face and chest. whereas another patient showed little change on a dose of 150 mg. orally. Tolerance is said to develop, although we have not noticed this in a few patients followed up to two months. Headaches, nausea or nervousness preclude its use in some patients. In general, reductions in blood pressure are brief and not very impressive—perhaps because sympathetic activity counteracts the action

of the drug. When given in combination with hexamethonium compounds, greater effectiveness is reported[8] and is confirmed by our experience with one case (Fig. 2). It would appear that this combination is our best method, short of sympathectomy, to reverse the progression of malignant hypertension.

The exact indications for use of this compound cannot now be established. We have seen real benefit in a few patients who experience good blood pressure reductions with the drug. Many

PROTOVERATRINE (Alkaloid from V. Album)

Central vasodilator, vagal, emetic effects
1-1.5 mg. (o) once daily after breakfast,
0.25 mg. 2 and 4 hours later, never
within 2 hours a. c.
Use in severe or malignant hypertension
especially with cardiac or cerebral signs.
Produces 6-8 hours of daily BP reduction.
Incorrect Dosage: No effect or nausea,
vomiting, heart block
Antidote: I.V. Atropin (1 mg.)

Fig. 5. Summary of protoveratrine.

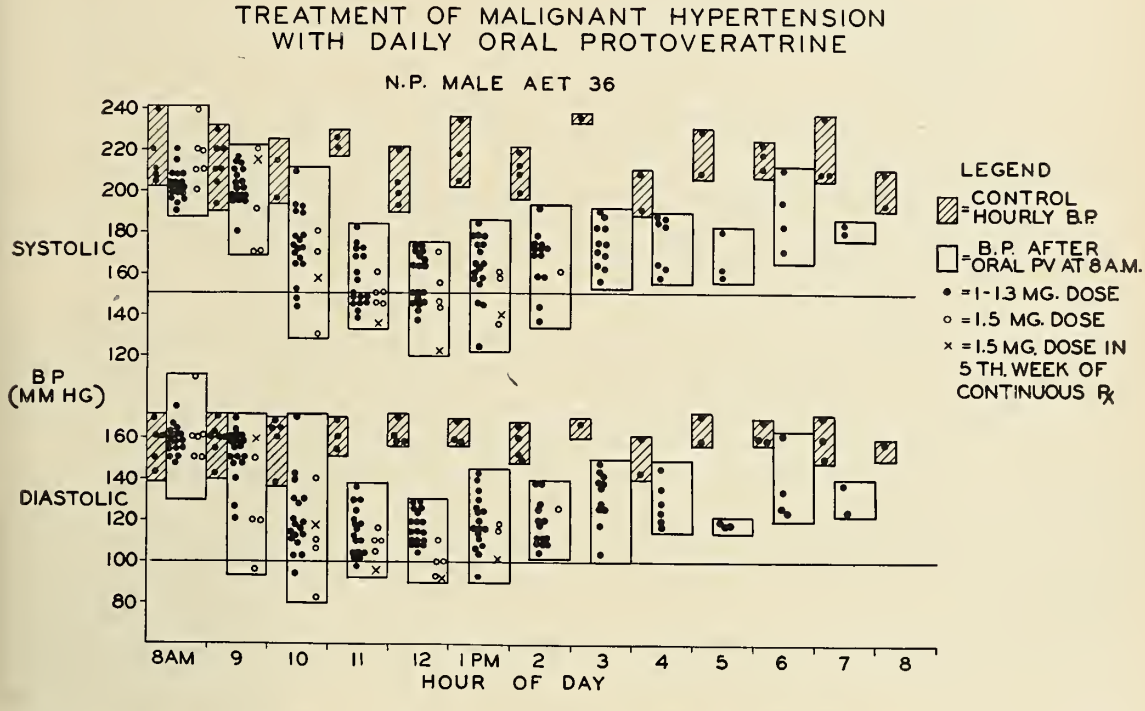


Fig. 6. Effect of protoveratrine in daily treatment of hypertensive cardiac patient.
Each point indicates a blood pressure reading at the hour indicated on a different day of treatment. Readings were taken by the patient or in the Hypertension Clinic. The cross-hatched area indicates the range of hourly blood pressure variation during placebo therapy. "X" indicates the response on the last consecutive day of therapy and shows that tolerance did not develop. Patient experienced marked relief of dyspnea during therapy and had only occasional nausea when blood pressure fell to lowest levels.

patients either do not respond or have distressing side effects when an effective dose is reached. The drug is now released for general use and its place in therapy will soon be established. In our clinic at present we use it in patients with severe hypertension who have not responded satisfactorily to sympathectomy or diet, but in whom the blood pressure is dangerously elevated. We have not yet had the opportunity to observe clinical improvement in congestive failure as our experience is as yet limited. It appears on theoretical, as well as clinical grounds, that this drug or related compounds may show considerable promise.

The third drug I should like to review is protoveratrine. This is not now clinically available but should be released soon. Its effects are summarized in Figures 5 and 6. This drug is a purified derivative of *veratrum album,* the European analogue of veratrum viride, studied by Meilman and Krayer[6] and first made available to us through their courtesy. The hypotensive

properties of the *veratrum viride* compounds are well known. They have been given as the crude extract, "veratrone," and in the more purified forms as "vertavis" and "veriloid." All these of headaches and encephalopathy attests to the beneficial effect of this drug. No tolerance has been seen to develop over six or more months of treatment. We have made extensive hemodynamic

TABLE I. MANAGEMENT OF HYPERTENSION

Treatment	Essential Hypertension				Hypertension with Papilledema		
	Diastolic B. P. Usually Less Than 110		Diastolic B. P. Usually More Than 110		Nonprotein Nitrogen		
	Symptoms or Cardiac-Cerebral Complications		Symptoms or Cardiac-Cerebral Complications				
	Absent	Present	Absent	Present	<45	45-65	>65
Reassurance Sedation Reg. 6 month follow-up	1	1	1	1	—	—	—
200 Mg. sodium diet	—	1	1	1	1*	1*	—
Splanchnicectomy (if under age 55)	—	?2	2	2	1	—	—
Protoveratrine	—	—	?	3	2	1	—
Hydrazinophthalazine	—	—	?	4	3	2	—
Hexamethonium	—	—	—	—	3	2	—

*If renal failure imminent, 200 mg. sodium diet may lead to sodium loss with progressive azotemia; 800 mg. sodium diet preferable.

A tabulation such as this serves only as a guide to therapeutic philosophy. Many exceptions will be recognized. By complications are meant cardiac enlargement by x-ray, prior focal cerebrovascular episodes or persistent albuminuria since in a previous study this was shown, independent of blood pressure levels, to alter prognosis seriously. The numerals in each column indicate the order in which treatments outlined should be tried. Usually a three month observation on a low sodium diet (verified by urinary chloride analyses) or a three month postoperative failure to reduce blood pressure after surgery is sufficient to indicate need for additional therapeutic measures.

produce nausea and vomiting at or very near the level of hypotensive action. In collaboration with Dr. R. W. Corley, Dr. T. G. Kabza and Dr. H. F. Loyke we have investigated the purified alkaloid, protoveratrine, which derives from *veratrum album* instead of *veratrum viride*.[4,5] We have found it possible to get satisfactory blood pressure reduction without nausea or vomiting if the following rules are strictly followed:

1. Give only one large dose daily and follow with two supplemental smaller does at two-hour intervals.

2. Give the drug only on a full stomach or more than two hours before a meal.

In practice this leads to a dosage schedule for the average patient as follows: 1 to 1.25 mg. protoveratrine with breakfast, .25 mg. two hours before lunch and one hour after lunch. This results in definite daily blood pressure reduction lasting about six to eight hours during the time when the highest blood pressure levels are most likely to occur.

The usual course of the blood pressure is affected favorably about one-third of each day. Although more prolonged effect is certainly desirable, the clinical improvement as manifested by reduced orthopnea, dyspnea and heart size, improved vision in malignant hypertension, and relief measurements which indicate moderate peripheral and renal vasodilatation with a decline in total peripheral resistance. It thus appears to act without compromising the regional circulation. Urine flow and glomerular filtration rate are reduced slightly, so that we must keep a careful eye on serum creatinine and nonprotein nitrogen in patients with borderline renal failure, but we have so far been able to treat patients with malignant hypertension and azotemia without deleterious effects on renal function. However, we have declined treatment of patients with terminal uremia and oliguria.

The foregoing examples reveal clearly that effective drugs for the treatment of hypertension are now available. Opinions concerning their indications and usefulness vary widely. Their place in the routine treatment of hypertension remains minor at present. Table I may give some indication of their relation to the other forms of management of patients presenting themselves to our clinic in various stages of hypertensive disease.

Summary

The place of certain newer drugs in the treatment of hypertension is reviewed. It is emphasized that their use is palliative, and their indications at present are limited.

Hexamethonium, a long-acting ganglionic block-

ing agent, given three times daily will in proper dosage lower the blood pressure of all hypertensive patients, but at the expense of unremittent orthostatic hypotension and with ileus and urine retention as occasional complications of treatment. On the other hand, it has been most effective in the treatment of malignant hypertension.

Hydrazinophthalazine offers real promise, although its action is transient, reductions in blood pressure are incomplete, and side effects, such as headache and gastrointestinal symptoms, occur frequently. It is an effective drug in certain forms of experimental hypertension and against certain presumed pressor substances.

Protoveratrine appears to be an improvement on the cruder veratrum compounds in that, with carefully adjusted oral dosage, reductions in blood pressure can be secured over about one-third of each day for long periods of time without emetic side effects or the development of tolerance.

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Post-Mortem Cesarean Section with Survival of Identical Twins

By Lloyd F. Teter, M.D.
Battle Creek, Michigan

DE LEE AND SHEARS both state that a fetus will live from five to twenty minutes following death of its mother. In the event of a sudden or unexpected death of a pregnant woman, the viable fetus is often forgotten and allowed to die without attempted post-mortem section. It is well to remember that, legally, a doctor does not have to have the husband or family's permission to perform the section, although this is preferable if possible. It is generally considered a lapse of six minutes is the maximum time a fetus can survive its mother's death. In the following case, there was a lapse of at least ten minutes, and possibly fifteen, between maternal death and successful post-mortem section.

Case Report

On April 1, 1948, I was notified by phone that my patient, Mrs. P. P., who was a patient at the Pekin Public Hospital, Pekin, Illinois, had developed a sudden severe convulsion and had expired. The patient was an elderly primigravida, aged thirty-eight, who had been admitted the previous evening, for severe toxemia of pregnancy with impending eclampsia. Roentgenograms taken one week previously had revealed a twin pregnancy of about seven months' gestation. I had seen her that morning at the hospital, her blood pressure was 180/100, she had pitting edema of her ankles and legs, and moderate anasarca of the abdomen. Examination of the urine revealed 4-plus albumen, the presence of hyaline, coarse and fine granular casts, and a specific gravity of 1025. She complained of dyspnea the previous night and had to sit up in bed for relief, but she slept well otherwise.

The patient was first seen on October 18, 1947, and a diagnosis made of pregnancy, at that time of about two and a half months' gestation. She was markedly edematous at that early date and weighed 185 pounds; blood pressure was 140/80, urine revealed 1-plus albumen, Rh was positive, and Kahn test negative. She had been under constant medical observation during her entire perperium. The last time she was seen at the office was March 29, 1948, and at that time her blood pressure was 190/120, weight 194 pounds; urine revealed specific gravity of 1.025, bile 1-plus, and albumen 4-plus. She

From Surgical Department, Leila Y. Post Montgomery Hospital, Battle Creek, Michigan.



Fig. 1. The twins, Lloyd and Floyd, are shown at the age of three and one-half years.

was edematous, but this was no more pronounced than it had been in the past three months. Patient had refused operative procedure either for termination of the pregnancy, which was suggested early in her pregnancy, or for cesarean section due to her religious beliefs. She agreed to enter the hospital for observation and evaluation, only because she was apprehensive about her increasing nocturnal dyspnea.

I was notified of her death about 10:10 a.m. I raced to the hospital, which was about one mile away. The patient had been admitted to a medical floor due to shortage of beds in the hospital. There was no sterile surgical setup available on the floor. The dressing cart was quickly moved into the room. The patient was rapidly draped with sterile towels, and the abdomen surgically prepared with tincture of merthiolate. I slipped on a pair of sterile gloves and opened the abdomen with a bayonet type of scalpel, which was the only one sterile on the cart. The uterus was quickly incised, and identical twins were rapidly extracted. Much to my surprise, both infants cried lustily on delivery. The twins were placed in an incubator and continued to gain in strength and vitality during the first twenty-four hours. Their weights were, respectively, 3 and 3¼ pounds. They were taken to St. Francis Hospital, Peoria, Illinois, the following day and placed in a premature station, where they remained until they had gained 5 pounds, when they were discharged in care of relatives.

Discussion

A plea is made for more post-mortem sections. It is often concluded that if section is not carried out immediately, or within five or six minutes, following maternal death, the procedure is useless. In the above case there was at least a lapse of ten or twelve minutes between the mother's apparent death and delivery of the twins. The procedure was well worth the effort, in spite of the attending difficulties, and surrounding excitement of unexpected and dramatic death.

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Ovarian Cyst in the Transverse Mesocolon

Report of a Case

By Meyer O. Cantor, M.D., and
Harold E. Kleinert, M.D.
Detroit, Michigan

CYSTS OF THE mesocolon are true mesenteric cysts. As such, their occurrence is fairly uncommon but not of sufficient importance to merit a case report. An ovarian cyst in the transverse mesocolon is rare.

In a review of mesenteric cysts, beginning with the first case reported by Benevieni[1] in 1507, it was noted that the mesocolonic location for the development of a mesenteric cyst appeared in approximately 11 per cent of all cases reported.[2] Dowd[3] reviewed all previously reported cases to 1900 and added a proved ovarian cyst arising in the transverse mesocolon. He noted six cysts reported in this location but not recognized as ovarian by the authors. The characteristics of the cyst wall and the type of fluid within the cyst led Dowd to consider these six case reports as representing probable ovarian cysts.

The consenus at present is the concept that such ovarian cysts in the transverse mesocolon arise from misplaced remnants of the germinal epithelium, which is the anlage for the ovary. The development of the germinal epithelium in the embryo appears in the retroperitoneal region of the kidney. The developing ovary which is formed from this germinal epithelium finally appears in the pelvis. It is reasonable to believe that the germinal epithelium or the ovary being formed might leave bits of developing tissue anywhere along the path it follows from its site of origin in the kidney region to its site of final arrest in the pelvis. Isolated case reports of ovarian cysts arising in the transverse mesocolon and in the mesosigmoid[4] as well accessory ovaries would furnish clinical evidence attesting to the truth of this belief.

The rarity of ovarian cyst formation in the transverse mesocolon is proved by the paucity of cases reported in the literature. This is further shown by the fact that in a review of the admissions to Grace Hospital for the years of 1945-1951, out of 129,748 patients, only two were found to have a mesenteric cyst, and only in one case was the cyst in the transverse mesocolon.

From Grace Hospital, Detroit.

Case Report

R.S., a forty-four-year-old woman, was admitted to Grace Hospital on November 17, 1951, complaining of a feeling of weight in the left upper abdomen. She had noted a feeling of discomfort in her abdomen for the past six months. At no time had there been any pain or any difference in her bowel habits. She had noted, however, that her abdomen appeared to be enlarging. The only positive finding in her past history was the report of a left oöphorectomy for ovarian cyst four years previously.

On examination, she was found to be a white woman resting quietly in bed and not apparently ill. She was well oriented and well hydrated. Head, ears, eyes, nose and throat showed no abnormality. There was an indurated scar on the right side of her neck along the anterior edge of the sternomastoid. This was the result of the surgical removal of a tumor mass six months previously. The nature of this mass was not determined. No lymphadenopathy. Chest: normal. Heart: normal in size to percussion; rate and rhythm normal; no murmurs; blood pressure 120/80. Lungs: tactile fremitus normal; resonant to percussion; expansion normal and equal; no râles. Breasts: no masses. Abdomen: flat; no tenderness or spasm. An elastic movable mass was palpable in the left upper quadrant. The mass was approximately 8 inches in diameter. It was poorly defined and felt cystic. There was no tenderness over this mass. The mass could be moved upward and downward rather freely, but its lateral movement was limited. A midline abdominal scar extended from the naval to the symphysis. Extremities: normal.

Upper gastrointestinal series showed no pathologic condition. A barium enema study showed no abnormality. Chest x-ray showed no pathology.

Cystoscopy and pyelograms showed no evidence of a pathologic process in the kidney-ureter-bladder tract.

Laboratory studies showed: red blood cells 3,810,000, hemoglobin 78 per cent, white blood cells 6,000, polymorphonuclear cells 68 per cent, filaments 65 per cent, non-filaments 3 per cent, lymphocytes 28 per cent, eosinophiles 4 per cent.

Nonprotein nitrogen was 25 mg per 100 c.c.

Urine: specific gravity 1.010, albumin negative, sugar negative. Sediment showed epithelial cells, few; pus cells, few; occasional red blood cell.

The Kahn test was negative.

A diagnosis of mesenteric or omental cyst was made on the basis of the clinical evidence associated with the absence of radiological findings of pathological changes in the gastrointestinal or urinary tracts.

Surgery.—On November 20, 1951, under nitrous oxide-oxygen-ether anesthesia, an upper left paramedian incision was made and the abdomen opened. On entering the

peritoneal cavity, a large cystic mass approximately 8 inches in diameter was found arising from between the leaves of the transverse mesocolon just to the left of the

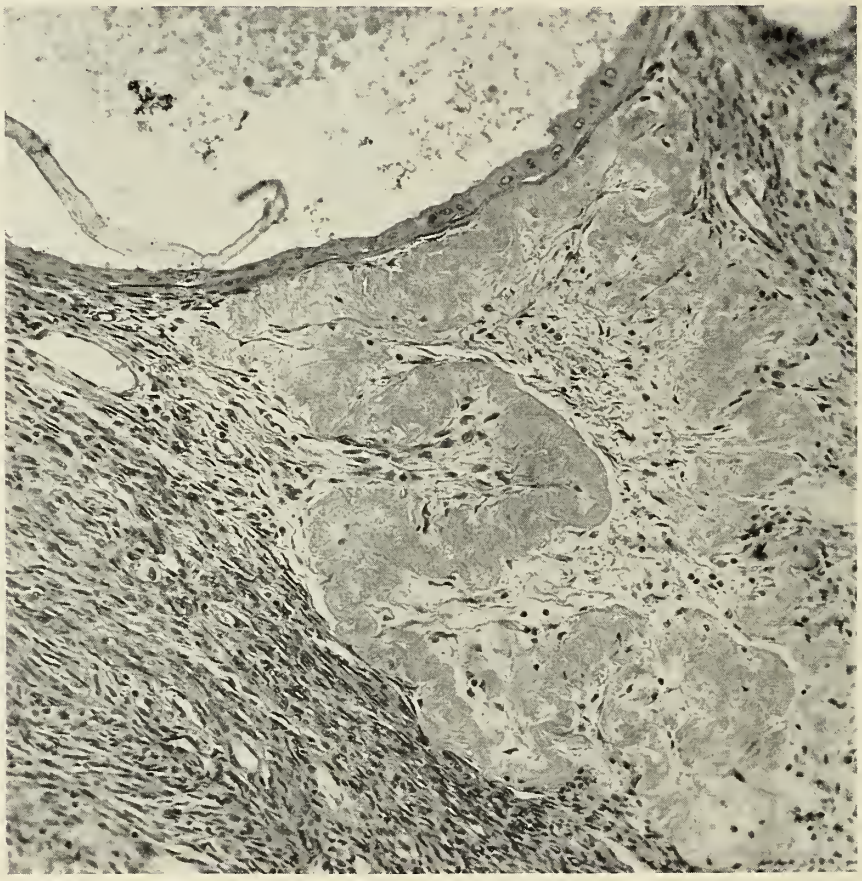


Fig. 1. Magnification ×150. Note the corpus albicans next to the fibromuscular stroma typical of ovarian tissue. Section taken from wall of the cyst.

ligament of Treitz. An incision was made over the avascular dorsal leaf of the transverse mesocolon and the peritoneum of the mesocolon was reflected laterally. The cyst was then enucleated intact. It was found that the cyst was intimately adherent to the tail of the pancreas and the splenic vein, from which structures it was dissected free. Two communicating venous openings from the cyst to the splenic vein were cut and ligated. The abdomen was closed in layers without drainage.

Pathologic Report.—Gross: The fluctuant cyst measured 10 by 9 by 8 cm. in size and was covered by a few fibrous tags. No excrescences were found on its external surface. The cyst was multilocular, and the lining of the various locules was smooth and light gray in color. The locules measured up to 3 cm. in diameter. The locules contained light gray mucoid material.

Microscopic: The specimen was a multilocular cyst. It had a capsule and trabeculae of fibrous and hyalin tissue, with the hyalin tisssue being seen in the capsule and not in the trabeculae. The trabeculae were quite variable in thickness and outline. The various cystic cavities were lined by a single layer of tall columnar epithelial cells, many of which were goblet in nature. In some places, structures indistinguishable from corpora albicantia of the ovary were present, and in some places the stroma was compact and had the appearance of ovarian stroma. The structure of the tumor was entirely consistent with a primary tumor in the ovary. Histologically there was moderate anaplasia in some areas, but the glands were well formed and well delineated. The anaplasia was manifested by hyperchromic nuclei in many of the cells. There was no involvement of the capsule in any of the sections made. The architecture in many areas was papillary.

Diagnosis: Papillary cystoma of ovary with focal anaplastic areas.

C. I. Owen, M.D. (pathologist).

The postoperative course was uneventful. The patient was discharged on December 4, 1951. A follow-up examination on January 30 showed the abdominal incision to be well healed and the patient completely relieved of all complaints.

Summary

The development of a proved ovarian cyst between the leaves of the transverse mesocolon is of

rare occurrence. Such ovarian cysts arise from misplaced pieces of germinal epithelium or from kidney-ureter-bladder tracts as shown by radiological study, should create a strong suspicion in

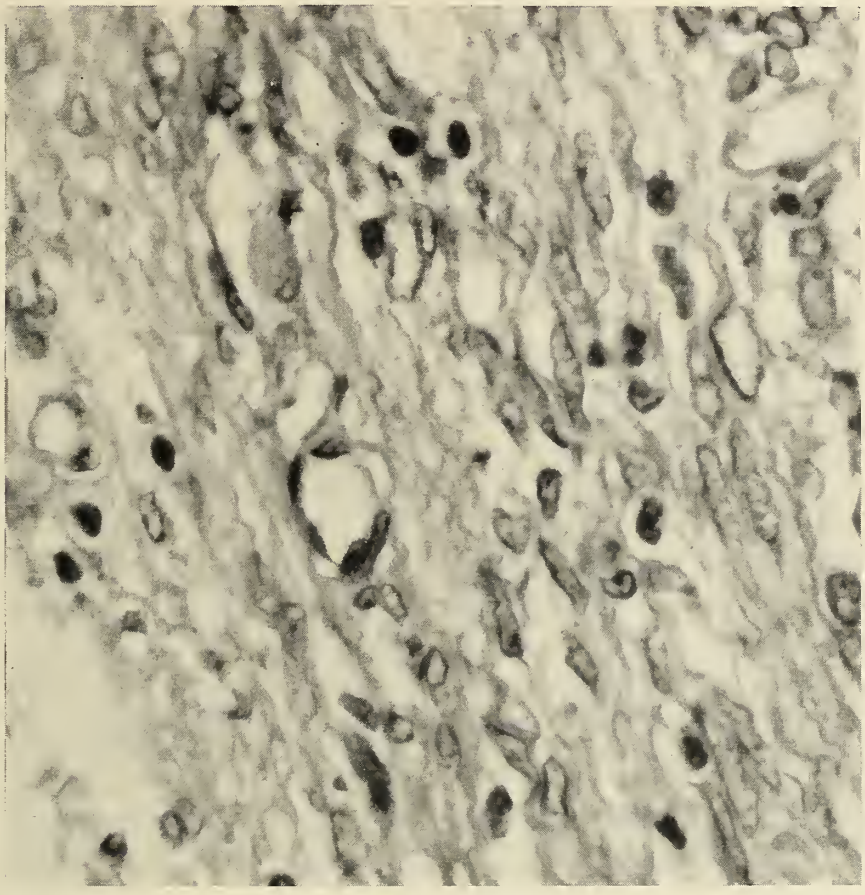


Fig. 2. Magnification ×450. Wavy fibromuscular stroma as found in normal ovary. Section taken from wall of the cyst.

misplaced sequestrations of ovarian tissue in its migration to the pelvis. Aside from the rarity of the occurrence of an ovarian cyst in this location, this type of case is of interest because it furnishes clinical proof of accepted embryological ovarian studies.

The presence of a cystic mass in the abdomen which is freely movable upward and downward and of limited movement laterally, which is relatively asymptomatic and produces no pathological changes within the gastrointestinal or the mind of the attending physician that he was dealing with a mesenteric cyst.

666 Maccabees Building.

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DISPENSING BARBITURIC ACID PREPARATIONS

The Director of Drugs and Drug Stores, Michigan Board of Pharmacy, invites the attention of all practitioners of medicine to the dispensing of barbituric acid preparations without proper labeling and marking on the containers dispatched and without the name of the patient. The Dangerous Drug Act specifically provides for such labeling and for the patient's name.

Toxoplasmosis

Clinical Discussion with Presentation of Three New Cases

By James R. Doty, M.D.
Lapeer, Michigan
and
N. L. Matthews, M.D.
Marquette, Michigan

IN RECENT years clinicians have become greatly interested in toxoplasmosis because of the increasing number of cases reported, its universal distribution, and the unlimited reservoir of infection.

The protozoan causing this disease was first discovered in 1908 by independent investigators in Africa and in South America. Nicolle and Manceaux[8] described the parasite in the gondi, a North African rodent, and Splendore[14] in Brazilian rabbits. It derives its name from its crescentic or curved shape (Greek: Toxon meaning bow or arc). In 1923, Janku[5] reported the first case of human infestation throught due to toxoplasma, an infant with encephalomyelitis in which human retinal parasites were described. Torres,[16] in 1927, and Richter,[11] in 1936, presented cases which appear to have belonged to the group of toxoplasma-like diseases. In 1939, Wolf, Cowen and Paige[17] showed conclusively that the granulomatous lesions of a thirty-one-day-old infant which died with encephalomyelitis contained toxoplasmic organisms. This they accomplished by animal inoculation of material from the lesions and recovery of the parasite after transmission. Many cases are now being discovered which were apparently heretofore unrecognized. Excellent reviews on the subject have now been written by Callahan, Russell and Smith,[1] by Sabin,[12] and others.[4,9,15]

The magnitude of the distribution of toxoplasma in animal life suggests that this disease may be considerably more wide-spread in man and potentially more dangerous than we realize. To date, isolation of the protozoan has been most intensive in the animal kingdom. It has been discovered in the United States, Argentina, Brazil, England, France, Germany, Italy, Tunesia, the Congo, Senegal, Iran, Gambia, India, Dutch East Indies, Japan and Formosa in animals, birds and reptiles. In this country it has been found in the dog, cat, sheep, guinea pig, rat, rabbit, squirrel, mink, fox, canary, sparrow, catbird, chipping sparrow, kingbird, red-eyed towhee, song sparrow, swamp sparrow, Baltimore oriole, cowbird, Savannah sparrow, house finch and the pigeon.

The mode of transmission to man is unknown. An insect vector had been postulated by some. Pinkerton and Henderson[10] reported two cases of adult toxoplasmosis several days following the removal of some engorged tics. However, no insect has been found to harbor the parasites. It may well be that man is infected through direct contact with members of the animal kingdom or by the excreta.

The acute disease in human infants, as a result of congenital infection, is severe. Indeed, all organs of the body are affected[13] although the most pronounced changes are in the central nervous system. Congenital cases which survive the disseminated acute phase have a more prolonged subacute state in which the organisms continue to proliferate in the central nervous system and retina. There results in the brain frequently a diffuse deposition of calcium salts (often visible in Roentgenograms) in the paraventricular region, secondary to necrosis in this area. There results hydrocephalus (more frequently) microcephalus (rarely), retarded mental development, convulsions, spasticity, as well as other neurological sequelae. The retinal lesions result in chorioretinitis.

Feldman and Sabin[2] and Frankel[3] have shown by dermal sensitivity and serum antibody studies that a large percentage, 65 and 28 per cent, respectively, in the two studies of older persons have antibodies to toxoplasma; Feldman and Sabin, on the other hand, demonstrated that only one child in forty, less than nine years, had a positive skin reaction. These studies point to the likelihood that infection after infancy may be relatively benign and, indeed, such has been reported.[7,10,13]

The following laboratory procedures have been utilized in the diagnosis of toxoplasmosis: (1) isolation of the toxoplasma directly or through animal inoculation; (2) demonstration of serum

This study was carried out at the Lapeer State Home and Training School, Lapeer, Michigan; Dr. A. T. Rehn, Superintendent. Dr. Doty is consulting physician at the Lapeer State Home and Training School; Dr. Matthews is Instructor in Pediatrics at the University Hospital, Ann Arbor, Michigan, and Pediatrician in Charge, Northern Michigan Children's Clinic, Marquette, Michigan.

neutralizing, complement fixing or cytoplasm modifying antibodies; (3) demonstration of dermal sensitivity to toxoplasmin.

Estimates of the importance of toxoplasmosis as a cause of mental deficiency appear not to have been made. This problem had been contemplated for a number of years at the Lapeer State Home and Training School but considered impractical because of the technical difficulties in the laboratory diagnosis in subacute and chronic cases. The development of the toxoplasmin skin test,[3] similar to the tuberculin skin test, and provision of the skin testing material by one of the drug firms* gave promise to bringing the problem nearer to solution, and the study herein reported resulted.

Material and Method

Case Material.—It was impossible for us to study all of the 4,500 feeble-minded patients present at the Lapeer State Home and Training School. Because it seemed likely that there would be fewer positive skin reactions as a result of the adult benign type of infection, a group having only infants and children was selected. There were 227 children originally in the group and three expired during the study, leaving 224 whose age ranged from one to fifteen years. There were in this group 13 macrocephalics, 5 microcephalics, 29 mongolians, and 64 spastics; the remainder of the children belong in various classifications of feeble-mindedness. One adult (aged twenty-one) known to have chorioretinitis and hydrocephalus was included in this series.

Procedure.—All cases were skin tested with the toxoplasma antigen. These cases reacting positively after forty-eight hours were retested with antigen and with control material. Ophthalmoscopic examinations were performed on all cases and findings recorded without knowledge of the results of other studies. Skull x-rays were obtained on all micro and macrocephalics, cases having positive skin tests and those showing chorioretinitis; a total of twenty-one cases.

Results

Three cases showed positive skin tests—case summaries appear for these cases below. These cases showed skin reactions of slight intensity, no induration and about 10 mm. of erythema. Repetition of the test showed the same reaction. No reaction to the control material was noted.

Skull x-rays showed five cases with intracranial calcifications. Three of these likewise are discussed below. There was one macrocephalic and one normocephalic who showed intracranial calcification without positive skin sensitivity or ocular findings.

Of the 224 cases examined ophthalmoscopically, five patients had been found with evidence of chorioretinitis. One of these had an early, diffuse, disseminated, bilateral, "salt and pepper" type of choroidal degeneration similar to early retinitis pigmentosa. This patient had one small calcification to the right occipital region and a normal size skull. Skin test with toxoplasmin was negative. A second patient had a disc sized patch of choroiditis in his left macular region. This patient had a normal sized skull, negative skin test and no cerebral calcifications. The remaining three patients with chorioretinitis were the same as those with positive skin tests and also fell into the group with cerebral calcifications. The case histories and physical findings of these three are hereby presented:

R. D., aged eleven, first child of seventeen-year-old mother. Mother said to be living; health unknown. Subsequent children said to be normal. No history of convulsions. Physical examination: Microcephaly, spastic quadriplegic idiot. Pupils react sluggishly to light. Rapid horizontal and rotary nystagmus. Cornea, lens and mediae clear. O.U. Right disc slightly pale with glial proliferation. There is a large glio-pigmentary mass in the macular area O.S., disc, vessels, choroid and retina appear normal. Toxoplasmin intradermal test positive. A.P. and lateral skull x-rays show several small calcifications whose position suggest they are within the ventricular wall.

H. C., aged twenty-one, eighth child of a thirty-year-old mother; seventh and ninth children had no stigmata of toxoplasmosis so far as can be ascertained. Mother died at age forty-eight of cancer or brain tumor. Has had convulsive seizures. Physical examination: Macrocephalus. Spastic quadriplegic imbecile. Horizontal nystagmus. O.D., pupil regular; reacts sluggishly to light. Disc flat, white, arteries and veins attenuated. Large area of destructive choroiditis in the macular region, 1½ disc diameters in size. O.S., phthisis bulbi. Toxoplasmin intradermal test positive. X-ray shows many large calcifications inside of the skull. Two large symmetrical calcifications seem to be localized in the floor of the lateral ventricles near the body. Several small spots of calcium can be visualized spread throughout the brain, probably localized in or near the cortex.

J. F., aged twelve, third child of twenty-three-year-old mother. Preceding and following children fairly normal. Mother living and well. Could not be contacted for skin testing. No history of convulsions. Skull normal size.

*We are indebted to the Eli Lilly Company, Indianapolis, Indiana.

Hyperactive, somewhat spastic, erratic child. Coarse horizontal nystagmus and complete lack of co-operation made detailed fundoscopic examination impossible. Cornea, anterior chamber and lens apparently normal O.U. Lens showed slight cloudiness O.U. Cloudy fluid vitreous with optic atrophy O.D. Disseminated chorioretinitis present O.U. Toxoplasmin intradermal test positive. Skull x-rays show one large calcification in the left parietal region and a smaller calcification in the right cortex in the parietal region also.

Discussion

Certain additional investigations would, of course, make our study more complete. For example, skull x-rays on all patients as well as serological studies of toxoplasma antibodies in addition to the dermal sensitivity tests might be performed. However, at the present time these are impractical.

Our studies showed only two positive skin tests in 223 unselected mentally defective children of all types. The reason for this low incidence as compared to studies done on normal chldren by others remains obscure. It is possible that the skin testing material used was of low antigen content and this resulted in the detection only of cases having large amounts of antibody. This suggestion is made because all of our cases showing positive skin tests had strong evidence otherwise of prior toxoplasmosis. There is a possibility that the negative skin reaction in one case with chorioretinitis and cerebral calcifications represented a false negative reaction.

Although exact figures are not possible, it is significant that toxoplasmosis is a cause of a small fraction of our mentally defective population and as a result of this study we were able to classify three previously unclassified cases as to etiology.

Summary

Toxoplasmin skin tests on 223 unselected mentally defective children with age range from one to fifteen resulted in two positive reactions. Since these two cases and an additional adult patient with positive skin test had chorioretinitis and intracranial calcifications, it is likely that they represent three additional new cases of toxoplasmosis. Toxoplasmosis would appear to be a rare cause of mental deficiency.

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MSMS

GET OUT THE VOTE

We observe that the customary slogan of "Get-Out-The-Vote" campaigns is to the effect: "We *do not care* how you vote, but vote." Is that statement true? It is perfectly natural for us to be interested and concerned about how the other fellow votes, though it would be most un-American and undemocratic to give anyone the right to dictate that vote, as is the case under totalitarian regimes. But we can, without partisan bias and quite properly in the interest of good government, urge the voter not to vote blindly, but as we ourselves should do, to study the issues and to learn as much as possible about the candidates, their backgrounds, reputations, characters, records, experience—then to vote for those issues and candidates that, in his opinion, would best serve the majority interest. An informed electorate is the best bulwark of our American institutions. How you vote may be even more important than that you do vote. Q.E.D., *Kiwanis Letter.*

The Medical and Case Work Approach to Epilepsy

By C. Arthur Hakenen
Saginaw, Michigan

ALTHOUGH HIPPOCRATES gave the first real description of epilepsy, it has remained for centuries one of the least known and most misunderstood of diseases. It is as common as clinical tuberculosis or diabetes, affecting some 600,000 people in the United States. Why then, was no little progress made in its treatment until the last twenty-five years? Dr. Frederic A. Gibbs of the Illinois Neuropsychiatric Institute in Chicago says it is because epilepsy has been a sort of orphan disease to which none of the medical specialties gave proper attention; the psychiatrist, pediatrician, neurologist, and internist have all been parties to its neglect. Neurology should have assumed major responsibility, but there are relatively fewer neurologists every year, according to Dr. Gibbs.

The first anti-convulsant was a long time coming. In 1857 an Englishman named Sir Charles Locock discovered that salts of bromide would reduce seizures. This discovery, however, revealed another problem which is still a factor in treatment today—it had unfortunate side effects. In 1912 Hauptmann, a German scientist, found a better anti-convulsant—phenobarbital, which marked the first real progress. The experiments of Merritt and Putnam produced dilantin in 1937, the first medication that was not a sedative. Since that period improved anti-convulsants came fairly rapidly: mesantoin, mebaral, glutamic acid, tridione, paradione, phenurone, and nuvarone, for example. The epileptic patient will benefit as these new medications become better known to the general practitioner.

Complicating the problem for the epileptic has been the attitude of the public. In ancient times a person with seizures was thought to be possessed of demons. Although physicians are learning to control epilepsy, the barriers of ignorance, superstition and fear still prevent the most effective use of this new knowledge. The impression still persists in the public mind that epilepsy is associated with mental deficiency or illness—This despite the demonstrated abilities of such epileptics as Alfred the Great and Julius Caesar; Lord Byron, Swinburne, and Guy de Maupassant in literature; and artists like Paginini, the violinist, and Van Gogh, the painter. The layman is disturbed when he witnesses a seizure; the grand mal type, for example, is not a pleasant sight. And yet the treatment of epilepsy can be managed as satisfactorily as diabetes, to which no social stigma is attached. It will take continued education to overcome this greatest barrier to the rehabilitation of the epileptic. Recent articles in *The Saturday Evening Post, Colliers,* and *Parade,* in which actual case histories with names were discussed are steps in the right direction.

Mr. Hakenen is district supervisor, Office of Vocational Rehabilitation, Saginaw, Michigan.

The Epileptic Himself

The concept of "the epileptic personality" no longer has general acceptance. The epileptic person cannot, however, escape the impact of public reaction to his illness. He is often denied admittance to schools; the family may feel disgraced; employers are reluctant to hire him; he may find himself an outcast in his social contacts, like the neurotic or post-psychotic. The occasional loss of sphincter control during a seizure is a source of personal embarrassment. It would take an extremely stable individual to escape these pressures on his personality.

The epileptic may need considerable supportive help from his physician and case worker, as well as the intelligent acceptance of his family. He will need to develop some insight into his illness and co-operate wholeheartedly with his physician in medication and other measures. The most important element is reduction or elimination of the seizures through supervised medication. Activity is good therapy—idleness promotes attacks.

The Role of the Family

The realistic understanding of the family is important. They should encourage the epileptic in his rehabilitation, and support his efforts to participate in normal living to the extent that his seizure pattern permits. Overprotection of the epileptic child or adult interferes with treatment and adjustment. The family must be able to give the physician such information as details on the warning aura, supplementing what the patient says; the nature of the seizure, its length, frequency, the

time of day it occurs; family background, and the patient's illnesses or injuries. There should be frank family discussion of their joint problem. The patient or family should become members of such organizations as the National Epilepsy League (130 North Wells Street, Chicago) and read its publications. Studies such as these are encouraging to all concerned. The knowledge that others similarly afflicted have joined forces with the medical profession, public and private rehabilitation agencies, informed employers and interested citizens in attacking the problem is a morale builder.

The Diagnosis

From the patient, the family, and the case worker the physician will get material helpful in making a diagnosis. To it the physician will add the general physical examination, neurological status, and his response to treatment. What causes seizures is not known; no one can predict when they will occur. From the patient's history and medical examinations the physician determines the nature of the seizure. Is it idiopathic, of unknown origin? Or is it symptomatic and indicative of brain lesions, traumatic in origin or the result of illness? Here the electroencephalograph is a diagnostic aid. The electroencephalograph helps to determine if pressure on the brain is the cause of the seizure. Since seizures are a disorder in the brain wave patterns, the electroencephalograph is a valuable instrument in research. It has been found that 87 per cent of epileptics have an irregular brain wave pattern; 15 per cent of non-epileptics show a similar pattern.

From these studies the physician arrives at the diagnosis. It may be one or a combination of four general types: (1) *Grand mal* (big illness) is the only one that may be called a convulsion, and is the one most familiar to the public. There is loss of consciousness from one to three minutes, rarely longer. Afterwards there may be a period of drowsiness and confusion for a half-hour or more. There may be tongue biting and loss of sphincter control. (2) *Petit mal* is a short seizure—10 to 30 seconds long. It is a temporary blackout, in which the patient loses contact with his surroundings. Unlike grand mal, he does not fall, and soon resumes what he was doing prior to the attack. These can occur as often as 100 times a day. (3) *The psychomotor attack* is the result of irritative injury to the anterior portion of the temporal lobe of the brain. It occurs in 3 per cent of the cases. These attacks are characterized by trance-like behavior, as though the patient were acting out a dream, and of which he has no recollection afterwards. Occasionally there is bizarre behavior. Dr. Jerry Price believes that such patients usually have personality disorders or even psychoses. (4) *The Jacksonian seizure* is the local attack. It can be limited to a finger or twitching of the mouth. Usually it is confined to one part of the body; for example, a peculiar sensation in one hand is followed by rhymical jerks of the thumb, first finger, or both. Symptoms may be limited to one side of the face or one-half the body.

Treatment

The medical treatment of seizures is a process in which various anti-convulsants are tried out on the patient, singly or in combination. The problem is to determine which medication procedure will reduce or eliminate the seizures, without toxic effect on the patient. Since the side effects of medication vary with each person, the physician has to conduct patient experimentation in dosage. If control is achieved at the expense of unpleasant symptoms another drug or combination must be tried. Dr. Gibbs says that increases or decreases must be gradual, or seizures may be precipitated. Blood studies, liver tolerance, and other laboratory tests are important aspects of determining toxicity.

Dr. Gibbs discusses treatment in the February, 1951, issue of The Journal of the Michigan State Medical Society in considerable detail. From his article, "The Treatment of Epilepsy," the general practitioner can apply basic procedures to his own patient. Page 147 contains a prescription chart with recommended dosages. For grand mal, psychomotor episodes, and Jacksonian attacks he recommends initial medication with dilantin and phenobarbital (the latter the least toxic and also the least potent.) Mild cases respond to phenobarbital alone, but more effective is its combination with dilantin. Dilantin at high dosage may produce such symptoms as dizziness, double vision, and inco-ordination, but these subside when the amount is reduced. If hypertrophy of the gums develops, nuvarone may be substituted or added to the dilantin. Mesantoin is another anti-convulsant which may be used as a substitute for phenobarbital in combination with dilantin or

nuvarone, but it requires careful supervision for possible blood damage. If there are reactions, they will subside when mesantoin is stopped, but it may be resumed in small doses if the blood count is entirely normal.

Dr. Gibbs reports that for petit mal attacks the medicines described above have little effect. Tridione has been used instead with remarkable results, not only stopping the disorder but actually tending to cure it. Paradione is also effective. Patients who have both grand mal and petit mal attacks have an added problem. Dilantin and mesantoin increase petit mal; tridione and paradione increase grand mal disorders. These combinations cannot therefore be used in such cases. For such mixed disorders phenurone, a new drug, is indicated.

In medical therapy the patient must repose absolute confidence in his physician and follow his instructions to the letter; otherwise the careful adjustment to the proper medication is impossible. The physician alone is responsible for procedure. Neither the patient nor his family should attempt self-diagnosis or changes in treatment. The patient should ignore advertised "cures."

When medical treatment fails to control seizures, surgery to remove the epileptic focus has been used in selected cases. This approach is reported to show improvement in 50 per cent of the cases but must still be considered experimental and needs further research. Where there is a significant emotional component to the illness, psychiatric evaluation and psychotherapy in conjunction with medication has produced good results.

The Case Worker's Function

The case worker has opportunity to play an important role in rehabilitating the epileptic. The family concerned about hereditary taint can be given assurance that only one in forty children born to near relatives of epileptics will have seizures —a very small percentage in a world filled with chance. About eighty out of every 100 persons can lead relatively normal lives with medical and social care. Epileptics are employed in occupations ranging from unskilled labor to the professions (including medicine), since they have the same range in native capacity as the general population.

The case worker's most effective work, however, is with the patient himself. He can help promote the most favorable psychological climate for control. He can give support to the physician's recommendations, prepare the client for his part in therapy, and give reassurance when side reactions develop. He needs to have some knowledge of anti-convulsants, in order to interpret medical procedures to the patient. The patient must be educated to the fact that medication must be maintained daily—that, like diabetes, it controls but does not cure.

Job placement in productive employment is the ultimate goal in adjustment of the epileptic. As was mentioned earlier, useful work is therapeutic and reduces seizures. Psychological tests are important, since in this particular disease the right work is of great significance. Vocational training may be necessary, where the patient can profit from it. A recent study of 1,000 epileptics of employable age by Lennox and Cobb reviewed the medical records as submitted by neurologists throughout the country. This research revealed that three-fourths of these adult patients were employed. Employers have hired epileptics, and the armed services have admitted them, but neither does so knowingly. Obviously it would be much better if hiring was done on the basis of medical recommendation and with proper safeguards, with the employer in complete knowledge of the facts. Otherwise the epileptic works in constant fear of the chance seizure that may cost him his job.

After the medical problem has been stabilized and the proper job objective has been co-operatively selected, the case worker can assist in placement. The employer should be advised that the patient is under competent medical care, and told about such safeguards as may be necessary for his protection and that of his co-workers. The epileptic should not be recommended for placement unless there is reasonable expectation of successful employment. Co-workers should be given instruction on what to do when a seizure occurs.

In summary, it should be noted that rehabilitation of the epileptic requires a team approach. Progress is being made through establishment of such centers as the Detroit Epileptic Clinic. Branches of this clinic in the upstate areas are under consideration. As Dr. Gibbs has indicated, there is no reason why the interested internist or general practitioner cannot undertake the modern treatment of epilepsy.

Detroit Physiological Society

MEETING OF MAY 22, 1952

Regional Differences in the Tensile, Compressive and Fatigue Strength of the Human Tibia

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The tensile, compressive and fatigue strength of compact bone from the tibia were determined by approved engineering techniques. The samples were cut longitudinally from the anterior, posterior, medial and lateral quadrants of the proximal, middle and distal thirds of the bone and then shaped to a standardized size in a milling machine.

The average tensile strength (lbs/in^2) of 94 samples from the left tibia of 7 white male individuals ranging from 23 to 61 years of age was greatest in the samples from the lateral quadrant while those from the middle and distal thirds were approximately equal.

The average fatigue strength (at a stress of 5000 lbs/in^2) of the samples thus far tested was greatest in those from the middle third and the posterior quadrant. The strength is recorded in the number of cycles to failure.

Below knee amputations, in which the proximal third of the bone was missing, were used for a comparison of the average compressive and tensile strength. The bones were divided into quadrants of the proximal and distal halves. So far the samples from the lateral quadrant and the distal half have the greatest average (lbs/in^2) tensile and compressive strength. The compressive strength is considerably greater than tensile strength.

All samples were obtained from amputation specimens and were tested in the wet condition. The age, sex, race and reason for amputation were known in all cases.

The investigation was supported (in part) by a research grant, RG 1925 (C2) from the National Institutes of Health, Public Health Service.

Extra-Caloric Significance of Glycolysis for Growth of Embryo Tissue in Culture

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During work with various carbohydrates as sources of energy for "growth" of chick embryo cells in tissue culture by the roller tube method, it was found that the hexoses, natural or phoshorylated, supported proliferation and explant integrity surprisingly well despite marked deficiencies of the cultural medium. When culture conditions are such that carbohydrate is the limiting factor in proliferation, i.e., with Tyrode's solution, amino acids, and hexose in the absence of embryo extract or serum, duration and area of proliferation and explant integrity were far superior to that seen when pyruvate or the dicarboxylic acids of the Krebs cycle were used as the source of energy instead of hexose.

This discrepancy in support of "growth" by the two groups of energy substances suggested an important extra-caloric function of glycolysis.

Vitamin or co-factor supplements tended to improve the quality of proliferation more with the Krebs group than with glucose. Further improvement occurred with the Krebs group when ribonucleic acid was added; but a similar addition to the glucose medium resulted in suppression of proliferation. Testing of nucleotides, nucleosides, or free purines and purimidines, alone or in combination re-affirmed the importance of this group of substances for proliferation when energy is obtained via the aerobic oxidative pathway, and their ineffectiveness during active glycolysis in chick tissues, which normally synthesize their own nucleic acids from non-purine precursors. One exception was found. Small concentrations of uridine invariably augmented the proliferation obtained with glucose, suggesting a special function of this nucleoside in glucose metabolism.

It is concluded that one of the extra-caloric aspects of glycolysis is participation in nucleic acid synthesis in a more fundamental way than merely insuring a supply of ribose.

Problems Relating to Central Pathways for Pain

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Old clinical observations and recently developed surgical procedures for the relief of pain tend to modify the general concept of the existence of a specific central pathway for pain. At midbrain level where pain fibers are isolated, spinothalamic tretotomy (Dogliotti operation) or coagulation (Spiegel, et al.) are followed by dysestesias, sometime called "painful," a feature also of the post. inf. cereb. art. syndrome. Frontal lobotomy abolishes the affective reactions to pain, not pain sensations. Our Marchi studies on chordotomy in monkeys and cats showed that spinoreticular fibers are an important component of the ascending degen-

(Continued on Page 1108)

Editorial

MICHIGAN STATE MEDICAL SOCIETY ANNUAL SESSION
SHERATON-CADILLAC HOTEL—DETROIT
September 24-25-26, 1952

FROM THE DECLARATION OF INDEPENDENCE AND CONSTITUTION

"WE HOLD THESE truths to be self-evident, that all men are created equal, that they are endowed by their Creator with certain inalienable rights, that among these are life, liberty and the pursuit of happiness. That to secure these rights, Governments are instituted among men, deriving their just powers from the consent of the governed."

From the Constitution of the United States:

"*We, the People* of the United States, in order to form a more perfect Union establish justice, insure domestic tranquility, provide for the common defence, promote the general welfare, and secure the blessings of liberty to ourselves and our prosperity, *do ordain and Establish*:" . . .

"All legislative powers *herein granted*:"

"The Congress shall have power to:"

(They are laboriously listed: Nineteen of them in the instrument besides those which have been allowed by amendment.

Seven prohibitions are also listed.)

"The right of the people to be secure in their persons, houses, papers and effects against unreasonable searches and seizures shall not be violated . . ."

Oath of office of the President: "I do solemnly swear (or affirm) that I will faithfully execute the office of President of the United States, and will to the best of my ability, preserve, protect, and defend the Constitution of the United States."

It is time this nation came back to fundamentals, as provided by the Declaration and the Constitution. We have watched increasing encroachments on basic rights. Any power which can steal steel can invade our individual rights as easily.

IODIZED SALT VS. GOITER

CHANGING the habits of people is a difficult task—particularly health habits. It can be done, however, without legislation. Using iodized salt has become sufficiently a habit in Michigan that simple colloid goiter is now almost nonexistent.

A survey in 1924 of the school age children in four counties demonstrated a high prevalence of palpable thyroid enlargement. Education techniques were introduced encouraging the use of iodized salt. The family doctor, the teacher, the public health worker, the editor and many others talked up the merits of iodized salt. Results? A resurvey of the school age children in the same four counties in 1951 revealed less than one per cent with palpable enlargement of the thyroid gland.

Persuasion to the point of changing health habits is a long term job. Information, based on sound facts, must be disseminated through every personal and mass medium of education.

Is the job finished? No, it isn't. Persistent, steady encouragement of the continued use of iodized salt must be maintained if gains are not to be lost. The family doctor is a key person in holding these gains. Tell your patients about the need for continuing to use iodized salt.

Urge your patients—and your family—to look carefully at the package on the store shelf to be sure of getting iodized salt.

Co-operative effort pays dividends.—J. K. ALTLAND, M.D.

HEALTH AND ACCIDENT INSURANCE

A COMMITTEE of the Council has been studying a suitable health and accident policy for the members of the Michigan State Medical Society. A preliminary report was made at the midsummer meeting of the Council, and a proposal will be presented to the House of Delegates at the annual meeting in September. This will represent many months of study and in the opinion of the committee offers the best protection for our members obtainable.

Members in practice up to age seventy-five are eligible. Many of our members are being asked

to invest in this insurance. Those who have such insurance should keep it.

All of our members should watch for the announcement following the annual (September) meeting. Even those who are already carrying this type of insurance might wish to increase their protection.

The proposed policies are individual contracts between the doctor and the insurance company, with the proviso that before they take effect 51 per cent of the membership must be obtained.

DEFICIT SPENDING IS LARCENY

DEFICIT SPENDING is the expenditure of more than the income by individuals, by institutions, business or the government. In the case of individuals, or business this leads to bankruptcy, and bankruptcy is nothing more than larceny from the creditor. Deficit spending in the case of government in times past led to printed money with loss of value. Now instead of printing money we are printing bonds for sale to our people, our banks and our investment trusts, insurance trusts, and widow's reserves. So long as these bonds are redeemable in dollars of equal value as when invested all is well, the government is financed, and the lender reaps some reward. But when the redeeming dollars are depreciated in value, the widow, the orphan, the fixed-income or retired person, the church, or school trust suffers.

Government has adopted another approach to the financing problem. It prints bonds which are offered to the public, bearing interest and payable in unstable dollars. It also prints bonds which are only offered to banks and banking institutions. These the bank may purchase in million dollar lots, depositing them as cash, and allowing the government to draw checks for the amount of the "loan." The banks customarily retain about twenty per cent of deposits in their vaults to cover all withdrawals. The balance or eighty per cent ($800,000.00 in this case) is available for other loans, to individuals, businesses, or even the government. Again twenty per cent may be reserved and again loans may be made. In this manner a bank may loan about five dollars for every dollar of its deposits. These loans are ultimately paid off, business goes on as usual, but the total structure is insecure.

Government by its deficit spending is increasing this insecurity. Every dollar spent in excess of income goes to reduce the value of the capital by just so much in percentage. Economists are beginning to appreciate this fact, and are suggesting ways to prevent deficit spending, which is inflation, and is larceny to speak in plain terms. There are bills in Congress to prohibit such spending, and to limit spending to not exceed tax receipts.

We should notify our Congressmen to support such bills. Every dollar of excess spending affects those of us who are saving for the future, for that nest-egg may fail us if the value of our money does not hold up. The person who is not looking to the future, who lives up to his income need not worry, for he gets the going value of his money as he earns it. Others, including the widows, schools, and beneficiaries of insurance will lose to the full extent of the loss due to inflation-deficit spending. Government and banks are not so interested in the problem here presented because they deal in dollars as measures of capital, not in the purchase power of the dollar as does the individual.

Write your U. S. Senators and Congressmen, today!

THE SOCIAL PLANNERS—THE FABIANS

ALL MEDICAL men, actively interested in medico-sociological affairs, have recognized for many years a systematized and constant pressure to advance the socialist state, and to make Medicine the prime point of attack. The goal is power for a small entrenched group which can pull strings and gain its ends by any trickery or subterfuge available.

The Communist party works that way. Less than two dozen wilful men now rule 65 per cent of the world's population.

The Fabian movement in Britain has been operating since the early memory of many of us. The plan was deceptive—the objective well outlined, but not so obvious as to invite much opposition, the end a socialized state.

In America the evidence of social planning developed about the time of the Committee of One Hundred. That was the first obvious evidence of the threat of socialized medicine. The attack became somewhat direct in the form the various Wagner-Murray-Dingel bills and their several predecessors.

American Medicine was alerted—and began

opposing. We opposed almost everything suggested, until we were recognized as "always opposing—never proposing." The Medical opponents became so omnipresent that the Social Planners took another tack. They outguessed us by two or three years—maybe more. The Wagner-Murray-Dingel bills are still in Congress—under different names—but the sponsors have no expectation of enacting them.

A different program of attack has developed. The pressure has been relaxed slightly upon medicine and stressed with considerable success on Education, Public Service, Electricity, Agriculture, Banking and the big industries—railroads and steel. Attention to medicine as the opening wedge of National Socialism is apparently being relaxed and many of our members have felt we had won the fight.

Not so. For several years a nibble has been taken here, a bite there, until we have approximately thirty-million of people under socialized medicine now with the number constantly increasing.

The Federal Securities Administration attempted within the year to add about twelve-million over-sixty-five persons to the list. The latest attempt to add a group was just vetoed in the House of Representatives. The concept was increased benefits for old age assistance and certain other groups. The hidden objective was control by The Federal Security Administrators of the amounts of benefits, method of payment, the medical service in determining the amount of help.

At present probably a more dangerous threat is attack from without. The International Labor Organization is setting up an international plan for Social Security for every member nation. The United States is a member nation. An analysis of its plan was publihed in *Journal American Medical Association,* May 31, 1952. The meeting to adopt was in Switzerland in July. The Director General of International Labor Organization refused to allow the medical world to make any suggestion for the regulation and furnishing of medical service.

Our members may say this cannot affect us—but it does directly. If adopted it can become the law of the land because the International Labor Organization and the United Nations which is suggesting the same program are accepted by us. We are a part, and by Treaty provision. The Constitution provides that International Treaties supersede the law passed by Congress or by any of our states.

Senator Bricker of Ohio and sixty-five others have a joint resolution in Congress to amend the Constitution canceling that provision. The United States is the only major nation acting under such control. The American Fabians—who are a world organization—saw this fault in the Constitution several years ago and began planning when they set up International Labor Organizations and United Nations. These Senators need our help and active support or socialism will prevail.

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OSTEITIS DEFORMANS

(Continued from Page 1007)

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Annual Reports

ANNUAL REPORT OF THE COUNCIL—1951-52

The Council had three sessions of eight days and the Executive Committee of The Council convened eight times (to September 20, 1952), a total of eleven meetings up to the 1952 Annual Session of the Michigan State Medical Society. All matters studied and recommendations made by The Council's thirty-nine Committees as well as the Society's thirty-two Committees and all business of the Society were referred to The Council or to its Executive Committee for consideration and action.

A total of 117 hours, over fourteen days of eight hours each, was spent by members of The Council and of the Executive Committee at the 1951-52 meetings; this total does not include the generous amount of time spent going to and returning from the meetings which were scheduled in various parts of the State.

Membership

Membership as of June 30 and as of December 31, from 1935 to 1952, is indicated in the following chart:

	1952	1951	1950	1945	1940	1935
June 30	4,776	4,647	4,881	4,425	4.401	3,410
December 31		5,214	5,114	4,686	4,527	3,653

The figures for 1952 include 4,495 Active Members, 118 Emeritus and Life Members, 10 Retired Members, and 153 Associate and Military Members.

Finances

As in the past, the first item of new business on the monthly agenda of The Council or its Executive Committee is "Study of Monthly Financial Reports." Every thirty days, therefore, the Society's financial picture is reviewed and governing policies established. In addition, the Finance Committee meets periodically (four times during the past year) to study and to advise The Council on particular fiscal questions.

The Auditor's report for 1951 plus the budgets of the Society for 1952 were published in JMSMS, March number, beginning on page 367. Members are invited to acquaint themselves with the financial status of their State Medical Society and to offer suggestions; these always are truly appreciated. As of June 30, 1952, 4,495 members paid Society dues amounting to $89,710.00. This was on the basis of $20.00 per member to the General Fund as established by The Council in January, 1952. An equal amount accrued to the Public Education Account for current activities, and $8,971.00 was set aside in a Building Fund as well as $6,728.26 in a contingent surplus fund.

A brief financial résumé of each of the MSMS activities as of June 30, 1952, is herewith presented:

	On Hand 1-1-52	Income to 7-1-52	Expenses to 7-1-52	Balance on Hand 7-1-52
General Fund	$ 70,923.65	$ 96,464.74	$ 53,500.75	$113,887.64
Annual Session	—	20,400.00	2,595.06	17,804.94
Clinical Institute	—	11,590.00	9,731.18	1,858.82
The Journal	—	33,773.61	26,162.90	7,610.71
Public Education	32,055.98	90,387.65	48,474.69	73,968.94
Public Education Reserve	30,000.00	—	—	30,000.00
Rheumatic Fever Control	26,431.80	8,250.00	12,442.56	22,239.24
Surplus from dues	7,117.81	6,728.26	—	13,846.07
Building Fund	9,490.42	8,971.00	6,340.69	12,120.73
Totals	$176,019.66	$276,565.26	$159,247.83	$293,337.09

The AMA dues collected by county medical societies and forwarded by MSMS to the American Medical Association during the six months to June 30, 1952, totaled $109,725.00. The high percentage of American Medical Association dues being paid by MSMS members is to be noted. The Council feels that the members of our State Society should be congratulated on their tangible co-operation with and support of the American Medical Association.

A résumé of the financial condition of the Michigan State Medical Society as of August 31, 1952, will be presented to the House of Delegates at its opening session of September 22, 1952—as a part of The Council's Supplemental Report.

In April, $55,000 in short-term U. S. Treasury Certificates of Indebtedness were purchased out of temporary surplus from 1952 dues; this transaction will yield 1.6 per cent interest—instead of no interest were the money allowed to lie idle in a commercial account.

In May, 1952, MSMS purchased a vacant lot at 311 Hillsdale Street, Lansing, to rectangularize the MSMS property, which now has a frontage of 126 feet on Townsend Street and 100 feet on Hillsdale Street.

We record with true regret the passing on February 3, 1952, of MSMS Treasurer Andrew S. Brunk, M.D.; a fitting resolution to his memory was published in the March Number of JMSMS.

Former President and Treasurer William A. Hyland, M.D., Grand Rapids, was re-elected MSMS Treasurer in March.

Journal

The Journal of the Michigan State Medical Society has now completed a half century of publication. The fifty-first year is well started, and the policy of making The Journal truly a presentation of the work, ambitions, and achievements of the Society has been continued. For several years, the editorial policy has been to expound to readers the socio-economic problems of our Society and our profession.

Through the years our Journal has presented our controversies and problems, has offered comments and solutions; Michigan has had the satisfaction to see many of our suggestions followed at the national level. Just a few ideas will illustrate the fact that Michigan has been in the front rank in the fight to preserve the independent and private practice of medicine: we were among the first to formulate a successful Medical Service plan; we proposed the Michigan plan of home town medical care of veterans; we established a fee schedule for governmental agencies; we early promoted post-graduate education; we established a public relations counsel and department.

For many years certain numbers of The Journal have been devoted to special interests of the Society or our members, or of practice, and our covers graphically illustrated that activity. Plans along this line are made for the balance of the year and for all of next year. We have had many compliments on our distinctive covers, and are proud of them.

We have tried to express in our editorial policy the concensus of The Council and of the Society in combating encroachments on our liberties, civil or personal. We shall continue that plan, devoting a considerable part of The Journal to such non-scientific information in addition to the host of highly scientific papers which we have published.

The Publication Committee and the Editor thank our MSMS members for their continued support, fellowship and encouraging help without which the publication of this Journal would be merely the task of issuing "another medical journal," rather than a true house organ of the Michigan State Medical Society. Expressions of appreciation from members have been a buoying influence over many trying periods.

Organization

1. The County Secretaries-Public Relations Conference, held January 27, 1952, in Detroit, not only broke all attendance records but featured the "Formula

For Freedom" on the Public Relations side and the "Beaumont Memorial Restoration" on the organizational side.

2. The Sixth Michigan Clinical Institute was held in Detroit, March 12-13-14, 1952, with a registration of 1,933—again a record. The popularity of this scientific graduate meeting is best reflected in the excellent newspaper and magazine coverage of the event.

3. Joint meetings of Michigan's Delegates to the American Medical Association with the Executive Committee of The Council (held before the June and the December Sessions of the American Medical Association) were continued during the past year. Wm. A. Hyland, M.D., Grand Rapids, was chosen Chairman of Michigan's Delegation to the American Medical Association, following a three-year tenure by W. D. Barrett, M.D., Detroit, who was praised for "building up Michigan's reputation among AMA Delegates to a high degree during his tenure."

4. The Student American Medical Association was recognized by MSMS during the past year by inviting the Presidents of the University of Michigan Medical School unit and of the Wayne University College of Medicine unit to attend the MSMS House of Delegates Session in Grand Rapids; this procedure will be followed routinely in future years. Also, MSMS sponsored the attendance of four student delegates from our two Michigan medical schools to the SAMA convention in Chicago in December, 1951. In addition, the president and secretary of the national SAMA met daily with Michigan's delegation during the AMA House of Delegates Session in Chicago, June, 1952.

5. The Executive Secretaries of five of Michigan's county medical societies (Genesee, Muskegon, Saginaw, Washtenaw, Wayne) attended a one-day study-conference in the new MSMS home in Lansing on April 16. The organizational benefits of this meeting were such that The Council voted to continue this meeting on an annual basis.

6. Organization among the fifty-five component societies is being maintained to a satisfactory degree. Grateful appreciation is again presented to those county medical societies which sponsor annual scientific postgraduate "clinic days." A continuation of these high quality training programs is recommended.

Public Relations

Public Relations activity has become an integrated inseparable part of modern medical organization. Although special campaigns are carried out in part or in whole by the Public Relations Committee, its main objective has been to make all activities of the MSMS bear weight to improve the attitude of the public toward doctors of medicine and their organization, and to stress the many medical-scientific advancements made through the labors of doctors of medicine. These were the key activities in public relations of the Michigan State Medical Society for 1951:

"Formula For Freedom"—this program wrapped into one package all the public relations activities of MSMS. It was developed on the basis that all medical public relations activities are designed to avoid compulsions so that the work of every doctor of medicine and every medical society might be carried out for the benefit of all persons with a minimum of interference from either government or outside forces—and with personal and professional freedom.

The program was introduced, following its adoption by the 1951 MSMS House of Delegates, by a series of twenty-three "Formula For Freedom Nights" before county medical societies, the Upper Peninsula Medical Society and several woman's auxiliaries.

First Element—Formula For Freedom

The first element "Know Yourself" was pushed forward by the Michigan State Medical Society-Michigan Health Council Joint Committee on Periodic Health Appraisal. This 19-man committee, with each member representing a different organization, met three times. It developed a personal health appraisal questionnaire for the public and a plan for an educational campaign to emphasize the concept and importance, both to doctors and the public, of periodic health appraisal. This proposal represents another "Michigan First."

Second Element—Formula For Freedom

The second element "Know How To Live" was implemented by an educational program that made use of the following media:

Newspapers, magazines, publications: These media were actively used for educational purposes. Eight thousand releases were made to newspapers on conventions and special projects of MSMS. In one of its numbers, the magazine *Inside Michigan* gave a cover and feature article to MSMS; 3,000 reprints of this article were distributed. The Medical Associates brochure "In Planning Your Career" was revised and a second printing of 10,000 copies was made. Public relations articles appeared in JMSMS, the JAMA, the J Student AMA and in *Medical Economics.*

Television: Fifty-two broadcasts of one-half hour each have been made of both the "It's Your Life" and the "Medical Mailbox" television programs. The former was broadcast over WJBK-TV Detroit and the latter over WXYZ-TV Detroit.

Radio: "Tell Me, Doctor" continued five days per week, on 14 stations full time and 12 additional stations part time. This five-minute daily health news program served to disseminate a wide variety of scientific and socio-economic health information. In addition to this program, many special radio shows were presented.

Cinema: Continued use was made of the motion pictures "Lucky Jr." and "To Your Health" which reached a total paid attendance in Michigan of over 700,000. These motion pictures were televised over four stations in Michigan with the total viewing audience of the picture in Michigan and in other states reaching over five million persons. The film, "To Save Your Life" has been broadcast over two TV stations and presented to seventy-three separate audiences. Twenty-five motion pictures were used on MSMS TV programs. Co-operation has been given to the Michigan Heart Association in the development of its new motion picture "New Hope for Hearts."

Exhibits: An exhibit at the State Fair was inaugurated last September. On that occasion 58,000 pieces of MSMS and AMA literature were distributed. Exhibits and literature were supplied to county medical societies for use at county fairs and to the Woman's Auxiliary for use at various public meetings. An MSMS exhibit was displayed at the Michigan Rural Health Conference.

Adult Education: A new program of Adult Education was developed in connection with the Adult Education Division of the Department of Public Instruction. Seven County Medical societies presented varying series of classes in 11 counties on the subject "Medical Care in the Home and Family," forty-eight doctors participated as teachers and over 5,500 classroom hours were accumulated by students in these classes: In addition, widespread publicity resulted when the programs were re-broadcast on radio stations.

Publicity at Annual Session and Michigan Clinical Institute: To maintain present good relationship with the press and radio as well as to obtain accurate interpretation of scientific papers, a pre-convention dinner was given by the MSMS Press Committee for the science writers of the press and radio. In addition to advance news releases which were sent to 359 newspapers and forty-six radio stations, special stories and abstracts were developed on major events of these meetings and a

schedule of four major radio broadcasts and addresses before six major service clubs was organized.

Office plaque and AMA publications distributed: In co-operation with the expanded AMA public relations program, over 1,000 Michigan doctors of medicine purchased and placed in their offices plaques designed to provide understanding between doctor and patient on the matter of services and fees.

Taking advantage of the new pamphlets developed by the AMA, Michigan doctors distributed over 100,000 pieces of literature on subjects such as "A Doctor For You," "Your Doctor For A Friend," "Medical Colleges in Vast Expansion," etc. The Woman's Auxiliary was very effective in assisting in this distribution.

Michigan's Foremost Family Physician: Providing an example of service rendered by the medical profession, the selection of Michigan's Foremost Family Physician received widespread attention. Statewide publicity was accompanied by a congratulatory resolution adopted unanimously by the Michigan Legislature. Following the development of a brochure on our Foremost Family Physician, Dr. Clayton Willison received the additional honor of being selected by the AMA as one of the three top family physicians in the country.

Awards: Several awards made by the MSMS to point out accomplishments made by particular groups or individuals in the health field were given widespread publicity. A special program honoring C. E. Wilson, Max R. Burnell, M.D., and Clarence D. Selby, M.D., of General Motors, was held in Detroit to point to outstanding work done in the field of industrial health. During the 1952 Michigan Clinical Institute, awards were made to the Hillsdale County Medical Society for the development of the "Hillsdale Cancer Detection Plan"; to Leo H. Bartemeier, M.D., Detroit, and to J. Milton Robb, M.D., Detroit, for national leadership in the respective fields of psychiatry and ophthalmology-otolaryngology.

Surveys: Three separate publications were distributed on the Michigan Health Survey. The two earlier reports were made on the Michigan Health Survey proper and on the distribution of M.D.s and osteopaths in Michigan. The third and latest report was made on the Two Community Survey (Pellston and Tecumseh). These were printed by Michigan State College and distributed to MSMS members. Observation and advice was given to the Lenawee County Survey made by Michigan State College for the Health Information Foundation. A survey of county medical society medical service programs was made and material prepared for newspaper releases based on the information obtained.

Michigan Rural Health Conference: The planning and publicity of this Conference emanated from the Public Relations Department of MSMS, also the idea of the "Court of Public Appraisal" which proved to be the Conference highlight.

Beaumont Memorial: To further develop the concept of medical progress, the brochure "That More May Know" was printed (10,000 copies) and distributed. A planograph was made following the development of an article on the Beaumont Memorial printed in the *Sault Ste. Marie Evening News;* ten thousand copies of this planograph were printed and distributed. Several news releases have been issued; two personal letters from President Otto O. Beck, M.D., were sent to all members of MSMS and one to all members of the MSMS Woman's Auxiliary as part of the fund-raising effort to restore the American Fur Trading store as a memorial to Dr. William Beaumont. The PR Field Secretaries have zealously urged attention to this project. A good response has been received from the letters and if this project is completed as planned it will serve as an excellent permanent public relations factor.

Assistance to others: Recognition of Michigan Medicine's leadership in public relations was indicated by the unusually large number of demands for advice and assistance on health matters that came from other groups. Michigan representatives acted on the AMA Public Relations Advisory Committee; provided speakers at the AMA Interim Session in Los Angeles and on the occasion of the newly developed Medical PR Conference in Chicago sponsored by the AMA. In addition to assistance given to eight other state medical societies and 15 out-of-state county medical societies, many ancillary and auxiliary organizations were aided. These include state and national hospital associations, business and professional organizations, voluntary health associations, medical and hospital service associations, and health councils. A wide variety of state organizations joined with the MSMS television programs, thereby stimulating greater co-operation in the various health fields in Michigan.

Third Element—Formula For Freedom

The third element "Know Your Government" was carried out by joint effort between the Legislative Committee, the Public Relations Committee, the Woman's Auxiliary, the Medical Assistants and others; it worked to effect improvements in Michigan laws (see Legislative Committee report) and changes in the Michigan constitution (Reapportionment of Legislature), get-out-the-vote, liaison with government agencies, and to inspire individual doctors of medicine to be politically active outside medical organizations.

In addition to usual contacts with government officials, a special tea was held for their wives through the excellent co-operation of the Ingham County Woman's Auxiliary. In lieu of Christmas cards a book "Key To Peace" was sent at Christmas time to U. S. Senators and Congressmen and to all Michigan Legislators.

Woman's Auxiliary

A keystone in the campaigns of the Michigan State Medical Society, particularly in the fields of legislation and public relations, has been the Woman's Auxiliary.

The support of these fine ladies has been marked by their enthusiastic willingness to co-operate closely with the policies adopted by MSMS and the component county societies of this State. In the activity of their 2,201 members they have doubled the personal strength of all the individual members of the medical society.

They have distributed thousands of pieces of literature; they have contacted hundreds of schools; they have obtained signatures, letters, endorsements, and funds as needed. Their personal contacts and telephone calls have given the necessary impetus to essential projects of the medical profession.

In addition to all these and their general assistance to the doctors, they have carried out their own program of civic and health betterment that has become a model to all women's organizations in Michigan.

The MSMS is deeply indebted to them for their splendid assistance, and confidently looks forward to their continued future help.

Contacts with Governmental Agencies

Contacts with federal, state and local agencies continue to grow and to be an important activity of the Michigan State Medical Society. Chief among these contacts during the past year were:

1. *Michigan Day in Washington, D. C.* Pursuant to the instruction of the 1951 MSMS House of Delegates, The Council again dispatched representatives to Washington, D. C., in April, 1952, on the occasion of this day sponsored by the U. S. Chamber of Commerce. Continually increasing goodwill results from these personal contacts with our friends in Washington.

A recommendation on this subject follows:

2. *Michigan Department of Health.* During the past year, State Health Commissioner A. E. Heustis, M.D.,

attended practically all meetings of The Council and of its Executive Committee, to discuss mutual plans, problems, and ambitions with MSMS. Important matters discussed were rules and regulations for hospitals with maternity departments; co-operation in the maternal mortality survey; revised birth and death certificates; medical civil defense; need for a physician at Beaver Island; special VD and TB survey in Detroit; joint efforts with the MSMS Child Welfare Committee on communicable disease control; and the publishing at State Health Department expense of the *Cancer Manual.* Commissioner Heustis has requested the assistance of MSMS in reviewing the public health programs of the State so that sound and worthwhile recommendations might be available in the case of future activity in governmental reorganization of the health field.

3. *The Michigan Crippled Children Commission,* and its Medical Director, Carleton Dean, M.D., maintained a spirit of excellent co-operation with MSMS during 1952. The Commission meets with the MSMS Council annually in July for a review of problems and matters of mutual interest.

The personnel of the Commission has been maintained at high level through the understanding of the Senate of the State of Michigan.

4. *Amendments to Medical Practice Act.* As a result of long study by a joint committee, representing the Michigan State Board of Registration in Medicine and of the Michigan State Medical Society, and upon the recommendation of the 1951 MSMS House of Delegates, the Legislature adopted long overdue amendments to the Medical Practice Act of 1899. Increased legal power and potential financial support given the Michigan State Board of Registration in Medicine now removes previously existing barriers to maximum effectiveness in (a) enforcement against offenders and (b) encouragement to more residents and interns to train in Michigan hospitals—with the inevitable result that many of these well-qualified M.D.s will remain to practice in this state. Michigan medical practice will benefit by this modern workable law. (See "Matters Referred to The Council by 1951 House of Delegates.")

5. *Amendments to Basic Science Act.* Significant changes in the Basic Science Act were made by the 1952 Michigan Legislature, as a result of a study made by a Committee of the Michigan State Medical Society and at the specific recommendation of the 1951 MSMS House of Delegates. A meeting with the Chairman and Vice-Chairman of the Michigan State Board of Examiners in the Basic Sciences, to discuss these sweeping legislative changes and other matters and mutual problems concerning administration of the law, was held by a special committee of MSMS in April, 1952. The streamlining of the Act permits truly efficient administration, which was the intent of the original law of 1937. The Board now has the legal opportunity and the social responsibility to make Basic Science work. (See "Matters referred to The Council by 1951 House of Delegates.")

6. *Michigan Department of Corrections.* A resurvey of hospital and medical facilities at the State Prison of Southern Michigan, by an MSMS committee upon the invitation of the Michigan Department of Corrections, was made during the past year to check up on conditions following the first survey of four years ago. A final report of the committee's two surveys, showing changes and contrasts over the four-year period, will be forthcoming in a short time.

7. *The usual number of contacts* were experienced during the last year with the Michigan Department of Public Instruction (re its adult education program); the Michigan Social Welfare Commission; the two medical schools in Michigan; Michigan Selective Service headquarters; the Michigan Advisory Hospital Council; the Governor's Commission on Problems of the Aging; the Governor's Commission on Alcoholism; Michigan Civil Defense; and the Governor's office re the Mental Health Commission and concerning appointments to various boards and commissions touching the practice of medicine.

Contacts with Voluntary Agencies and Organizations

1. *Blue Shield.* The professional relations efforts of Michigan Medical Service have been outstanding in scope and importance and therefore have been crowned with success. A special feature on this important phase of Michigan's Blue Shield was published in the June, 1952, JMSMS. The article gave merited praise to John W. Castellucci of Michigan Medical Service who has forwarded the professional relations of Michigan Medical Service and of other Blue Shield plans throughout the United States. A Liaison Committee of MSMS headed by Council Chairman William Bromme, M.D., is advisory to Mr. Castellucci and his MMS staff.

A progress and the annual financial reports on Michigan Medical Service will be submitted to its Members at their Annual Meeting of Tuesday, September 23, at 2:00 p.m. in the Grand Ballroom of the Sheraton-Cadillac Hotel, Detroit. MMS President R. L. Novy, M.D., urges all delegates to be present at this session. (MSMS Delegates are Members of Michigan Medical Service.)

2. *Blue Cross.* A Physician's Relationship Division recently was created by Michigan Hospital Service and as of August 17, 1952, the services of Harry F. Becker, M.D., Battle Creek, were secured to further this effort.

Request has been received from Michigan Hospital Service for the formation of a Medical Advisory Committee "to aid and implement better understanding with the medical profession: to delineate and plan the scope" of the specified doctor's service. The Council on July 12, 1952, designated the medical representatives to the Board of Trustees of Michigan Hospital Service: Wm. S. Reveno, M.D., Detroit, Chairman; E. C. Baumgarten, M.D., Detroit; Otto O. Beck, M.D., Birmingham; Wm. Bromme, M.D., Detroit; R. L. Novy, M.D., Detroit; D. R. Smith, M.D., Iron Mountain; L. Fernald Foster, M.D., Bay City, Secretary.

This committee is requested to report its findings and recommendations to The Council on September 21, 1952.

3. *Michigan Heart Association.* Excellent co-operation with this four-year-old but sturdy organization continues, thanks to the fine leadership of President F. Janney Smith, M.D., Detroit, and to Past Presidents Douglas Donald, M.D., Detroit; P. S. Barker, M.D., Ann Arbor, and W. B. Cooksey, M.D., Detroit

MSMS continues to be grateful to the Michigan Heart Association for its generous grants toward the maintenance of the Michigan Rheumatic Fever Control Program. Michigan Heart Association, an agency of the United Health and Welfare Foundation and the United Foundation of Detroit, is now the sole financial sponsor of our pioneer rheumatic fever program.

4. *The Michigan Health Council.* This organization assumed greater responsibilities during the past year and, through augmented financial help from MSMS and Blue Cross-Blue Shield, was able to meet its increased obligations for community leadership by securing the services of a field secretary.

The Council now has 27 member organizations and 35 associated community health councils.

MSMS co-operated with the Michigan Health Council in the development of its new TV program "Court of Health."

5. *Michigan Foundation for Medical and Health Education, Inc.*—MSMS co-operated with the Foundation and with the Michigan Health Council in the sponsorship of the outstandingly successful Michigan Rural Health Conference held on the campus of the University of Michigan at Ann Arbor in January, 1952. Ninety-two organizations co-sponsored this interesting Conference.

6. *American Medical Association.* Again, the MSMS Council expresses appreciation for the excellent work that the American Medical Association is doing for the people of the United States, especially in bringing forward a public awareness of the advantages and benefits of the voluntary way of medical service.

A recommendation on this subject follows.

7. *Other volunteer groups* with which MSMS has been in close contact during the past year include the Michigan Epilepsy Center, Inc.; Michigan Diabetes Association; the Arthritis and Rheumatism Foundation, Michigan Chapter; State Bar of Michigan; the Michigan Public Health Officers Association; the Michigan Nursing Center Association (re district conferences for the improvement of nursing and the State Advisory Committee for Practical Nurse Education); Michigan Industrial Institute; Michigan Tuberculosis Association; Michigan Hospital Association; the United Cerebral Palsy Foundation; Michigan Division, American Cancer Society; the American Hospital Association; the Detroit Committee on Alcohol (re Institute on Alcoholism); the four veterans organizations in Michigan; and the Kellogg Foundation.

Society Home

The MSMS "home" was used for the first time on July 27, 1951. The building alone is appraised at $49,000 (not including the property), a figure somewhat higher than the purchase price of both the building and property. As previously announced, an additional lot facing Hillsdale Street has been purchased to give the MSMS property greater usefulness.

Necessary replacements and repairs to keep the building in Class A condition were ordered by The Council. A Past President's room was created on the first floor; fluorescent lights were installed throughout; the interior was completely redecorated; necessary repairs were made to the garage; stacks for supplies and files were erected in the basement; and a small parking lot was authorized. With these improvements and alterations, 606 Townsend is now a credit to its owners, the members of the Michigan State Medical Society.

Beaumont Memorial Restoration

This strictly medical project was discussed at every meeting of The Council and its Executive Committee during the past year. The actual work of seeking contributions for the restoration of the old American Fur Company store on Mackinac Island where Dr. Beaumont performed his pioneer experiment on his famous patient, Alexis St. Martin, did not begin until March, 1952. It is with pride that we report that the total contributions to July 15, 1952, amounted to $20,154. Plans to begin the restoration in the summer of 1952, if possible, have been discussed with the Mackinac Island State Park Commission. It is hoped that the Beaumont Memorial will be dedicated, with ceremony and circumstance befitting such an event, in the summer of 1953.

A recommendation on this subject follows.

Committees

A total of fifty meetings of Committees of the Michigan State Medical Society and of The Council were held during the ten months' period ending July 31, 1952. The constant and progressive work of these active groups is best portrayed in the informative annual reports of our committees. Sincere gratitude is expressed to the chairmen and to the members of all committees for their contribution of invaluable time and sincere effort given during the past year in behalf of all the medical men and the public of Michigan.

1. A number of new committees were created during the past Society year: (a) Liaison Committee with Veterans Organizations of Michigan; (b) Study Committee on the "Little Hoover Commission" Report on Health (Report No. 8); (c) Committee on Model Code for M.D. Announcements. (See final report in May, 1952, JMSMS, page 554); (d) Committee on Arbitration in Matters Affecting the Uniform Fee Schedule for Governmental Agencies; this committee held its first meeting on July 14, 1952, and demonstrated its capacity to answer questions connected with the uniform fee schedule.

(e) Committee on Study of Group Insurance. This Committee of The Council gave study to:

I. Group malpractice insurance. The Committee felt that this proposed insurance would gain nothing for the MSMS membership because the mathematics and experience of underwriting is involved; there would be compromise and involvement of entire independence of individuals of the profession in malpractice cases; it would involve the Society in administrative and policy functions of an entirely commercial project; and the management and the law involved in the servicing of professional liability claims and suits are each and both handicapped by group insurance arrangements. The Committee felt that something might be lost—not gained—by embracing group malpractice insurance.

II. Group health and accident insurance for MSMS members: A nine months' study has been given to this project and is still in progress; a written report with the substance of the study will be presented to the MSMS House of Delegates on September 22, 1952.

(f) Hospital Relations Committe, an MSMS Committee to discuss mutual problems and ambitions with the Michigan Hospital Association, was created during the past year and held two meetings.

(g) Liaison Committee with Michigan Medical Service. This Committee was created during the past year and has held one organizational meeting. It is available at all times for co-operative effort to further Michigan Medical Service and to preserve professional supervision of its service program.

2. Committees especially active during the past year include: (a) Rheumatic Fever Control Committee which developed an "Outline for the Organization of Rheumatic Fever Centers according to the Plan of the Michigan State Medical Society." (b) Mental Hygiene Committee which developed "Suggested Plan for Department of Mental Health" which was presented to the Governor's Commission on Mental Health. (c) Legislative Committee which laid the groundwork for a very successful program of health legislation, culminating in the Legislature's approval of amendments to the Medical Practice Act (S.B. 301) and amendments to the Basic Science Act (S.B. 251), previously indicated. (d) Committee of Seven to Study the Basic Science Law and the Committee on Study of the Medical Practice Act. (See the Legislative Committee report). (e) The Maternal Health Committee in co-operation with the Michigan Department of Health continued its important survey of maternal deaths.

3. Two committees enlarged their activities during the past year: the Geriatrics Committee and the Emergency Medical Service Committee.

4. The Committee on Scientific Work arranged the excellent program for the 1952 Annual Session. The many months of preparation spent by this planning committee will result in a stimulating three-day postgraduate course that will be enjoyed by approximately 3,000 doctors of medicine who visit Detroit in September.

Matters Referred to the Council by the 1951 House of Delegates

1. *Amendments to the Basic Science Act.*—As previously reported, the Basic Science Act was amended by the 1952 Michigan Legislature, so that the Act omits the examination in public health and hygiene; the records of the Board of Examiners in the Basic Sciences are deposited with the Secretary of State and are available for public inspection; nobody who has satisfactorily passed his examination in any Basic Science subject shall be required to submit a second time to an examination in the basic sciences for the purpose of qualifying under the Basic Science Act; and interns and residents are permitted to train in Michigan hospitals without the necessity of passing the basic science examination.

The Basic Science Act has been modernized with necessary amendments, and the instruction of the House of Delegates has been followed to the letter.

2. *Amendments to the Medical Practice Act.*—Again, in response to recommendations of the House of Delegates, important amendments to the Medical Practice Act of 1899 were made by the Michigan Legislature.

The most important improvement permits the Michigan State Board of Registration in Medicine to grant temporary annual licenses to residents, renewable over a period not exceeding five years. One provision adopted by the 1952 Legislature, which was *not* recommended by MSMS, requires that a doctor of medicine to receive a license to practice must be a citizen of the United States or have taken out his second naturalization papers. To some, this amendment beclouds the issue so far as the problem of displaced persons is concerned; however, it was the intent of the Legislature that a displaced person may take additional training, under the temporary annual license provision of the law, when pursuing post-graduate study in approved training hospitals. The MSMS Council hopes that this intent of the Legislature will be the interpretation placed on this phase of the law by the Michigan State Board of Registration in Medicine.

3. *Little Hoover Commission.*—The objections of the MSMS House of Delegates to the unwise concentration of power in the health field, as recommended in Staff Report No. 8 of the Michigan Joint Legislative Committee on Reorganization of State Government ("Little Hoover Commission") were found to be so uniformly similar among many Michigan groups and individuals that, after vigorous objections were registered, nothing came of the Commission's recommendations. However, it is to be expected that the same proposal for concentrated power will be advanced to each succeeding Legislature, so MSMS and other organizations interested in the best health for the people of Michigan must be vigilant in their opposition to such grandiose, dangerous plans.

A plan of reorganization of the health functions of the State of Michigan was published in the March, 1952, JMSMS, page 292; this presented the Michigan State Medical Society's *positive* approach to reorganization of the medical and health functions of the state as opposed to the inflated proposals of the Little Hoover Commission. (See Legislative Committee Report).

4. *Comprehensive Physical Examination.*—In response to the House of Delegates instructions, the compilation of a comprehensive physical examination was referred by The Council to a joint committee composed of representatives of MSMS and of the Michigan Health Council. This work is outlined in the section above devoted to "Public Relations."

5. *Grand View Hospital, Ironwood.*—Following the directive of the House of Delegates, a letter of congratulation was dispatched to the Trustees of Grand View Hospital, Ironwood. The legal battle, to determine who has the right to practice in a hospital, may be decided in August, 1952. Progress will be submitted in the Supplemental Report of The Council. Proffers of assistance have been made by MSMS to the Trustees of the Hospital as well as to the Gogebic County Medical Society.

6. *Annual Contributions to American Medical Education Foundation.*—Following the House of Delegates instructions, periodic appeals to the MSMS membership have been made, urging annual and more frequent contributions to the AMEF. In addition, a speaker representing the Foundation has been invited to speak at the 1952 MSMS Annual Session. Contributions may be ear-marked for one or both of Michigan's two medical schools.

The purpose of this Foundation—to aid American Medical Schools in a *voluntary* way—is important if not vital to the individual doctor of medicine who should be continually reminded of this opportunity to perpetuate freedom.

A recommendation on this subject follows.

7. At the House of Delegates' instruction, a Liaison Committee with Michigan Medical Service was appointed in November, 1951, and has held one successful meeting.

8. Teaching of civil defense in the two medical schools of Michigan. This Resolution was referred to the MSMS Committee on Emergency Medical Service which studied the subject at two meetings and still has it under consideration.

A preliminary report indicates this thinking: (a) give the first year medical students a good course in first aid, so they can teach lay groups; (b) develop and train teams consisting of a senior, a junior, a sophomore and a freshman for every casualty care station unit, to do first aid and lab work.

9. Resolution re teaching of medical ethics in the two Michigan medical schools. This resolution was referred for implementation to the MSMS Ethics Committee. The replies of the two Deans show that concepts of medical ethics essential to good teaching, sound research, and unimpeachable practice have been incorporated within the curricula of our two Michigan medical schools.

(Complete copies of the Deans' letters will be made available to the House of Delegates Reference Committee).

10. Following the instruction of the House of Delegates, Michigan's Alternate Delegates to the American Medical Association have been invited and have attended AMA Sessions.

11. Clarification of the words "Executive Committee" in Annual Report of the MSMS Advisory Committee to National Foundation for Infantile Paralysis (1950-51 report): the Chairman of the Advisory Committee indicated that "Executive Committee" referred to each county chapter of the National Foundation. The Council felt that this recommendation was inconsistent with the fact that in the average county, doctors of medicine most interested in infantile paralysis and its victims—because of their type of practice—are usually those sought as members of the executive committee of the local chapter. Thus it would be forcing off these executive committees the best medical brains and ability of the community. The MSMS Committee was so advised. The Council hopes that the 1952 House of Delegates will concur in its judgment on this matter.

Recommendations

The Council respectfully recommends:

1. That MSMS representatives be instructed to continue their yearly visit to Washington, D. C., on the occasion of Michigan Day sponsored by the U. S. Chamber of Commerce.

2. That the MSMS Committee on Distribution of Medical Care, which for several years has been inactive, be abolished. (This will require amendments to the By-Laws, Chapter 10, Section 1-c with the renumbering of 1-d-e-f; Section 4; also Sections 5, 6 and 7 will have to be renumbered Sections 4, 5 and 6).

3. That continued active tangible co-operation with the American Medical Association be maintained by every MSMS member who is urged to continue and strengthen his support of the AMA. Strength comes from unity and work, joined hand in hand. It flows from the roots to the trunk.

4. That contributions to the Beaumont Memorial Restoration Fund, by every individual member of the MSMS, be urged; and that the members of the MSMS House of Delegates in their individual districts be delegated as committees to spearhead this drive so that the fund of $40,000 may be obtained before the end of 1952. A memorial to Dr. Beaumont on Mackinac Island will be a lasting shrine to the science of medicine and to the generosity of Michigan practitioners of medicine.

5. That members continue to remember in their generosity the American Medical Education Foundation —our only bulwark against socialized medical education —and that annual and more frequent contributions be

urged upon every member of the MSMS and their friends who are interested in a maintenance of the present high unfettered standards in medical education.

Respectfully submitted,
WILLIAM BROMME, M.D., *Chairman*
L. W. HULL, M.D., *Vice Chairman*
R. S. BREAKEY, M.D.
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J. D. MILLER, M.D.
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OTTO O. BECK, M.D., *President*
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L. FERNALD FOSTER, M.D., *Secretary*
W. A. HYLAND, M.D., *Treasurer*
C. E. UMPHREY, M.D., *Immediate Past President*

ANNUAL REPORT OF PERMANENT CONFERENCE COMMITTEE (WITH MICHIGAN HOSPITAL ASSOCIATION AND MICHIGAN NURSING CENTER ASSOCIATION—1951-52

This Committee, consisting of members representing each of the two above named groups, and the Michigan State Medical Society, has met at three month intervals during the fiscal year of 1951-52. The meetings have been held in Lansing with good attendance on the part of all the groups.

Most of the deliberations of this Committee have been concerning problems of nursing care. There have been a few minor problems of relationship between doctors, hospitals and nurses, in addition.

Concerning nursing problems, recruitment of student nurses has been furthered through several established channels and a better utilization of present registered nurses has been planned both generally and in detail by the following means:

1. The additional training and utilization of practical nurses; and, in this respect, much time was spent in an advisory discussion of the proposed new bill for licensure of registered nurses, practical nurses, and other trained attendants. This bill has now been passed and should be of great help in adding auxiliary help to our nursing supply.

2. Working conferences for the improvement of nursing services have been held in Lansing, Grand Rapids and Detroit. These conferences have included members of the medical staffs, the hospital administrators, and nursing administrators of all of the hospitals concerned in the districts in which the conferences have been held. These conferences have resulted in a much closer co-operation in working out means by which nursing services may be extended in the hospitals. The results of the conferences are being circulated to chiefs of staffs, hospital administrators, and nursing administrators in all the hospitals concerned.

Respectfully submitted,
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J. A. WITTER, M.D.

ANNUAL REPORT OF THE PUBLIC RELATIONS COMMITTEE—1951-52

The basic activity of the Michigan State Medical Society public relations program continued to function smoothly during the past year. Even during periods when it was necessary to request the public relations personnel temporarily to direct its activities to other projects of importance to the medical profession, the public relations pattern progressed with high momentum. The success of the program is in a large part due to the excellent leadership and co-operation of the fifty members of the Public Relations Committee and the members of the Public Relations subcommittees. This leadership closely integrated the media projects into the overall MSMS public relations program. For that reason, the annual reports of the subcommittees are included in the complete report of the Public Relations Committee.

One of the outstanding examples of the MSMS public relations program, which fostered in the public an attitude of approval of medical action, was evident in the results of our 1952 legislative program. During the Michigan Legislative Session of 1952, two bills of great importance to the profession were passed by the Legislature and signed by the Governor. These were amendments to the Basic Science Act (S.B. 251) and to the Medical Practice Act (S.B. 301).

During the past year the medical profession occupied a position of alertness for any reappearance of legislated socialized medicine. At the same time, members of the Michigan medical profession laid the groundwork for the development of an awareness on the part of the people of Michigan to any threat to their liberty and freedom plus a positive long term program to strengthen, through use and understanding, the essential freedoms of the people and of the profession. This augmented program was called "Formula For Freedom."

Formula For Freedom

The basic reason why the MSMS has interested itself in obtaining public approval and acceptance is because it wishes to avoid restrictions or compulsions on medicine which would hinder the effectuation of the aims and purposes of the Society and its members' service to the public.

Consequently "Formula For Freedom" is the name given the public relations program. This program has three elements:

Know How to Live
Know Yourself
Know Your Government

1. The "Know How to Live" element attempted to obtain an accord with the public as the MSMS:

(a) Carried out its responsibilities in a manner acceptable to the public.
(b) Refrained from actions which are contrary to public ideologies.
(c) Took steps to build a backlog of public approval by a long term, but unostentatious, display of its activities as they pertain to the public interest.
(d) Carefully attempted to maintain the doctor as a "personality" who is loved, respected and admired.

2. The "Know Yourself" element is being carried out as an attempt to emphasize to the membership a basic concept of exactly what the MSMS is, what its potentials are and the extent of its limitations. Under this element the MSMS also is attempting to emphasize to the public the importance of the responsibility of every individual for his own health.

3. The "Know Your Government" element recognized that if the medical profession is to maintain its desired freedoms, there must be on the part of each doctor of medicine a knowledge of government and a participation in it. On the part of the Society there must be a

satisfactory liaison with government combined with projects to observe, and, when necessary, influence governmental action against schemes inimical to public health.

Introduced as a program of the MSMS, the basic soundness of the approach has appealed to other organizations which are in the process of adopting the program in part or in whole.

The Formula For Freedom as an action program within the medical profession was introduced through a special F.F.F. presentation program. The first of these was inaugurated at the September meeting of the MSMS House of Delegates in Grand Rapids. A second program reaching many members of the medical profession was held at the MSMS County Secretaries-Public Relations Conference in Detroit in January.

Committee on Speakers Bureau.—Twenty-two Formula For Freedom nights were held, co-operating were 21 county medical societies, one Woman's Auxiliary group and Medical Assistants group and the Michigan Tuberculosis Association. In addition, a F.F.F. program was held in Iron Mountain during the Annual Meeting of the Upper Peninsula Medical Society. A total of 68 talks were given by officers of the medical society, government officials and MSMS PR personnel. Outstanding contributions were made by MSMS Secretary L. Fernald Foster, M.D., and Michigan's State Treasurer, D. Hale Brake, LL.D.

Members of the Committee are: G. E. Millard, M.D., Chairman, S. W. Hartwell, M.D., F. P. Husted, M.D., and H. F. Osterhagen, M.D.

In other aspects under the Formula For Freedom program, close liaison was maintained between organizations concerned with the health activities of the people of Michigan.

Under the element, Know Your Government, the MSMS Legislative Committee maintained close contact with county medical societies during the 1952 Legislative Session. To keep key medical society personnel instantly informed on bills of importance to the Medical profession a total of 14 Legislative Bulletins were issued plus special mailings.

Special Committee on Education.—This committee continued to act as an ex officio executive committee of the Public Relations Committee, this group laid the groundwork in revitalizing the CAP and Good Citizenship programs.

Committee on Education Programs in Schools and Universities.—The committee viewed with enthusiasm the action of the Executive Committee of The Council relating to the teaching of business courses to medical school students. It recommended that colleges be urged to co-operate in the Medical Associates program.

Also in the field of Medical Associates the committee urged that the Medical Associates' brochure "In Planning Your Career" be given wide distribution in schools. This brochure, developed by the MSMS Commission on Health Care, was so popular both in and outside Michigan that the original printing of 17,000 copies was exhausted and a revised second printing of 10,000 has been made. Also, the MSMS films are being offered to vocational education classes.

The committee introduced a new concept of teaching physiology and hygiene in schools which would take the "mystery and magic" out of medicine. The students under this new concept would be taught what is actually happening to their physical processes during different types of illnesses.

One of the newest innovations introduced by the committee was in the field of adult education. Adult education classes were set up in co-operation with individual county medical societies and the local adult education department in the community. Seven county medical societies developed courses which range from six to eight weeks. These seven county medical societies sponsored the courses in eleven different communities in the state. These communities were: Lansing, Port Huron, Bay City, Flint, Millington, Lake Fenton, Royal Oak, Ferndale, Negaunee, Ishpeming, and Marquette. Participating county medical societies were: Ingham, St. Clair, Bay, Genesee, Tuscola, Oakland and Marquette-Alger. This program will be continued and amplified in the coming year. Members of the committee are: H. J. Meier, M.D., Chairman, J. F. Konopa, M.D., and A. H. Steele, M.D.

Woman's Auxiliary.—As in the past, this organization has responded with complete co-operation to a variety of public relations projects. Great assistance was given by members of the Auxiliary on issues of paramount importance to the MSMS. In addition, the Woman's Auxiliary has continued its activities in the distribution of literature to schools and in maintaining contact with other women's organizations. Assistance was given the Woman's Auxiliary in the publication of two NEWS BULLETINS (at their mid-year board meeting in March, the name of the NEWS BULLETIN was changed to the AUXILIARY NEWS).

A special Formula For Freedom supplement was prepared and published in conjunction with the January, 1952, *News Bulletin* of the Auxiliary.

Michigan Rural Health Conference.—This year the Fifth Annual Michigan Rural Health Conference was sponsored by 99 separate organizations. Activities in the rural health field through the liaison with the Michigan Health Council have continued so that the Michigan Health Council functions in part as an elongation of the MSMS Public Relation program.

Outstanding in the Michigan Rural Health Conference was the presentation of a Court of Public Appraisal of Health.

Scientific Committees.—These MSMS committees were aided through guidance in publicity by MSMS Public Relations personnel. Particular aid was given to the Cancer Control Committee and the Industrial Health Committee through representation at their specified "Days." The Annual Meeting of the Michigan Association of Industrial Physicians and Surgeons was supplied with press coverage through MSMS P.R. personnel.

Surveys.—The MSMS acted to review publications made by Michigan State College on the results of the Michigan Health Survey. A representative of MSMS and one from the Michigan Health Council participated in the guidance of the Health Survey in Lenawee County carried on by Michigan State College through grants from the Health Information Foundation.

Services to Officers and The Council.—Throughout the year, P.R. personnel has been assigned to duties as a necessary function of MSMS which assist the Secretary and the Executive Director. These assignments have been concerned with correspondence, developing of speeches, preparation of reports, preparation of brochures, etc.

Use of Media

The use made of media in giving visibility to a public relations program can be seen in the reports of the various media subcommittees of the Public Relations Committee. The use of all media has been extensive during the past year.

Committee on Newspapers.—This Committee sets as its goal the complete and the proper utilization of newspapers for the Public Relations Program and for other MSMS activities:

1. Special emphasis was given the publicity campaign for the 86th MSMS Annual Session in September, 1951, and the Michigan Clinical Institute in March, 1952. The publicity for the Annual Session reached an all time high in coverage, both for advanced coverage of the meeting and on the staff reporting during the meeting. The Clinical Institute in March was also well publicized both by advance releases and at the scientific meeting. Press dinners were held in Grand Rapids and Detroit one week prior to the respective Conventions. During the Annual

Session of the Clinical Institute press rooms were maintained by the Committee with the assistance of Public Relations personnel to insure proper and widespread news coverage at these meetings.

2. An accurate record was made of the news stories, both advance releases and on the spot coverage, at the 1951 Annual Session. Information was later compiled into a survey and analyzed to determine if the schedule of sending out advance releases could be improved and to determine the topics which appear to be of greatest interest to the editors of Michigan. The subject matter of the news releases for the 1952 Annual Session was revised to conform with the pattern of interest the editors had indicated. Every daily newspaper in Michigan with one exception printed at least one news release about the 86th Annual Session.

3. In addition to the two postgraduate sessions, publicity was prepared and assistance given for Michigan Industrial Health Day in May, 1952, the 5th Annual Michigan Rural Health Conference in January, 1952, and the Annual Cancer Day Program in October, 1951.

4. The Relationship between MSMS and the daily and weekly newspapers in Michigan continues to be one of co-operation because of contacts with the press by MSMS representatives and Public Relations field secretaries.

5. The Committee provided facilities to serve as a source of information on all queries from newspapers by reporters, and individual contacts were maintained with science writers from major newspapers. To be better equipped to answer individual queries from newspaper reporters, questionnaires were distributed to all county medical societies on the topics of Scholarships, Mediation and Doctor Availability. The results were catalogued so that an over-all picture in the state as well as the conditions in a newspaper's particular circulation area are continually available.

6. As another aid to better co-operation between the press and the medical profession the Committee authorized the development of a set of Guiding Principles Medical-Press relations. This set of Guiding Principles is to be developed for distribution to County medical societies and newpapers and individuals requesting it.

7. The Committee also recommended means by which individual county medical societies could obtain a better press for medicine.

8. Assistance was also tendered the Beaumont Restoration Committee for its campaign to raise money for a shrine to Dr. William Beaumont on Mackinac Island. This included preparation of brochure and letters, contracts through P.R. Field Secretaries, and publicity campaign resulting in a number of news stories published in daily and weekly newspapers.

9. One of the best news stories of the Michigan State Medical Society in regard to public interest was the annual selection of Michigan's Foremost Family Physician, Clayton Willison, M.D., of Sault Ste. Marie.

10. Approximately 8,000 releases were issued by the Michigan State Medical Society periodically throughout the year to both daily and weekly newspapers in Michigan.

Members of the Committee on Newspapers are: C. L. Weston, M.D., Chairman, A. B. Gwinn, M.D., and R. A. Johnson, M.D.

Committee on Cinema.—The Michigan State Medical Society film "To Your Health" has been screened in 281 theaters before an audience of 356,179 persons. The film "Lucky Junior" has been shown in 331 theaters with audiences totalling 421,786 persons. In addition, both of these films which were originally produced on 32 mm. film, have now been released as 16 mm. films for showings before local groups such as service clubs, PTA organizations, schools, etc.

A high point in the 1951-52 activities of the Committee on Cinema was the release of the latest MSMS 16 mm., sound, color film "To Save Your Life." The picture is a straighforward documentary of the preparation for medical practice. The picture reveals the long, exacting and costly process every doctor of medicine goes through in one form or another before he hangs up his shingle. By using MSMS staff personnel to develop, produce, write and narrate the picture it was produced at the exceptionally low cost of $4,100 although valued by commercial producers at $40,000. The film has a ring of authenticity because all of the sequences were shot right where they happen every day of the year in the doctor's office, hospital, university, college, or high school. There are a total of 260 characters in the motion picture. At least 170 persons played a prominent part in the sequences. To date, the film has been shown on television to thousands of persons and before more than 46 groups in Michigan plus groups at the American Medical Association and lay and professional organizations in the western part of the United States. Requests are continually being received at the MSMS Executive Offices for prints of this picture.

The Committee authorized the sale of "To Save Your Life" to other state and county medical societies outside of Michigan at a cost of $300 a print. Mimeographed promotional materials were developed to increase the sale of "To Save Your Life" to these organizations.

The Committee also considered the possibility of producing further motion pictures on topics of direct benefit to MSMS. The possibility of producing medical education films for use for instruction in medical schools and in postgraduate courses of study is being investigated by the Committee.

In October, 1951, the Committee on Cinema, anticipating the future of medical activities in the field of motion pictures and television, recommended that a Committee on Television be formed and that the TV activities of the Committee on Cinema be transferred to this new Committee so that the Committee on Cinema could devote its entire efforts to the production of motion pictures.

Members of the Committee on Cinema are: R. F. Salot, M.D., Chairman, E. F. Sladek, M.D., R. J. Noer, M.D., A. E. Schiller, M.D., and Wayne Whitaker, Ph.D.

Committee on Television.—The Committee on Television was appointed by MSMS President Otto O. Beck, M.D., at the January, 1952, meeting of The Council. At its inception two highly successful television shows were being produced by MSMS. Each one of these shows presented a medical topic which was discussed by doctors of medicine and/or laymen who were specialists in that particular field.

1. The first show "It's Your Life"—a half-hour video production—was telecast each Sunday on WJBK-TV (Channel 2). The popular MSMS series, "It's Your Life" was concluded on May 28, 1952, after a year and a half of weekly production which began December 17, 1950. During that time 71 shows were produced. In the year and a half that "It's Your Life" was telecast, 81 different doctors of medicine appeared on the show in addition to 27 lay persons who had a particular interest in the topic being considered for that week. The Committee on Television extends a vote of thanks to those doctors of medicine for their unselfish response to requests to appear on the show.

2. The continuity of health information was not interrupted on WJBK-TV by the cessation of the MSMS-TV show "It's Your Life." The air time was taken by the Michigan Health Council for the production of a series called "Court of Health." (MSMS Public Relations Committee members are on the TV Committee of the Michigan Health Council. It is chairmanned by R. W. Teed, M.D., of Ann Arbor.)

3. The second MSMS production is "Your Medical Mailbox" which is presented each week on WXYZ-TV (Channel 7), Detroit. This show is a half hour portion of the Bud Lanker program, and has run continuously since June 27, 1951. Topics of special interest to women regarding medicine and health are discussed each week.

The members of the Committee on Television are: A. E. Schiller, M.D., Chairman, R. A. Frary, M.D., R. C. Kingswood, M.D., and E. C. Long, M.D.

Committee on Radio.—During the past year the Committee on Radio made the following progress regarding the use of radio time to further ideas and projects of the Michigan State Medical Society:

1. The "Tell Me, Doctor" radio series—five minute health programs—was broadcast five days a week by 14 Michigan radio stations and several other radio stations on a part time basis. Many of these programs have commercial sponsors. The following radio stations now broadcast the series: WELL, Battle Creek; WIBM, Jackson; WJIM, Lansing; WATT, Cadillac; WATZ, Alpena; WKZO, Kalamazoo; WKNK, Muskegon; WHSB, Benton Harbor; WOAP, Owosso; WJBK, Detroit; WSOO, Sault Ste. Marie; WMLN, Mount Clemens; WMIQ, Iron Mountain; and WMDN, Midland.

The series was also used by state and county medical societies outside of Michigan. The organizations still purchasing electrical transcriptions and/or scripts were Oklahoma State Medical Association and Dade County Medical Association (Florida).

A revision in the distribution of the "Tell Me, Doctor" series has been made. Starting July 1, 1952, the cost for the production of the "Tell Me, Doctor" programs was reduced to $16,500 annually. Besides reducing the cost of the program, the distribution was changed to 17 Michigan radio stations. More than 1600 scripts have been prepared since the series was inaugurated in 1946 and 3,905 broadcasts made this year.

2. The Committee on Radio has approved the plan for a series of 13 weekly half-hour dramatic health broadcasts on radio station WWJ, Detroit. These programs will begin in the fall as the main "showpiece" feature of WWJ, Detroit. The MSMS will prepare the material and the scripts for the shows and the direction, musical and dramatic talent, as well as air time will be provided by WWJ.

3. The Committee on Radio recommended that the Michigan State Medical Society and County Medical Societies continue to respond to requests for appearances by doctors of medicine on established radio programs including both medical and non-medical broadcasts.

Members of the Committee on Radio are: C. A. Payne, M.D., Chairman, F. L. Doran, M.D., W. G. Gamble, Jr., M.D., W. J. Herrington, M.D. and R. W. Teed, M.D.

Committee on Public Relations Publications.—This Committee was active in the distribution to state and national publications of numerous articles on MSMS activities—particularly the Formula For Freedom program. The development of brochures for the various activities of the medical profession was continued throughout the year. The accomplishments of the Committee on Public Relations Publications was as follows:

1. Information was disseminated on the Formula For Freedom program by means of MSMS and allied health publications. This included a series of articles and charts in the JOURNAL OF THE MICHIGAN STATE MEDICAL SOCIETY on Formula For Freedom. This material was published in the November, 1951; January, 1952; February, 1952; and March, 1952, issues of the JOURNAL. Articles on Formula For Freedom were published in the Michigan Health Council bulletin and in other state medical society journals. Requests were received from other media with national distribution for Formula For Freedom articles. The March issue of *Medical Economics* carried an article called "Doctors Need an Old Fashioned Crusade." Articles have been prepared for other national magazines.

2. The October issue of *Inside Michigan* published an article called "Return of the Family Doctor" which covered aspects of the Michigan medical profession. Ten thousand reprints of the article were distributed to interested persons and organizations as an aid to develop a more favorable attitude and understanding by the people of the important role played by a doctor of medicine in his community.

3. Brochures were also developed for MSMS on special projects or activities. These included the brochure "That More May Know" for the MSMS Beaumont Restoration Committee, the preliminary programs for the MSMS 86th Annual Session and the Michigan Clinical Institute and other MSMS publications.

Members of the Committee on Public Relations Publications are Kenneth H. Johnson, M.D., Chairman, L. T. Henderson, M.D., A. C. Pfeiffer, M.D., and L. Fernald Foster, M.D., Advisor.

Respectfully submitted,

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SERENDIPITY

Serendipity—word of interesting significance coined by Horace Walpole more than one and a half centuries ago. It is commonly defined as the "gift of finding valuable or agreeable things not sought for." Dr. Irving Langmuir, the noted research scientist, gives it this more succinct and expressive definition: "the art of profiting from unexpected occurrences." Its usual application has been in the field of research, but through its implications, it is equally applicable in other fields of human activity and behavior. It implies that its beneficiary should have an open receptive mind free of unfounded prejudice, an inquiring intellect and a spirit of optimism—all qualities that are worthy of cultivation.

Michigan State Medical Society

Roster 1952

(Special Memberships are indicated as follows: "E" for Emeritus Members; "L" for Life Members; "R" for Retired Members; "A" for Associate Members; "M" for Military Members; all others are Active Members)

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Rummel, Robert J. Fennville
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Ries, Robert C. Rogers City
Riker, John L. Peoples State Bank Bldg., Alpena
Rowell, Wilfred J.....Alpena General Hospital, Alpena
Spens, James E. Professional Building, Alpena
Trudeau, J. M. (M)
U. S. Army Hospital, Camp Cooke, Calif.
Wagoner, Darwin E. Lincoln
Wienczewski, Theophile W. 811 Chisholm, Alpena

BARRY COUNTY

Birk, Wilbur R. 146 E. State, Hastings
Clarke, Daniel M. 304 S. Jefferson, Hastings
Finnie, R. G. 118 E. Walnut St., Hastings
Gwinn, Alexander B. City Bank Bldg., Hastings
Harkness, Robert B. (L)
305 N. Broad St., Kennett Square, Pa.
Keller, Guy C. (L) 302 W. Green St., Hastings
Lofdahl, Stewart Nashville
Logan, Wesley G. City Bank Bldg., Hastings
Lund, C. A. E. Middleville
Morris, Edgar T. (L) 26 S. Main St., Nashville
Pryor, R. B.....334½ S. State St., Hastings
Phelps, Everett L. 118 E. Walnut St., Hastings
Slee, Vergil N. 912 N. Broadway, Hastings
Wedel, Herbert S. 134 E. State St., Hastings

BAY COUNTY

Alcorn, Kent A.....1420 Center St., Bay City
Alcorn, Marshall W.....1420 Center St., Bay City
Allen, Arthur D. 101 W. John St., Bay City
Asline, J. Norris 207 Walnut St., Essexville
Austin, Justus J. 513 W. Bay, Tawas City
Ballard, W. R. (E) 2000 Fifth St., Bay City
Boulton, Arthur O. (E) Gladwin
Bowman, David A. 1705 Third St., Bay City
Brown, George M. 207 N. Walnut, Bay City
Campbell, J. S. 704 N. Jackson St., Bay City
Chapin, Frederick J.
Allen Medical Bldg., 101 W. John, Bay City
Connelly, C. James 1104 S. Madison, Bay City
Cook, Hugh K. 101 W. John, Bay City
Cosens, Stanley A. 101 W. John St., Bay City
Crissey, Robert R. 101 W. John St., Bay City
Criswell, Robert H. 407 Phoenix Bldg., Bay City
Dardas, Michael J. 605 Fifth Ave., Bay City
De Waele, Paul L. 1106 N. Johnson St., Bay City
Dolbee, Malcolm K.....Sanford Bldg., Standish
Drummond, Fred H. Kawkawlin
Fisher, Robert E. 900 N. Jackson, Bay City
Foster, L. Fernald 919 Washington, Bay City
Freel, John A. 207½ Center Ave., Bay City
Gamble, William G., Jr. 2010 Fifth Ave., Bay City
Gehman, J. R. Au Gres
Groomes, Charles A. P.O. Box 2488, Reno, Nev.
Grosjean, J. C. (L) 1214 McKinley Ave., Bay City

Gunn, R. P. Davidson Bldg., Bay City
Hagelshaw, G. L. 101 W. John, Bay City
Hess, C. L. (R) 4301 N. 24th St., Phoenix, Ariz.
Heuser, Harold H. 207 Davidson Bldg., Bay City
Horowitz, S. Franklin 904 N. Madison Ave., Bay City
Howland, Walter L.....Pinconning
Huckins, Edward S. 436 Cass Ave., Bay City
Huckins, Rodger S. 436 Cass Ave., Bay City
Hughes, E. C. (L).....505 N. Madison, Bay City
Husted, F. Pitkin.....812 N. Grant, Bay City
Jacoby, A. H.....2202 Ninth St., Bay City
Jens, Otto F. 1106 Prairie, Essexville
Johnson, Orlen J. 207 N. Walnut, Bay City
Jones, Culver 900 Jackson Ave., Bay City
Kessler, Mana 201 Shearer Bldg., Bay City
Kessler, Saba.....201 Shearer Bldg., Bay City
Knobloch, Howard T. 1102 Columbus Ave., Bay City
Lambert, Leslie A.....304 Newman St., East Tawas
Loftin, Robert L. City Hall, Bay City
McDonnell, Walter R. Pinconning
McEwan, John H. 307 Davidson Bldg., Bay City
MacPhail, Lt. Comdr. J. C. (M).....
2819 Marlboro St., Norfolk 4, Va.
MacRae, L. Douglas 813 Sherman St., Bay City
Medvezky, M. J. 1104 S. Madison, Bay City
Miller, Edwin C. 101 W. John St., Bay City
Mitton, Orland W. East Tawas
Moore, George W. (L) 200 N. Barclay, Bay City
Moore, Neal R. 704 N. Jackson, Bay City
Mosier, Dwight J. 101 W. John St., Bay City
Pearson, Stanley M. 101 W. John St., Bay City
Reed, William S.....Dept. of Surgery, Univ. Hosp., Ann Arbor
Reuter, Clarence W.....101 W. John, Bay City
Schuele, J. M. Au Gres
Shafer, Harold C. 101 W. John St., Bay City
Sherman, R. N. (R) Bradenton Beach, Fla.
Smith, J. Campbell 101 W. John St., Bay City
Staley, Hugh O. Omer
Stinson, W. S. 101 W. John St., Bay City
Switzer, Lars W. Chevrolet Motor Co., Bay City
Tarter, Clyde S. 1712 Center Ave., Bay City
Taylor, R. S. 900 N. Jackson, Bay City
Tompkins, D. A. (M)
c/o J. L. Tompkins, Bonner Springs, Kan.
Urmston, Paul R. 303 Davidson Bldg., Bay City
Vail, Harry F. 1942 Woodside, Bay City
Warren, E. C. (E) 1100 Fifth Bay City
Wilcox, James W. 1115 Fifth Ave., Bay City
Wilson, Thomas G. 900 N. Jackson, Bay City
Wittwer, E. A. (L) 107 North Erie St., Bay City
Woodburne, H. L. Davidson Bldg., Bay City
Wright, T. B. 101 W. John St., Bay City
Zaremba, Aloysius J. 108 S. Madison Ave., Bay City
Ziliak, A. Lawrence, Jr.....707 N. Lincoln, Bay City

BRANCH COUNTY

Aldrich, Napier S. 15 E. Pierce St., Coldwater
Andrews, Frank A. Box 148, Coldwater
Bailey, J. E., Jr. 73 W. Chicago, Coldwater
Beck, Perry C. 235 N. Walker St., Bronson
Culver, Dean T. 78 Division, Coldwater
French, Merle R. 35 South Sprague St., Coldwater
Fraser, R. J. 22 W. Pearl St., Coldwater
Gomley, Henry C. 108 E. Chicago, Bronson
Leitch, R. M. 304 N. Broadway, Union City
McLain, R. W. (L) 37 Janoah, Battle Creek
Meier, H. J. 87 W. Pearl St., Coldwater
Mooi, H. R. 72 W. Chicago St., Coldwater
Olmstead, Kenneth L. 131 N. Hanchett St., Coldwater
Rees, Kendall B. Box 148, Coldwater
Rennell, E. J. Box 148, Coldwater
Slosser, Paul J. 101 Church St., Tekonsha
Thomas, J. A. 18 N. Monroe St., Coldwater
Wade, R. L. (L) 116 E. Chicago St., Coldwater
Walton, N. J. 61 E. Chicago St., Quincy
Weidner, H. R. 50 Division St., Coldwater

BERRIEN COUNTY

Anderson, Bertha M. G...262 Pleasant St., Benton Harbor
Bailey, John H. 204 Fidelity Bldg., Benton Harbor
Bliesmer, A. F. 2208 Lakeview, St. Joseph
Bronfenbrenner, Jack ..316 Fidelity Bldg., Benton Harbor
Burrell, H. J. (R) 754 Ogden, Benton Harbor
Butler, W. J. 12 Peoples State Bank Bldg., St. Joseph
Cawthorne, H. J. 239 Pipestone St., Benton Harbor
Coffelt, Carl F., Jr...Shepard & Banning Bldg., St. Joseph
Conklin, F. L. Berrien Center
Conway, Joseph Watervliet
Conybeare, R. C. 416 Fidelity Bldg., Benton Harbor
Cooper, Leroy G. 903 Wisconsin Ave., St. Joseph
Cowdery, K. H. 1600 Niles, St. Joseph
Crowell, Richard C.
12 Peoples State Bank Bldg., St. Joseph
Dunnington, Ruel N. 143 Pipestone, Benton Harbor
Elliott, J. Colin 207½ E. Front St., Buchanan
Emery, C. S. 1020 Niles St., St. Joseph
Emery, William K.....1020 Niles Ave., St. Joseph
Faber, Michael 209 State Bank Bldg., Benton Harbor
Fattic, G. R., Jr. P.O. Box 234, Niles
Feeley, M. J. 505 Pleasant St., St. Joseph
Friedman, M. E. Box 87, New Buffalo
Gallas, James Coloma
Garrett, Evan L. 204 Starr Bldg., Niles
Gillette, Clarence Niles
Haglin, John J. 536 W. Main St., Niles
Harper, Ina M. 190 Michigan Ave., Benton Harbor
Harrison, L. L. 304 Main St., Niles
Hart, Russell T. 2 Walton St., Niles
Helkie, William L. (E)
203 S. Ironwood Drive, South Bend, Ind.
Henderson, Fred C. 107 N. Second, Niles
Hershey, N. J. 107 N. Second, Niles
Holt, Robert E., Jr. 107 North Second, Niles
Huff, H. D. 107 N. Second St., Niles
Johnston, William 505 Pleasant St., St. Joseph
Kelsall, H. I. 1600 Niles, St. Joseph
Kennedy, Francis A. 239 Pipestone St., Benton Harbor
King, B. B. 210 Fidelity Bldg., Benton Harbor
King, Frank A., Jr.....610 Fidelity Bldg., Benton Harbor
Klos, Henry J. X-Ray Dept., Mem. Hosp., St. Joseph
Landgraf, R. L. 107 N. Second St., Niles
Lawton, Clare V. 610 Fidelity Bldg., Benton Harbor
Leva, John B. 312 Fidelity Bldg., Benton Harbor
Lindenfeld, Frederick H. 8 N. St. Joseph, Niles
Lininger, R. E.....Mercy Hospital, Benton Harbor
Louisell, C. T. (A) College Ave., St. Paul, Minn.
Louisell, James M. Bridgman
Manning, John T.....922 Main St., St. Joseph
McNabb, Arthur A. 469 Main St., Watervliet
Miller, E. A. Berrien Springs
Mitchell, Carl A. (L) Box 614, Tavares, Fla.
Moore, T. Scott Niles
Ozeran, Charles J. 98 Water St., Benton Harbor
Parker, L. B.....104½ W. Ferry St., Berrien Springs
Polansky, Sanford 84 West Main St., Benton Harbor
Porter, Charles B. 170 Wall St., Benton Harbor
Pritchard, Harold M. 12 N. Fourth St., Niles
Rague, P. O. Mercy Hospital, Benton Harbor
Ray, Dean K. 617 Elm St., St. Joseph
Reagan, Robert E. 190 Michigan St., Benton Harbor
Rice, F. A. 318 N. Fourth St., Niles
Rice, F. G. 324 N. Fourth St., Niles

Richmond, D. M. 314½ State St., St. Joseph
Sowers, Bouton F. 210 Fidelity Bldg., Benton Harbor
Strayer, John W. 107 N. Second St., Niles
Strick, Marvin H. 311 Fidelity Bldg., Benton Harbor
Thorup, D. W. 610 Fidelity Bldg., Benton Harbor
Vastine, Russell 113 N. Portage, Buchanan
Westervelt, H. O. 539 Pearl St., Benton Harbor
Winegar, A. C. 190 Michigan Ave., Benton Harbor
Woodford, Hackley E. 191 Michigan, Benton Harbor

CALHOUN COUNTY

Albright, Arnold A., Col., MC (M)
Percy Jones General Hospital, Battle Creek
Amos, Norman H. 1704 Wolverine Tower, Battle Creek
Anderson, Harold E. 501 Post Bldg., Battle Creek
Ashby, John, Maj., MC (A)
Percy Jones Army Hospital, Battle Creek
Barden, Stuart P.
Leila Y. Post Montgomery Hosp., Battle Creek
Baribeau, Roy H. 531 Post Bldg., Battle Creek
Becker, Harry F. Route 3, Box 303A, Battle Creek
Beuker, Herman 120 E. Mich. Ave., Marshall
Bodine, Harold R. 1506 Security Bank Bldg., Battle Creek
Bonifer, P. P. 1008 Wolverine Tower, Battle Creek
Bonzelaar, Marvin, Lt., MC (M)
Percy Jones Army Hospital, Battle Creek
Brainard, C. W.....1002 Security Bank Bldg., Battle Creek
Brown, Robert W...1206 Security Bank Bldg., Battle Creek
Calloway, N. O., Maj., MC (M)
Percy Jones Army Hospital, Battle Creek
Campbell, A. F. 103 E. Mulberry St., Albion
Campbell, Richard J. 140 Capital Ave., N.E., Battle Creek
Capron, Manley J. 618 Post Bldg., Battle Creek
Chandler, Edward M.
1407 Security Bank Bldg., Battle Creek
Chynoweth, W. R. 207 Post Bldg., Battle Creek
Cooper, J. E. (L) 298 W. Van Buren, Battle Creek
Curry, Robert K. Homer
Custer, H. R. (A) Leila Hospital, Battle Creek
Diamante, Paul J. 1704 Wolverine Tower, Battle Creek
Dickson, A. R. 1002 Sec. Bank Bldg., Battle Creek
Dodge, Warren M., Jr.
1207 Wolverine Tower, Battle Creek
Fairbanks, Stephen 119½ N. Superior, Albion
Finch, D. L. 806 Sec. Nat. Bank Bldg., Battle Creek
Forsyth, J. E. 217½ S. Superior, Albion
Fraser, Robert H. 1112 Sec. Bank Bldg., Battle Creek
Funk, L. D. Athens
Gething, Joseph W. (L)
803 Security Bank Bldg., Battle Creek
Gilfillan, Margery J. (L)..Battle Creek San., Battle Creek
Gorsline, C. S. (L) 85 Orchard Place, Battle Creek
Graubner, F. L. Marshall
Hansen, E. L. 216 North Ave., Battle Creek
Hansen, Harvey C. 417 Post Bldg., Battle Creek
Haughey, Wilfrid (L) 610 Post Bldg., Battle Creek
Heald, C. W. (L) 291 W. Michigan, Battle Creek
Henderson, Philip M. 109 West Erie St., Albion
Herzer, Henry A. (L) 101½ N. Superior, Albion
Hibbs, Donald K. 622 Post Bldg., Battle Creek
Holtom, B. G. 815 Security Bank Bldg., Battle Creek
Hoyt, A. A. (L) 612 Sec. Bank Bldg., Battle Creek
Hubly, James W.....1407 Sec. Nat. Bk. Bldg., Battle Creek
Humphrey, A. E. 122 N. Madison, Marshall
Humphrey, Arthur A...914 Sec. Bank Bldg., Battle Creek
Jeffrey, J. R. Battle Creek San., Battle Creek
Jesurun, Harold M., Lt. Col. MC (M)
Brooke Army Hospital, Fort Sam Houston, Texas
Jones, Aubrey H. (A)....Veterans Hospital., Fort Custer
Jones, T. K. 118 W. Green St., Marshall
Keagle, Leland R. 196 North Ave., Battle Creek
Keeler, K. B. 205½ S. Superior St., Albion
Kelleher, George T. 613 Post Bldg., Battle Creek
Kimball, A. S., Jr. (A)
196 Capitol Ave., N.E., Battle Creek
Kinde, M. R. 258 Champion St., Battle Creek
Kingsley, Paul C. 1407 Sec. Bank Bldg., Battle Creek
Knapp, Nettie E. Battle Creek San., Battle Creek
Kolvoord, Theodore....505 Sec. Bank Bldg., Battle Creek
LaFrance, N. Francis (A)....Veterans Hosp., Fort Custer
Lam, Francis L. 408½ Capital, S.W., Battle Creek
Lancaster, V. B., Capt., MC (M)
Percy Jones Army Hospital, Battle Creek
Levy, Joseph, Jr., ...1208 Wolverine Tower, Battle Creek
Lewis, W. B. 367 Champion, Battle Creek
Lowe, Kenneth H. 401 Sec. Bank Bldg., Battle Creek
Lowe, Stanley T. 1009 Sec. Bank Bldg., Battle Creek
MacGregor, Archibald E. (L)
1510 Security Bank Bldg., Battle Creek
Mantz, Frank A., Lt. Col., MC (M)
Percy Jones Army Hospital, Battle Creek
McCuaig, Alfred 806 Sec. Bank Bldg., Battle Creek
McNair, Lawrence N. 205½ S. Superior St., Albion
Medinets, H. E., Capt., MC (M)
Percy Jones Army Hospital, Battle Creek
Meister, F. O. 1007 Security Bank Bldg., Battle Creek
Melges, Fred J. 1506 Security Bank Bldg., Battle Creek
Mercer, C. M.
512 Michigan Nat. Bank Bldg., Battle Creek
Moody, J. E. (A)
Detroit TB San., 1800 Tuxedo Ave., Detroit
Morrison, Donald B. 806 Sec. Bank Bldg., Battle Creek
Moss, H. L. (A) Leila Hospital, Battle Creek
Mowrey, F. H., Col., MC (M)
Percy Jones Army Hospital, Battle Creek
Mullenmeister, Hugh F.,...275 Capital, N.E., Battle Creek
Mustard, Russell L.,....1407 Sec. Bank Bldg., Battle Creek
Passino, James W. (A)..Leila Y. Post Hosp., Battle Creek
Patrick, Gilbert T. 505 Sec. Bank Bldg., Battle Creek
Pearson, Donald J. 302 Post Bldg., Battle Creek
Power, J. R. 140 NE Capital, Battle Creek
Roberts, E. H. American Legion Hosp., Battle Creek
Robbert, John....1407 Security Bank Bldg., Battle Creek
Robins, Hugh B. 237 Fremont, Battle Creek
Robinson, A. L. 231 S. Fourth St., Burr Oak
Rorich, Wilma Weeks..166 Capital Ave. N.E., Battle Creek
Rosenfeld, J. E. 158 Capitol, N.E., Battle Creek
Royer, Clark W. 1508 Wolverine Tower, Battle Creek
Rowan, Russell C. 205½ S. Superior, Albion
Schwarz, Frank W. 31 Orchard Place, Battle Creek
Sharp, A. D. 308 S. Superior, Albion
Shellanberger, H. M. 108½ W. Michigan, Marshall
Shipp, Leland P. 1414 Sec. Bank Bldg., Battle Creek
Sibilsky, A. C. 900 Wolverine Tower, Battle Creek
Simpson, Robert S.....1507 Wolverine Tower, Battle Creek
Slagle, George W. 140 N.E. Capitol, Battle Creek
Sleight, James D., ...401 Sec. Bank Bldg., Battle Creek
Smith, George W., Maj., MC (M)
Percy Jones Army Hospital, Battle Creek
Stadle, Wendell H. 1506 Sec. Bank Bldg., Battle Creek
Stiefel, Richard A.....1407 Sec. Bank Bldg., Battle Creek
Strohmenger, Frank J. 400½ S. Superior St., Albion
Swartz, George K. Battle Creek San., Battle Creek
Tannenholz, Harold S.
1614 Security Bank Bldg., Battle Creek
Taylor, Clifford B. 308½ S. Superior St., Albion
Taylor, Harlan H., Col., MC (M)
Percy Jones Army Hospital, Battle Creek
Tazelaar, M. A. 219 Madison, Marshall
Teter, Lloyd F. (A) Leila Hospital, Battle Creek
Upson, W. O. (L) 422 S. Freeman, Oceanside, Calif.
VanderVoort, Wm. V. (L)
Battle Creek San., Battle Creek
Verity, Lloyd E. 1414 Sec. Bank Bldg., Battle Creek
Vertuno, J. Lewis, Lt., MC (M)
Percy Jones Army Hospital, Battle Creek
Waide, Margaret E. (A)....Leila Hospital, Battle Creek
Walker, Charles S. 709 W. Van Buren, Battle Creek

Walters, John F. 41 North Washington, Battle Creek
Wencke, Carl G. 1015 Sec. Bank Bldg., Battle Creek
Winslow, Sherwood B. 612 Post Bldg., Battle Creek
Worgess, Duane R. 45 Territorial Rd. W., Battle Creek
Wu, Jack Foy American Legion Hospital, Battle Creek
Yannitelli, S. A. A. S. Kimball San., Battle Creek
Zheutlin, Bertram 158 Capital Ave., N.E., Battle Creek
Zindler, George A.....1206 Sec. Bank Bldg., Battle Creek

CASS COUNTY

Adams, U. M. Marcellus
Clary, Rudolph I. 126½ Front St., Dowagiac
Comstock, L. D., Jr.....216½ Front St., Dowagiac
Everett, Daniel W. Edwardsburg
Hickman, John K.....212½ S. Front St., Dowagiac
Loupee, George E.....Dowagiac
Loupee, S. L. (L) Dowagiac
Newsome, Otis E. R.F.D. No. 3, Cassopolis
Pierce, Kenneth C.....140½ S. Front St., Dowagiac
Rutz, Lawrence M. Marcellus
Zwergel, Edward H.....Cassopolis

CHIPPEWA-MACKINAC COUNTIES

Bandy, Festus C. (R).....Franklin Manor, Sarasota, Fla.
Blair, Herbert M. 300 Court St., Sault Ste. Marie
Blue, J. J. Cedarville
Clausen, C. H. 300 Court St., Sault Ste. Marie
Conrad, G. A. (E) 521 Ashmun, Sault Ste. Marie
Cowan, Donald A.....R.F.D. No. 1, Sault Ste. Marie
Finlayson, D. D. 309 Ashmun, Sault Ste. Marie
Goddard, G. B. Pickford
Goldberg, A. H. Haller Block, Sault Ste. Marie
Hagele, Marie A.....300 Court St., Sault Ste. Marie
Harrington, H. M. 519 Ashmun, Sault Ste. Marie
Hamel, Herbert E.....St. Ignace
Howe, Donnell C. 300 Court St., Sault Ste. Marie
Howe, Gertrude E. 300 Court St., Sault Ste. Marie
Mackie, T. B. 300 Court St., Sault Ste. Marie
McBryde, L. M. Masonic Bldg., Sault Ste. Marie
Mertaugh, W. F.
Central Savings Bank Bldg., Sault Ste. Marie
Montgomery, B. T. 309 Ashmun, Sault Ste. Marie
Rhind, E. S. 300 Court St., Sault Ste. Marie
Scott, D. F. 300 Court St., Sault Ste. Marie
Trapasso, T. J. 300 Court St., Sault Ste. Marie
Venier, A. G. 519 Ashmun St., Sault Ste. Marie
Wallen, L. J. 409 Ashmun St., Sault Ste. Marie
Willison, Clayton (E)
Central Savings Bank Bldg., Sault Ste. Marie
Yale, I. V. (L) 200 Ashmun St., Sault Ste. Marie

CLINTON COUNTY

Bennett, George W. Elsie
Cook, Bruno C. Westphalia
Elliott, Bruce R. Ovid
Fillinger, Wells B. Ovid
Foo, Charles T. St. Johns
Graber, Virgil R. St. Johns
Henthorn, A. C. R.F.D. No. 3, St. Johns
Kirker, J. G. Fowler
Luton, F. E. (E) St. Johns
McNamara, J. W. 604 Mason, Chenoa, Ill.
McWilliams, W. B. Maple Rapids
Russell, Sherwood R. St. Johns
Sheline, V. L. Ashley
Slagh, Earl M. Elsie
Smith, F. W. Ovid
Stephenson, W. F. 108 East McConnell, St. Johns
Stoller, Paul F. 308 N. Mead St., St. Johns

DELTA-SCHOOLCRAFT COUNTIES

Anderson, F. C. First Nat. Bank Bldg., Escanaba
Benson, G. W. 100 N. Tenth, Escanaba
Bernier, A. B. Nahma
Boyce, D. H. 1007 Ludington, Escanaba
Brenner, Ervin J. Manistique
Carlton, A. J. (L) 1103 Ludington, Escanaba
Chenoweth, Nancy R. (E)....Peterborough, Ont., Canada
Defnet, H. J. 121 South 11th St., Escanaba
Dehlin, J. R. 1102 Wisconsin Ave., Gladstone
Frenn, Nathan J. Bark River
Fyvie, James H. 202 S. Cedar, Manistique
Groos, H. Q. 1015 S. First, Escanaba
Groos, L. P. 1015 S. First, Escanaba
Harrison, William C. 403 S. Seventh St., Escanaba
Hult, O. S. 1005 Delta Ave., Gladstone
Kee, C. E. 1102 Wisconsin Ave., Gladstone
Larson, F. W. 202 S. Cedar St., Manistique
Lemire, D. F. 1104 S. First, Escanaba
Lemire, W. A. 1106 S. First, Escanaba
Lindquist, N. L. 205 S. 10th St., Escanaba
McInerney, T. A. 1221 Ludington, Escanaba
Miller, A. H. 904 Wisconsin, Gladstone
Ryde, R. E. 1219 Ludington, Escanaba
Van Arsdale, William L. Manistique
Walch, J. J. 1103 Ludington, Escanaba
Wehner, Merle E. Manistique

DICKINSON-IRON COUNTIES

Addison, E. R. 412 Superior, Crystal Falls
Alexander, W. H.
Commercial Nat. Bank Bldg., Iron Mountain
Boyce, G. H. First Nat. Bank Bldg., Iron Mountain
Browning, J. L. 212 East B St., Iron Mountain
Cooper, C. A. 230 Washington Ave., Stambaugh
Fiedling, William Norway, Mich.
Haight, H. H. (A)
Navy Dept., Bureau of Medicine and Surgery, Room 7, Bldg. No. 20, Washington 16, D. C.
Hayes, Willard N. Norway
Huron, W. H. 107 East "A" St., Iron Mountain
Irvine, L. E. 422 Third St., Iron River
Kofmehl, Wm. J. Stambaugh
McCormack, Edward Niagara, Wis.
Menzies, Clifford G. 416 W. Brown, Iron Mountain
Palm, E. T. 412 Superior St., Crystal Falls
Retallack, R. C. 422 Third St., Iron River
Schmutzler, W. A. 373 Woodward, Iron Mountain
Schroeder, J. M. 1115 Stockbridge, Iron Mountain
Silas, R. M. Veterans Hospital, Iron Mountain
Smith, Donald R. 105 East A St., Iron Mountain
Steinke, C. G. 517 Stephenson, Iron Mountain

EATON COUNTY

Arner, Fred L. 231½ N. Main St., Bellevue
Brown, B. P. 339 S. Cochran St., Charlotte
Carothers, Daniel J. 201½ S. Cochran St., Charlotte
DeLand, C. L. 121 S. Main St., Olivet
Garlock, F. C. Grand Ledge
Hannah, Harry W. 226 S. Cochran St., Charlotte
Harrod, Gordon R. Grand Ledge
Hoffer, W. E. 115 S. Washington St., Charlotte
Imthun, E. F. 113 E. Jefferson, Grand Ledge
Johnson, Robert C. (M) Charlotte
Meinke, A. H. 101 W. Plain St., Eaton Rapids
Myers, Albert W. Potterville
Sevener, Lester G. 236 S. Cochran St., Charlotte
Van Ark, Bert 101 West Plain, Eaton Rapids
Van Ark, H. F. 101 W. Plain St., Eaton Rapids
Whitlock, Stanley C. Dimondale
Willits, C. O.....201 W. Seminary, Charlotte

GENESEE COUNTY

Adams, Burnell H. 2002 E. Court St., Flint
Adams, Chester H. 310 E. First St., Flint
Anderson, H. H. 11280 N. Saginaw, Mt. Morris
Andrews, Nelson A. C. 310 E. Main St., Flushing
Anthony, George E. R.....1015 Detroit St., Flint
Backus, Glenn R. 633 Mott Foundation Bldg., Flint
Baird, W. C. (A) 1818 Ramsey Blvd., Flint
Bald, Frederick W. 610 Mott Foundation Bldg., Flint
Barbour, Fleming A. ..1439 Mott Foundation Bldg., Flint
Baske, Franklin W. 923 Maxine St., Flint
Bateman, L. G. 1928 Lewis, Flint
Benson, J. C., Sr. (L) 727 Clifford St., Flint
Benson, John C., Jr.....709 Genesee Bank Bldg., Flint
Berman, Harry 3309 Fenton Rd., Flint 7
Bernstein, Eli N. 409 Kresge Bldg., Flint
Beyer, Damon P. 145 Vienna St., Clio
Beyer, George D. 145 Vienna St., Clio
Bishop, D. L. 2226 Detroit St., Flint 5
Blakeley, A. C.
Veterans Admin., Med. Dept., 310 E. Jefferson, Detroit
Bogart, Leon M. 1008 Genesee Bank Bldg., Flint
Boles, William P. 714 Beach St., Flint
Bonathan, Alvin T. 606 First Nat. Bldg., Flint
Bradley, Robert M. 420 Genesee Bank Bldg., Flint
Brain, R. Gordon 509 First Nat. Bank Bldg., Flint
Branch, Hira E. 821 Mott Fd. Bldg., Flint
Brasie, Donald R. 907 Citizens Bank Bldg., Flint
Briggs, Guy D. 225 Genesee Bank Bldg., Flint
Bruce, William W. 5045 Morrish Rd., Swartz Creek
Bryant, Donald R. 621 Mott Fd. Bldg., Flint
Buchanan, William F. 104 W. Caroline St., Fenton
Burkett, L. V. County Court House, Flint
Burnell, Max R. 3301 Westwood Parkway, Flint
Caster, E. Wilbur (L)....13312 Wales, Huntington Woods
Chambers, Myrton S. 839 Moot Fd. Bldg., Flint
Chandler, M. E. (L) 929 Woodlawn Park Drive, Flint
Charters, John H. (E) 311 East Fourth St., Flint 3
Collins, James I. 902 Stockdale, Flint
Colwell, C. W. 706 Citizens Bank Bldg., Flint
Connell, John T. 305 Dryden Bldg., Flint
Conover, George V. 420 Genesee Bank Bldg., Flint
Conover, McClellan B. 312 Paterson Bldg., Flint
Conover, T. Sidney 420 Genesee Bank Bldg., Flint
Cook, Henry 326 Genesee Bank Bldg., Flint
Covert, Floyd L. (L) Gaines
Craig, W. G. 717 Mott Fd. Bldg., Flint
Crane, Harley C. 124 W. 4th St., Flint
Credille, Barney A. 813 Genesee Bank Bldg., Flint
Curry, George J. 402 Genesee Bank Bldg., Flint
Curtin, John H. A.C. Spark Plug Plant, Flint
Cutler, G. Campbell 2415 Detroit St., Flint
Dawson, Ralph E. 804 Metropolitan Bldg., Flint
DelZingro, Nicholas Davison
Denholm, Nan H. 811 Mott Foundation Bldg., Flint
Dickstein, Bernard 201 Dryden Bldg, Flint
Dimond, E. G. 209 Genesee Bank Bldg., Flint
Dodds, Frederick E. 1336 Lewis St., Flint
Dorsey, Philip W. 220 Genesee Bank Bldg., Flint
Drewyer, Glen E. 907 Welch Blvd., Flint
Eichhorn, E. M. 1112 Mott Fd. Bldg., Flint
Eickhorst, Thomas N. 210 E. Court St., Flint
Elliott, Hardie B. 409 Dryden Bldg., Flint
Engelman, R. M. 1013 Mott Fd. Bldg., Flint
Ettinger, Ralph D. 111 S. Walnut St., Fenton
Farhat, Maynard M. 620½ W. Court St., Flint
Fee, Manson G. 311 Kresge Bldg., Flint
Finkelstein, Theodore 1415 Broadway, Flint
Flynn, Southard T. 1121 Mott Fd. Bldg., Flint
Foley, Sydney I. 2217 Mason St., Flint
Fuller, Harvey T. Mt. Morris
Gelenger, S. M., Lt. Col., MC (M)
A.P.O. 59, c/o P.M., San Francisco
Gleason, N. A. 1310 Mott Foundation Bldg., Flint
Golden, H. Maxwell 215 N. Saginaw, Flint
Goodfellow, B. T. (L) 560 Page St., Flint
Gorne, Saul S. 400 F.P. Smith Bldg., Flint 3
Grady, Donald R. 5009 N. Saginaw St., Flint
Griffin, Ernest P., Jr. 619 Mott Fd. Bldg., Flint
Grover, H. F. 310 Dryden Bldg., Flint
Guile, Gurdon S. 1621 Dupont St., Flint
Gundry, G. L. 11736 Saginaw, Grand Blanc
Gutov, Isadore H. 607 Citizens Bank Bldg., Flint
Gutov, J. J.....607 Citizens Bank Bldg., Flint
Hackley, Richard D. 4120 Western Rd., Flint
Hague, Robert F. 210 E. Court St., Flint 3
Halligan, Raymond S. (L) 405 East First St., Flint
Hamady, Ruth E.....228 Welch Blvd., Flint
Hamilton, A. J.
Fisher Body Co., No. 2, 3100 Van Syke Rd., Flint
Harper, Homer Buick Motor Co., Flint
Harrison, Leo D. (R) 1132 Woodside Drive, Flint
Hauser, Frederick V. 1012 Mott Fd. Bldg., Flint
Hawkins, James E. 1226 Leith St., Flint
Hays, George A.....City Health Dept., Flint
Hing, William 326 Stockdale St., Flint
Hiscock, Harold H. 1315 Mott Fd. Bldg., Flint
Hooper, Kendall 714 Beach St., Flint
Houston, James (L) Swartz Creek
Hubbard, Wm. B. 302 Paterson Bldg., Flint
Hurd, Clayton E. First and Walnut St., Fenton
Jermstad, Robert J. 633 Mott Fd. Bldg., Flint
Johnson, Arthur H. 3219 North St., Flint
Johnson, Frank D. 312 Paterson Bldg., Flint
Johnson, R. E. 1621 Dupont St., Flint
Jones, Lafon 1004 Genesee Bank Bldg., Flint
Judd, A. E. 2315 Davison Rd., Flint
Kaleta, Edward J. 3101 N. Saginaw St., Flint
Kaufman, L. D. 4002 N. Saginaw, Flint
Knapp, William D. 201 Kresge Bldg., Flint
Koop, C. S. Genesee Co. San., Flint
Kretchmar, Arthur H. 608 First Nat. Bldg., Flint
Kurtz, John J. 421 Dryden Bldg., Flint
Laird, James I. 10114 Main St., Goodrich
Leach, J. Leonidas 3007 Industrial Ave., Flint
Limbach, David R. Hurley Hosp., X-Ray Dept., Flint
Livesay, Jackson E. 619 Mott Fd. Bldg., Flint
Logan, George W. (L) Flushing
Lukens, T. John 1327 Mott Fd. Bldg., Flint
MacGregor, Delbert M. 701 Dayton, W., Flint
Macksood, Joseph A. 2501 N. Saginaw St., Flint
John T. Manwaring 1002 Citizens Bank Bldg., Flint
McArthur Arthur 1539 Mott Foundation Bldg., Flint
McCabe, Margaret M. 420 Genesee Bank Bldg., Flint

McGarry, B. G. (L) Fenton
McGarry, Roy A. 418 Dryden Bldg., Flint
McKenna, Oscar W. (E) 507 Harrison St., Flint
McLeod, K. W. A. 2801 N. Saginaw, Flint 5
McTaggart, David 507 Metropolitan Bldg., Flint
Michael, S. R. 907 Welch Blvd., Flint
Michels, Robert M. 610 E. Main St., Flushing
Miller, Loren Eugene 2645 Corunna Rd., Flint 3
Miltich, Anthony J. 415 Dryden Bldg., Flint
Moore, Kenneth B. 1613 Moot Foundation Bldg., Flint
Moore, Wesley P.....3101½ Industrial Ave., Flint
Morrison, William H. 205 Perry Rd., Grand Blanc
Morrissey, V. H. 101 Stockdale St., Flint
Mosier, Edward C. Otisville
Neiswander, Paul L.
Fisher Body Truck Plant, Grand Blanc
Odle, Ira D. 201 Welch Blvd., Flint
O'Neil, C. H. (R) Deckerville
Orr, J. Walter (L) Orrs Point, Lake Fenton, Fenton
Osher, Seymour L. 506 National Bldg., Flint
Pfeifer, Archibald C. 11610 N. Saginaw St., Mt. Morris
Phillips, Robert L. 706 Citizens Bank Bldg., Flint
Phillips, Robert W. 829 Stockdale, Flint
Pratz, Oliver C. 1303 Detroit St., Flint
Preston, Otto J. Chevrolet Motor Company, Flint
Purcell, F. L. Goodrich Hospital, Goodrich
Ragan, Russell M. 3602 Beecher, Flint 3
Rawlings, J. Mott City Health Dept., Flint
Reeder, Frank E. 808 Genesee Bank Bldg., Flint
Reichard, Orill (L) 1507 Detroit St., Flint
Reid, Wells C. Goodrich
Reynolds, A. J. (L) 806 Genesee Bank Bldg., Flint
Rieth, George F. 1402 Davison Rd., Flint
Roberts, Floyd A. 428 Thompson St., Flint
Rowe, John B. 312 Paterson Bldg., Flint
Rulney, Max 1128½ Chevrolet Ave., Flint
Rundles, Walter Z. 304 First National Bldg., Flint
Rundles, Walter Z., Jr., ...304 National Bldg., Flint
Rynearson, W. J. 308 Roberts St., Fenton
Sandy, Kenneth R. 2701 Detroit St., Flint
Scavarda, Charles J. 304 First National Bldg., Flint
Schiff, B. A. 200 Sill Bldg., Flint
Schreiber, E. Oskar 421 Kresge Bldg., Flint
Schwartz, J. M.
4300 S. Saginaw St., Fisher Body Plant No. 1, Flint
Scott, Robert D. 1215 Detroit St., Flint
Searles, Karl F. 2932 Corruna Rd., Flint
Shantz, Leighton O. 1239 Mott Fd. Bldg., Flint
Shapiro, Joseph 402 Metropolitan Bldg., Flint
Sheeran, Daniel H. 809 Genesee Bank Bldg., Flint
Shipman, Charles W. 325 E. First St., Flint
Simoni, Lewis E. 4301½ S. Saginaw St., Flint
Sirna, Anthony R.
Chevrolet Motor Co., 300 N. Chevrolet Ave., Flint
Sleeman, B. R. 129 E. Broad St., Linden
Smith, DeVerne C. (L) 810 Sill Bldg., Flint
Smith, Eugene C. 814 Mott Foundation Bldg., Flint
Smith, Maurice J. 2801 N. Saginaw, Flint
Sniderman, Benjamin F. 727 Beach St., Flint
Snyder, Charles E. 8042 Miller Rd., Swartz Creek
Sorkin, Morris L. 718 Beach St., Flint
Sorkin, Samuel S. 718 Beach St., Flint
Sparks, Harvey V. 603 First National Bldg., Flint
Steffe, Ralph S. 610 Mott Foundation Bldg., Flint
Steinman, Floyd H.....734 Mott Foundation Bldg., Flint
Stevens, P. K. 201 Michigan Theatre Bldg., Flint
Stevenson, William W. 416 Kresge Bldg., Flint
Streat, Rudolph W. 218 East 8th St., Flint
Strong, Kirk H. Buick Motor Co., Flint
Stroup, Clayton K. 2002 E. Court St., Flint
Sutherland, James K. 402 E. Third St., Flint
Sutton, George D. 303 W. Court St., Flint
Sutton, Mahlon R. (L) 2110 Detroit St., Flint
Swantzendrubee, F. J.....Goodrich Gen. Hosp., Goodrich
Thompson, Alvin 1121 Mott Foundation Bldg., Flint
Thompson, Jack W. 507 Citizens Bank Bldg., Flint
Tofteland, Elmer H. 302 W. Third Ave., Flint
Tower, R. B.
Genesee County San., Ballenger Hwy., Flint
Treat, David L. (L) 1110 S. Drive, Flint
Trumble, George W. (L) 2500 S. Saginaw, Flint
Turner, Merald G. 316 Dryden Bldg., Flint
Tuuri, Arthur L. Mott Clinic, Hurley Hospital, Flint
Van Harn, R. S. Buick Motor Co., Flint
Vary, Edwin P. 608 First National Bldg., Flint
Vaughan, Edgar J. Linden
Wajert, Josephine (A).....811 Mott Fd. Bldg., Flint
Walcott, Carver G. Fenton
Ward, Nell M. 1139 Mott Foundation Bldg., Flint
Ware, Frank A. 514 Genesee Bank Bldg., Flint 3
Wark, David R. 1315 Detroit, Flint
Wentworth, John E. 1651 Chevrolet Ave., Flint
Werness, Inga W. 314 First National Bank Bldg., Flint
White, C. H. 106 River St., Fenton
White, Herbert T. (L) ..504 First Nat. Bank Bldg., Flint
Williams, William S. 3398 S. Saginaw, Flint
Willoughby, Gordon L. 5009 N. Saginaw St., Flint
Willoughby, Leslie L. (L) 1402 Davison Rd., Flint
Wills, Thomas N. 706 W. Court St., Flint
Winchester, Walter H. (L) 515 Genesee Bank Bldg., Flint
Woughter, Harold W. 1312 Mott. Fd. Bldg., Flint
Wright, Donald R. 403 W. Court St., Flint
Wyman, J. S. 1604 Mott Foundation Bldg., Flint
Zeis, M. G. 718 Beach St., Flint

GOGEBIC COUNTY

Albert, Samuel G. 119 Suffolk St., Ironwood
Davidson, Donald L. 2001 Sophie, Bessemer
Eisele, D. C. 2nd Fl., 109 E. Aurora St., Ironwood
Franck, John R. Wakefield
Gertz, M. A. 109 E. Aurora St., Ironwood
Gingrich, W. A. 2nd Fl., 109 E. Aurora St., Ironwood
Gorilla, A. C. 2nd Fl., 210 S. Suffolk St., Ironwood
Harrington, R. R.....103 S. Suffolk St., 2nd Fl., Ironwood
Lieberthal, M. J. 104 S. Suffolk, Ironwood
Lieberthal, Paul R. 104 S. Suffolk, Ironwood
Lojacono, Salvatore Grand View Hospital, Ironwood
Maccani, Wm. L. Ironwood
Nezworski, H. T. 210 S. Suffolk, Ironwood
O'Brien, A. J.
Gogebic Clinic, 216 E. Aurora St., Ironwood
Pinkerton, H. A. Newport Hospital, Ironwood
Santini, F. J. 2nd Fl., 109 E. Aurora St., Ironwood
Stevens, Charles E.
Gogebic Clinic, 216 E. Aurora St., Ironwood
Tressel, Henry A. Wakefield
Wacek, W. H. Grand View Hospital, Ironwood

GRAND TRAVERSE-LEELANAU-BENZIE COUNTIES

Beall, J. G. 118½ E. Front, Traverse City
Bolan, Ellis J. Suttons Bay
Brownson, K. N. 116 Cass, Traverse City
Bushong, B. B. 116 Cass, Traverse City
Christie, J. W. Northport
Duiker, Henry Box C, Traverse City
Ellis, Claude I. Suttons Bay
Godfroy, Bernard M. P.....106½ E. Front, Traverse City
Goodrich, Dwight (R).....601 W. Front, Traverse City
Gunderson, Edward P. Frankfort
Haberlein, C. R. 123½ E. Front, Traverse City
Hall, J. W. 212½ E. Front, Traverse City
Hamilton, E. E. 530 S. Union St., Traverse City
Herkner, Mildred L. 876½ E. Front St., Traverse City
Huene, Nevin 112 E. Front, Traverse City
Huston, Russell R. Elk Rapids

Hyslop, W. T. Box C, Traverse City
Jerome, J. T. 105 State Bank Bldg., Traverse City
Lemen, C. E. 216½ E. Front, Traverse City
Lossman, R. T. Munson Hosp., Traverse City
Milliken, John G. 436½ W. Front, Traverse City
Nickels, M. M...Traverse City State Hosp., Traverse City
Osterhagen, H. F. W. Bay Shore Rd., Traverse City
Osterlin, Mark F. 201 State Bank Bldg., Traverse City
Pike, D. G. 876 E. Front, Traverse City
Power, F. H. 116 Cass, Traverse City
Salon, Dayton D. 108½ E. Front, Traverse City
Sheets, R. P. Traverse City State Hosp., Traverse City
Sladek, E. F. 123 E. Front, Traverse City
Stone, Fordyce H. Beulah
Swartz, F. G. 301 State Bank Bldg., Traverse City
Thacker, Fred R. Frankfort
Thirlby, E. L. (L).....116 Cass, Traverse City
Thirlby, Richard L. 711 Second St., Traverse City
Van Leuven, B. H. (R) Empire
Way, L. R. (R) 436 E. State, Traverse City
Weitz, H. L. 529 Monroe, Traverse City
Wieh, J. E. 118½ E. Front, Traverse City
Wilhelm, E. C. 438 W. Front, Traverse City
Zielke, I. H. 212 E. Front, Traverse City
Zimmerman, J. G.....306 State Bank Bldg., Traverse City

GRATIOT-ISABELLA-CLARE COUNTIES

Aldrich, Alfred L. Ithaca
Barstow, D. K.....St. Louis
Barstow, W. E. St. Louis
Becker, M. G. Edmore
Bergin, Joseph H. 1437 Michigan, Alma
Budge, M. J. Ithaca
Burch, L. J. (E) Mt. Pleasant
Burt, C. E. Ithaca
Burt, Loren G. Alma
Chamberlain, R. W. Mt. Pleasant
Davis, Lionel L. Mt. Pleasant
Drake, Wilkie M. (L) Breckenridge
DuBois, C. F. Alma
Graham, B. J. Alma
Hall, R. F. 1014 S. Lansing, Mt. Pleasant
Hammerberg, Kuno 622 McEwan, Clare
Harrigan, W. L. Mt. Pleasant
Hersee, Wm. E. Mt. Pleasant
Hobbs, A. D. St. Louis
Hoogerland, C. L. 514 Iowa, Alma
Hyslop, L. F.....Mt. Pleasant
Johnson, P. R. Mt. Pleasant
Juhnke, L. W. Mt. Pleasant
Kilborn, H. F. Ithaca
Lownik, F. J.....Mt. Pleasant
McArthur, Stewart C. Clare
Nickel, W. O. Mt. Pleasant
Oldham, E. S. Breckenridge
Palmer, F. W. P.O. Box 32, Mt. Pleasant
Robinson, F. W. Mt. Pleasant
Rottschafer, J. L. Alma
Silvert, Pasche P. Vestaburg
Strange, R. H. 630 S. College, Mt. Pleasant
Waggoner, R. L.....St. Louis
Wallman, C. H. 630 State St., Alma
Wickert, L. R. Mt. Pleasant
Wilcox, Rex A. Alma
Wilson, Earl C. Harrison
Wolfe, K. P. 427 W. Superior, Alma
Wood, C. B. Mt. Pleasant

HILLSDALE COUNTY

Bates, M. P. 108 S. Manning, Hillsdale
Davis, L. A. Camden
Day, Luther W. 111 Evans St., Jonesville
Hanke, George R. R.F.D., Osseo
Hodge, C. L. Reading
Hughes, Henry F. (L) Hillsdale
MacNeal, John A. 76 Manning St., Hillsdale
Martindale, E. A. (L) Hillsdale
Mattson, H. F.....32 S. Broad St., Hillsdale
McFarland, O. G. North Adams
Miller, Harry C. (L)
4760 Panorama Drive, San Diego 3, Calif.
Peterson, Carl A. First National Bank, Hillsdale
Sawyer, W. W. 61 N. Howell St., Hillsdale
Stein, Arthur J. 96 S. West St., Hillsdale
Strom, Arthur W. 32 S. Broad St., Hillsdale
Trapp, Donald G. 32 S. Broad St., Hillsdale
Wiggins, Ira W. 205 East St., Jonesville

HOUGHTON-BARAGA-KEWEENAW COUNTIES

Aldrich, A. B. 503 Sheldon Ave., Houghton
Aldrich, L. C. 1609 E. Houghton Ave., Houghton
Bourland, P. D. (L) 134½ Calumet Ave., Calumet
Brewington, G. F. (E)
309-A North 6th St., Las Vegas, Nev.
Burke, John J. 10 Duncan Ave., Hubbell
Gregg, W. T. S. (E)
Gerry's Landing, Cambridge 38, Mass.
Hayward, J. C. 5454 First St., Lake Linden
Hillmer, Raymond E. 1 Algomah, Painesdale
Hosking F. S. (M) 328 Florida St., Laurium
Janis, Anton J. East Hancock, Hancock
King, William T. (E) Ahmeek
Kirton, J. R. W. (E) 1111 Calumet Ave., Calumet
Kolb, F. E. 128 Calumet, Calumet
LaBine, Alfred 1019 College Ave., Houghton
Lepisto, V. E. 414 Hecla St., Laurium
Levin, Simon (E) 1209 College Ave., Houghton
Manthei, W. A. 5426 Calumet, Lake Linden
Murphy, P. J. 130 Calumet, Calumet
Repola, K. L. (M).....282 Jasper St., Ishpeming
Roberts, M. D. (L) 404 Hancock St., Hancock
Roche, Andrew M. 221 Fifth St., Callumet
Sloan, P. S. 214 Clark St., Houghton
Smith, Charles R. Hancock
Stern, I. D. 220 Hubbell, Houghton
Whitmore, Ray C. (R) Hancock
Wickliffe, J. T. P. 1167 Calumet Ave., Calumet
Winkler, Henry J. L'Anse

HURON COUNTY

Bentley, M. D., Capt., MC (M)
064928 U.S. Army Hosp., A.S.U. 5011, Camp McCoy, Wisc.
Dixon, Ralph C. Pigeon
Gettel, Roy R. Bad Axe
Herrington, Charles I. Bad Axe
Herrington, Willet J. Bad Axe.
Monroe, Duncan J. (L) Elkton
Oakes, C. W. Harbor Beach
Ritsema, John Sebewaing

Scheurer, Clare A. Pigeon
Sorensen, Maurice G. Kinde
Steinhardt, Edward E. Elkton
Strempek, W. F. Pigeon
Turner, Phillip R. Harbor Beach
Weiss, Arno W. Bad Axe

INGHAM COUNTY

Alexander, Reuben G. 301 Seymour, Lansing
Altland, J. K. Michigan Dept. of Health, Lansing
Asselin, David C. 503 Amer. State Bank Bldg., Lansing
Badgley, W. O. 624 N. Capitol Ave., Lansing
Baker, Arthur G. Michigan Dept. of Health, Lansing
Bartholomew, Henry S. (R) Harbor Beach
Bates, R. C. 1820 E. Michigan, Lansing
Bauer, Theodore I. 808 Olds Tower, Lansing
Beaubien, M. S. 601 Notre Dame, Grosse Pointe
Behen, William C. 535 S. Capitol, Lansing
Bellinger, E. G. (L) 114 W. Lenawee, Lansing
Bevez, Frank L. 2806 N. East St., Lansing
Black, Charles E. 529 W. Grand River, Williamston
Black, Gertrude C.
529 W. Grand River Ave., Williamston
Bobczyinski, Wilhelmina E.
234 W. Michigan, East Lansing
Bowersox, R. J. 108 Division, East Lansing
Bradford, C. W. 419 S. Walnut, Lansing
Breakey, Robert S...1211 Bank of Lansing Bldg., Lansing
Brenner, J. J.....122 W. Hillsdale, Lansing
Briede, Paul C. St. Lawrence Hospital, Lansing
Brown, Fred W., J. 536 Tussing Bldg., Lansing
Brubaker, Earl W.....1406 Bank of Lansing Bldg., Lansing
Brucker, Karl B. 122 W. Hillsdale, Lansing
Burhans, R. A. 808 Olds Tower, Lansing 8
Calomeni, Anthony D. 309 Seymour, Lansing
Carr, Earl I. 300 W. Ottawa, Lansing
Chaskes, Marian Iddings.....226 S. Capitol Ave., Lansing
Cheney, William D. 412 La Salle Blvd., Lansing
Christian, L. G. 108 E. St. Joseph, Lansing
Clark, W. E. 136 W. Ash St., Mason
Clarke, Emilie A. 5551 Vancouver Ave., Detroit 4
Clinton, George R. 339 E. Oak, Mason
Cook, R. J. 2601 S. Cedar St., Lansing
Cope, H. E. Michigan Dept. of Health, Lansing
Corneliuson, Goldie B. Mich. Dept of Health, Lansing
Cowan, J. A. 825 Touraine, East Lansing
Crandall, Clarence 4341 West Delhi Rd., Holt
Cross, Frank S. 426 W. Ottawa, Lansing
Cummings, G. D. Michigan Dept. of Health, Lansing
Darling, L. H. 115 W. Hillsdale, Lansing
Dean, Carleton 252 Hollister Bldg., Lansing
De Kleine, William 301 Seymour St., Lansing
DeVries, C. L. F. 320 Townsend, Lansing
Dexter, Mary J. 1022 E. Michigan, Lansing
Doyle, C. P. (E) 1408 Bank of Lansing Bldg., Lansing
Drolett, Donald J. 901 Prudden Bldg., Lansing
Drolett, Fred J. 900 Prudden Bldg., Lansing
Drolett, Lawrence A. 903 Prudden Bldg., Lansing
Dunn, F. M. 301 Seymour, Lansing
Ellis, Bertha W. (R) Route 1, West Olive
Ellis, C. W. (L) Route 1, West Olive
Feeney, Kenneth J. 1908 Olds Tower, Lansing 8
Folkers, Leonard M. 911 Rosewood, East Lansing
Fosget, Wilbur W. 303 Bauch Bldg., Lansing
Fortino, S. P. 502 Bauch Bldg., Lansing
French, Horace L. 301 Seymour, Lansing
Gardner, C. B. 320 Townsend St., Lansing
Garlinghouse, A. John 215 N. Walnut, Lansing
Goldner, Roy E. 1318½ S. Washington, Lansing
Hackman, Pearl E.....4455 Turney Rd., Cleveland, O.
Harris, Herbert W. 301 Seymour, Lansing
Harrison, W. H. 834 W. St. Joseph, Lansing
Harrold, J. F. 420 W. Ottawa, Lansing 15
Hart, L. C. 119 W. Lenawee, Lansing
Hayes, R. E. 1312 Woodbine, Lansing
Hayford, W. D. 211 Milford St., East Lansing
Heald, G. H. 234 Michigan Ave., East Lansing
Heckert, Frank B. 1105 Bank of Lansing, Lansing
Heckert, J. K. 1105 Bank of Lansing Bldg., Lansing
Henry, L. L. 326 Townsend, Lansing
Hermes, E. J. 310 Townsend, Lansing
Heustis, Albert E.
Michigan Dept. of Health, DeWitt Rd., Lansing
Himmelberger, R. J. 320 Townsend, Lansing
Hockman, T. A. 234 Michigan Ave, East Lansing
Holland, Charles F. 166 Orchard St., East Lansing
Huggett, Clare C. 126 W. Grand River, Lansing
Hurth, M. S. 1717 Jerome St., Lansing
Isbister, J. L.
Michigan Dept. of Health, DeWitt Rd., Lansing
Jacob, S. Sprigg.....201 Ann St., East Lansing
Johnson, Henry T. 420 West Ottawa St., Lansing
Johnson, Kenneth H. 1116 Olds Tower, Lansing
Johnston, D. W. (M).....
Jones, Francis, Jr. 716 Olds Tower Bldg., Lansing
June, R. C.....Michigan Dept. of Health, Lansing
Kahn, David.....401 American State Bank Bldg., Lansing
Kalmbach, R. E.....301 Seymour St., Lansing
Keim, C. D. 502 Bauch Bldg., Lansing
Kent, Edith Hall.....311 S. Pine, Lansing
Kent, Herbert K.....311 S. Pine, Lansing
Kenyon, Fanny H.....Michigan Dept. of Health, Lansing
Klunzinger, Willard R.....420 W. Ottawa, Lansing
Kraft, L. C.....209 S. Main, Leslie
Landy, G. R.....226 S. Walnut, Lansing
Lange, Phillip (M).....1st Lt. 0192087
Med. Co. 23rd Inf. Reg., 2nd. Div.
A.P.O. 248, P. M. San Francisco, Calif.
Lanting, Helen E.....611 Ardson, East Lansing
Lanting, Roelof.....207 City Hall, Lansing
Laughead, Charles A.....108 E. St. Joseph, Lansing
Lauzun, Virginia.....309 W. Main, Lansing
LeDuc, Don M.....310 Townsend Street, Lansing
Leeder, Fred S.....Mich. Dept. of Helth, Lansing
LeVett, Harry L.....117½ W. Shiawassee, Lansing
Loree, Maurice C.....120 W. Hillsdale, Lansing
Lucas, T. A. 426 W. Ottawa, Lansing
Ludlum, L. C.....1126 W. Saginaw Street, Lansing
Marriner, E. F. (M).....
Martin, W. O.....1017 Cleo, Lansing
McConnell, E. G. (R).....212 Leslie Street, Lansing
McCorvie, C. Ray.....129 East Gran River, East Lansing
McCoy, Earl M. (R).....Grand Ledge
McElmurry, Leland R.....209 N. Walnut, Lansing
McGillicuddy, Oliver B.....1816 Olds Tower, Lansing
McGillicuddy, R. J.....300 W. Ottawa, Lansing 15
McIntyre, J. E. 600 S. Grand Avenue, Lansing
McNamara, B. E.....326 Townsend, Lansing
McNamara, William E.....326 Townsend, Lansing
Meade, Robert J.....1023-25 E. Michigan Ave., Lansing
Meade, William H.....1023 E. Michigan, Lansing
Mercer, W. E.....304 Evergreen, East Lansing
Meyer, H. R. (R) 2117 Teel Ave., Lansing
Molina, Elba.....1512 E. Michigan, Lansing
Monfort, Robert N.....Health Center, MSC, East Lansing
Morris, M. K.....107 S. Pennslvania Avenue, Lansing
Morrow, R. J.....409 W. Ottawa, Lansing
Ochsner, P. J.....Fisher Body Plant, Lansing
Parker, Earl E.....207 E. Bellevue. Leslie
Pinkham, R. A.....535 N. Capital Avenue, Lansing
Place, Edwin H.....Oldsmobile Division, Lansing
Plesscher, W. H. 119 E. Grand River, East Lansing
Pomeroy, Richard W.....609 N. Washington, Lansing
Ponton, Joseph C.....117 E. Oak, Mason
Poppen, Clarence J.....Mich. Dept. of Health, Lansing
Potter, Earl C.....110 W. Hillsdale, Lansing
Prall, H. J.....505 Bauch Building, Lansing
Price, Florence R. V.....415 W. Barnes, Lansing
Randall, O. M.....802 Am. State Bank Bldg., Lansing
Rector, F. L.....P. O. Box 539, Lansing

Reynolds, E. E.....153 E. Grand River Ave., Williamston
Richards, F. D.....Dewitt
Richardson, M. L.....Sparrow Hospital, Lansing
Robson, Edmund J.....215 N. Walnut, Lansing
Rozan, J. S.....511 Bk. of Lansing Bldg., Lansing
Ruhmkorff, R. H.....
Mich. State Col. Health Center, East Lansing
Russell, Claude V. (R).....Northport
Rutledge, Samuel H.....309 Seymour, Lansing
Sander, J. F.....Cherry Hill Farm, Okemos
Scvheidt, R. Rudolph....126 W. Grand River Ave. Lansing
Schoff, Charles A. 129 E. Grand River, Williamston
Schultz, Arthur E.....
119 E. Grand River Ave., East Lansing
Seger, F. L. (L)..1035 Cherry St. NE, St. Petersburg, Fla.
Shapiro, Hyman D.....125 W. Saginaw, Lansing
Sharp, Mahlon S.....606 W. Shiawassee Street, Lansing
Shaw, Milton.....320 Townsend, Lansing
Sherman, G. A.....112 W. Hillsdale, Lansing
Sichler, Harper G.....301 Seymour, Lansing
Silverman, Irving E.....313 Tussing Bldg., Lansing
Sleight, Justin L.....117½ W. Shiawassee, Lansing
Smith, Anthony V.....116 W. Sycamore Street, Mason
Snyder, LeMoyne..705 American State Bk. Bldg., Lansing
Snyder, Ruth C. E.....234 W. Michigan, East Lansing
Spagnuolo, A. J.....326 Townsend Avenue, Lansing
Spencer, Perry C.....320 Townsend, Lansing
Stanka, A. G.....Alexander Bldg., Grand Ledge
Stanley, Arthur L.....408 Whitehall Dr., East Lansing
Steiner, A. A. Route No. 3, Grand Ledge
Steiner, S. D...Oldsmobile Div., Gen. Mot. Corp., Lansing
Stiles, Frank.....2012 Olds Tower, Lansing
Strauss, P. C.....408 Am. State Bank Bldg., Lansing
Stringer, C. J.....Ingham County Sanatorium, Lansing
Swartz, F. C.....215 N. Walnut Street, Lansing
Tamblyn, F. W.....333 Seymour, Lansing
Toothaker, K. W.....320 Townsend, Lansing
Towne, Lawrence C.....300 W. Ottawa, Lansing
Trescott, Robert F.....716 Olds Tower, Lansing
Trimby, Robert H.....122 W. Hillsdale, Lansing
Troost, F. L.....4341 W. Delhi Road, Holt
Vander Slice, E. R. (L)....142 Moss Ave., Oakland, Calif.
VanderZalm, T. P.....701 S. Capital Ave., Lansing
Venier, Joseph H.....326 Townsend, Lansing
Wadley, Ralph.....333 Seymour, Lansing
Walker, Leo W...Dept. Path., St. Lawrence Hosp. Lansing
Webb, Roy O.....2176 Hamilton Road, Box 3, Okemos
Wellman, John M.....301 Seymour Avenue, Lansing
Wilensky, Thomas.....301 Seymour, Lansing
Wiley, Harold W.....137 N. Larch Street, Lansing
Willson, Howard S.....704 Olds Tower, Lansing
Wilson, Harry A.....703 S. Capitol, Lansing
Worthington, Ralph.....303 Tussing Building, Lansing

IONIA-MONTCALM COUNTIES

Anderson, Donald H.....Portland
Bracey, L. E. (L).....Sheridan
Bird, Wm. L.....Greenville
Bunce, E. P.....Trufant
Bunce, Leo W.....Trufant
Cook, George H.....Ionia State Hospital, Ionia
Dunkin, Lloyd S.....Greenville
Fleming, J. W. C. Pewamo
Foust, Joseph C.....Ionia
Fox, Harold M.....Portland
Geib, O. P.....Carson City
Glerum, John B.....Greenville
Haarer, John.....State Hospital, Ionia
Hansen, Carl M.....Stanton
Hansen, M. M.....Greenville
Haskell, Robert H.....Wayne Co. Train. School, Northville
Hoffs, M. A.....Lake Odessa
Hollard, A. E.....Belding
House, Glenn W.....602 W. Orange, Greenville
Kelsey, L. E.....Lakeview
Kopchick, Joseph.....Muir
Lilly, Isaac S.....Stanton
Lincoln, Norman.....Lake Odessa
Marston, L. L.....Lakeview
McCann, John J.....Ionia
Peabody, C. H. (L).....Lake Odesso
Reid, Harold E.....Stanton
Rice, Robert E.....Greenville
Robertson, P. C.....Ionia State Hospital, Ionia
Seidel, Karl E.....302½ W. Main Street, Ionia
Slagh, Milton E.....Saranac
Snider, J. D.....Ionia
Socha, Edmund S.....Ionia
Swift, E. R. (L).....Lakeview
Tannheimer, J. F.....Ionia
Trinca, Peter J. Ionia
Van Loo, J. A.....422 S. Pleasant, Belding

JACKSON COUNTY

Abraham, A. O.....Hudson
Adams, Ellis W.....517 Wildwood, Jackson
Ahronheim, J. H.....1410 Greenwood, Jackson
Anderson, W. B.....404 Carter Bldg., Jackson
Appel, Saul.....510 Dwight Building, Jackson
Baker, George M.....Parma
Bartholic, Frank W.....Homer
Beckwith, Sidney A.....Stockbridge
Brashares, Z. A.....Brooklyn
Bullen, G. Rex.....418 Third, Jackson
Clarke, Corwin S.....605 Dwight Bldg., Jackson
Cochrane, Wayne A. (L).....511 Wildwood, Jackson
Cooley, Charles W.....Mercy Hospital, Jackson
Cooley, Randall M.....141 East Robinson, Jackson
Corley, Cecil.....1201 National Bank Bldg., Jackson
Corley, Ennis H.....1211 W. Franklin St., Jackson
Cox, Ferdinand (L) 434 Wildwood Avenue, Jackson
Culver, Guy D. (L) Stockbridge
DeMay, Cuthbert E.....403 E. Michigan, Jackson
DeMay, John D.....403 E. Michigan, Jackson
Deming, Richard C.....517 Wildwood, Jackson
Dengler, Charles R.....504 Third Street, Jackson
Dickman, Harry M.....120 N. Michigan, Hudson
Douglas, E. W.....4000 Cooper Street, Jackson
Edmonds, John M.....Horton
Enders, W. H. (L).....1102 National Bank Bldg., Jackson
Filip, H. K.....755 W. Michigan Avenue, Jackson
Finch, R. L.....4000 Cooper St., Jackson
Finton, Robert E.....290 W. Michigan, Jackson
Finton, Walter L.....290 W. Michigan Avenue, Jackson
Foust, W. L.....Grass Lake
Gibson, Frank J. (L).....
2056 Second Avenue N., St. Petersburg, Fla.
Greenbaum, Harry.....1203 Greenwood, Jackson
Growt, Bowers H.....Addison
Habenicht, Hilda A.....910 Reynolds Bldg., Jackson
Hackett, Thomas L.....401 Carter Bldg., Jackson
Hanft, Cyril F.....Springport
Hanna, Roger J.....1204 Fourth Street, Jackson
Hardie, George C.....290 W. Michigan, Jackson
Harris, Lester J. (E).....604 W. Washington, Jackson
Hicks, Glenn C. (L).....615 Dwight Bldg., Jackson
Holst, John B.....1023 Francis Street, Jackson
Holstein, Arthur P.....214 Ann Arbor St., Manchester
Hunt, Maurice E.....2534 Francis Street, Jackson
Huntley, W. B.....Hudson

Joerin, W. A.....734 Griswold, Jackson
Keefer, A. H.....Concord
Kempton, George B.....290 W. Michigan Avenue, Jackson
Kudner, D. F. 435 Wildwood, Jackson
Lake, Edward C.....612 First Street, Jackson
Landron, Daniel.....Michigan Center
Leahy, Edward O.....1205 National Bank Bldg., Jackson
Lenz, Charles R., Jr.....405 First Street, Jackson
Leonard, Clyde A...1401 Jackson City Bk. Bldg., Jackson
Lewis, E. F.....901 Reynolds Bldg., Jackson
Linden, V. E.....605 Dwight Bldg., Jackson
Ludwick, J. E.....326 W. Cortland, Jackson
McGarvey, William E.....802 City Bank Bldg., Jackson
McLaughlin, M. J.....502 W. Michigan, Jackson
McLauthlin, Herbert B.....439 Wildwood Avenue, Jackson
Meads, Jason B.....1406 City Bank Bldg., Jackson
Medlar, Robert E.....505 Dwight Building, Jackson
Miller, Jack L.....519 North East Avenue, Jackson
Miller, Samel L.....775, 41st Ave., San Francisco, Calif.
Munroe, Colun D. (E)....740 W. Michigan Ave., Jackson
Munro, James E.....144 W. Pearl Street, Jackson
Munro, Nathan D.....740 W. Michigan Avenue, Jackson
Murphy, Bernard M.....1010 E. Michigan Ave., Jackson
Newton, Ray E.....910 Reynolds Bldg., Jackson
Oleksy, Stanley P. (A)..3800 Brockman Blvd., Ann Arbor
O'Meara, James J.....1508 Reynolds Bldg., Jackson
Otis, Grant L.....525 Wildwood Avenue, Jackson
Payne, Andrew K.....Foote Hospital, Jackson
Porter, Horace W.....505 Wildwood Avenue, Jackson
Pray, Frank F.....310 Steward Avenue, Jackson
Pray, G. R. (E).....404 S. Jackson, Jackson
Rice, J. W.....603 Jackson City Bank, Jackson
Ries, Richard G.....290 W. Michigan Ave., Jackson
Riley, Philip A.....500 S. Jackson St., Jackson
Sargent, Leland E.....424 W. Michigan, Jackson
Sautter, W. A.....Horton
Schmidt, T. E.....1202 Reynolds Building, Jackson
Scott, Benton V. D.....2122 Dale Street, Jackson
Scott, John A.....432 W. Michigan Avenue, Jackson
Shaeffer, Arthur M.....290 W. Michigan Ave., Jackson
Shaeffer, L. Dale.....290 W. Michigan Ave., Jackson
Sill, Henry W.....290 W. Michigan, Jackson
Sirhal, Alfred M.....Brooklyn
Smith, Dean W.....500 W. Michigan, Jackson
Southwick, W. A. (A).....362 E. Main Street, Springport
Stewart, L. L. (E).....308 Edgewood, Jackson
Stewart, L. L., Jr.....290 W. Michigan Ave., Jackson
Stolberg, Carl A.....517 Wildwood Avenue, Jackson
Stone, Ethon L.....143 N. Jackson, Jackson
Sugar, Samuel.....509 Reynolds Building, Jackson
Tate, Cecil E.....1315 Francis Street, Jackson
Taylor, Ross V.....517 Wildwood, Jackson
Thayer, E. A.....1104 National Bank Bldg., Jackson
Thalner, L. F.....609 West Michigan Avenue, Jackson
Thompson, Tom B.....290 W. Michigan, Jackson
Torwick, E. T.....501 Dwight Bldg., Jackson
Townsend, J. W.....108 Hague, Vandercook Lake, Jackson
Van Schoick, Frank.....419 W. High Street, Jackson
VanSchoick, John D.....Hanover
Van Wagnen, Frederick I., Jr.....
434 Wildwood Ave., Jackson
Vivirski, Edward E. 603 South Elm St., Jackson
Wallace, Warren S. 816 Second St., Jackson
Way, Kenneth E. 755 W. Michigan, Jackson
Wholihan, John W. 102 Lydia St., Jackson
Wickham, Woodward A. 420 W. Michigan, Jackson
Wilson, Norman D. (L).....1107 Reynolds Bldg., Jackson
Winter, G. E. (E).....420 Rogers Bldg., Jackson

KALAMAZOO COUNTY

Aach, Hugo A. ..1318 Amer. Nat. Bank Bldg., Kalamazoo
Alexander, C. A. 118 W. North, Kalamazoo
Andrews, Sherman E. 224 E. Cedar St., Kalamazoo
Appel, B. A. 310 Bronson Medical Center, Kalamazoo
Appel, Wm. P. 310 Bronson Med. Center, Kalamazoo
Armstrong, Robert J. 605 Hanselman Bldg., Kalamazoo
Banner, Lawrence R. 507 S. Burdick St., Kalamazoo
Barak, Herbert G. 224 McNair Bldg., Kalamazoo
Barnabee, James W. (E) 503 S. Burdick, Kalamazoo
Barrows, Winona M. Pinecrest San., Oshtemo
Barry, M. Leroy Kalamazoo State Hospital, Kalamazoo
Benjamin, Margaret H. 2217 Parchmount, Kalamazoo
Bennet, Charles L. Bronson Medical Center, Kalamazoo
Bennett, Keith F. 252 E. Lovell, Kalamazoo
Betz, E. G. 216 Bronson Medical Center, Kalamazoo
Birch, W. G. 212 Bronson Medical Center, Kalamazoo
Bodmer, Harvey C. 403 W. Kalamazoo St., Kalamazoo
Borgman, Wallace 723 W. South St., Kalamazoo
Boys, Charles E.....420 John St., Kalamazoo
Breneman, James C. 25 Pearl St., Galesburg
Brown, Irmel W.
306 Kalamazoo Nat. Bank Bldg., Kalamazoo
Burbidge, Earl L.
Upjohn Company, 301 Henrietta St., Kalamazoo
Burrell, R. B. 907 Amer. Nat. Bank Bldg., Kalamazoo
Chrest, Clarence P. 458 W. South St., Kalamazoo
Cobb, Horace R. 305 Pythian Bldg., Kalamazoo
Conrad, Maynard M. 252 E. Lovell St., Kalamazoo
Cook, R. G. 222 McNair Bldg., Kalamazoo
Cooper, Paul F. 252 E. Lovell St., Kalamazoo
Crane, Warren B. 420 S. Rose St., Kalamazoo
Crawford, Kenneth L. 612 Douglas Ave., Kalamazoo
Creager, Ray O. 823 Wheaton, Kalamazoo
Cretsinger, Francis C. 224 E. Cedar St., Kalamazoo
Currier, R. K.....6646 Portage St., Kalamazoo 25
Dahlstrom, Doris E. ..723 S. Westnedge Ave., Kalamazoo
Dana, Robert L. 228 W. Cedar St., Kalamazoo
DeGroat, Albert F. 458 W. South St., Kalamazoo
Delbert, Stewart G. 530 W. Lovell St., Kalamazoo
DeLong, Robert E. Borgess Hospital, Kalamazoo
DePree, Harold E...216 Bronson Med. Center, Kalamazoo
Dew, Robert R. 252 E. Lovell, Kalamazoo
DeWitt, Norman L. 802 Hanselman Bldg., Kalamazoo
Dick, Leo A.....1001 Amer. Nat. Bank Bldg., Kalamazoo
Doezema, E. R. 316 Bronson Med. Center, Kalamazoo
Dowd, B. J. 420 John St., Kalamazoo
Doyle, Frederick M.
1001 American Nat. Bank Bldg., Kalamazoo
Estill, Don V. 414 W. Patterson St., Kalamazoo
Fast, R. B. 1410 American Nat. Bank Bldg., Kalamazoo
Fath, August F. ..907 Amer. Nat. Bank Bldg., Kalamazoo
Finton, Max A. 252 E. Lovell, Kalamazoo
Fopeano, John V.
815 American Nat. Bank Bldg., Kalamazoo
Fulkerson, C. B. (L).....
402 Kalamazoo Nat. Bank Bldg., Kalamazoo
Fuller, Paul M. 419 S. Burdick St., Kalamazoo
Gerstner, Louis W. 420 John St., Kalamazoo
Goodhue, Lolita G.
915 American Nat. Bank Bldg., Kalamazoo
Grant, Frederick E. (E) 214 Douglas Ave., Kalamazoo 48
Green, William L.
810 American Nat. Bank Bldg., Kalamazoo
Grekin, R. H.....1310 Amer. Nat. Bank Bldg., Kalamazoo
Hammer, J. M. 100 Maple St., Parchment
Hanson, Curtis M...217 Bronson Med. Center, Kalamazoo
Hayner, Russell A. 1043 E. Cork St., Kalamazoo
Herbert, Walter N. 422 John St., Kalamazoo
Heersma, H. S.....252 E. Lovell, Kalamazoo
Hildreth, Ross C. 458 W. South St., Kalamazoo
Hodgman, Albert B.....612 Douglas Ave., Kalamazoo
Hoebeke, W. G. 212 Bronson Med. Center, Kalamazoo
Holder, Charles O.....Kalamazoo State Hosp., Kalamazoo
Howard R. Grant....Borgess Hosp., Suite 583, Kalamazoo
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315 Bronson Medical Center, 252 E. Lovell St., Kalamazoo
Huyser, William C. 427 S. Burdick St., Kalamazoo
Irwin, William D. 805 Hanselman Bldg., Kalamazoo

Jackson, Howard C.
252 E. Lovell St., Rm. 220, Kalamazoo
Jennings, R. M. Box A, Kalamazoo
Jennings, Wesley O. 420 John St., Kalamazoo
Kavanaugh, Wm. R. 1029 W. North St., Kalamazoo
Kilgore, Robert N. 252 East Lovell St., Kalamazoo
Klerk, William J. 234 E. Cedar St., Kalamazoo
Koestner, Paul A. 1303 Portage, Kalamazoo
Lambert, Rudolph H. Fairmount Hosp., Kalamazoo
Lawrence, J. O. 301 Henrietta St., Kalamazoo
Lavender, Howard C. (R) ..252 E. Lovell St., Kalamazoo
Light, Richard U. 828 W. South St., Kalamazoo
Light, S. Rudolph
503 American Nat. Bank Bldg., Kalamazoo
Littig, John D. 815 Amer. Nat. Bank Bldg., Kalamazoo
Locklin, W. Kaye
1410 American Nat. Bank Bldg., Kalamazoo
Loynd, J. W. 1010 American Nat. Bank, Kalamazoo
MacDonald, Marshall A.
319 Bronson Medical Center, Kalamazoo
MacGregor, J. R. 100 Maple St., Parchment
Machin, Harold A. 420 John St., Kalamazoo
Malone, James G. 420 John St., Kalamazoo
Margolis, Frederick J.
909 American Nat. Bank Bldg., Kalamazoo
Marshall, Don 252 E. Lovell St., Kalamazoo
Marshall, William P. 160 Edgemoor Ave., Kalamazoo
Martens, Irvin J. 252 E. Lovell St., Kalamazoo
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McCarthy, Joseph S. 1005 Oakland Drive, Kalamazoo
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Morter, Roy A.
Box A, Kalamazoo State Hosp., Kalamazoo
Nell, Edward R. 207 McNair Bldg., Kalamazoo
Nibbelink, Benjamin 903 Hanselman, Kalamazoo
Oberbey, Charles B. State Hospital, Kalamazoo
Patmos, Martin 306 Bronson Med. Center, Kalamazoo
Pearson, Edwin O. 458 W. South St., Kalamazoo
Peelen, J. William 316 Henrietta St., Kalamazoo
Peelen, Matthew 320 Bronson Med. Center, Kalamazoo
Perry, Clifton W.
1307 American Nat. Bank Bldg., Kalamazoo
Pratt, F. A. (L) 2318 Crest Drive, Kalamazoo
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Prothro, Winston B.
Health Dept., City Hall Annex, 303 Ionia Ave., N.W., Grand Rapids
Pullon, Alton E. 422 John St., Kalamazoo
Rasmussen, Leo B. 152 N. Main, Vicksburg
Reames, Harold R. 2333 Waite St., Kalamazoo
Rigterink, Gerald H. 2424 S. Park Ave., Kalamazoo
Rigterink, H. A. (L) 321 S. Burdick St., Kalamazoo
Roberts, Millard S.
303 American Nat. Bank Bldg., Kalamazoo
Rockwell, Donald C.
1418 American Nat. Bank Bldg., Kalamazoo
Rogers, R. I. (A).....108 Mill St., Vicksburg
Ryan, Frederick C. 507 S. Burdick, Kalamazoo
Sage, Edward D. (E) 127 S. Burdick, Kalamazoo
Scholten, D. J.....522 S. Burdick, Kalamazoo
Scholten, Roger A. 252 E. Lovell St., Kalamazoo
Scholten, William (R)
Kalamazoo State Hospital, Kalamazoo
Schrier, C. M. Kalamazoo State Hospital, Kalamazoo
Schrier, Paul G. 317 Bronson Med. Center, Kalamazoo
Schrier, Thomas Comstock
Scott, William A. ..208 Bronson Med. Center, Kalamazoo
Shackleton, William E. (R)....420 S. Rose St., Kalamazoo
Shook, Ralph W...611 Amer. Nat. Bank Bldg., Kalamazoo
Siemsen, W. J. 252 Lovell, Room 316, Kalamazoo
Simpson, Bernard W. 610 S. Burdick St., Kalamazoo 8
Sisk, Wilfred N.
Upjohn Company, 301 Henrietta St., Kalamazoo
Slatmyer, Karel R. 605 Hanselman Bldg., Kalamazoo
Smith, T. C. Kalamazoo State Hospital, Kalamazoo
Sofen, Morris B.
603 Kalamazoo Nat. Bank Bldg., Kalamazoo
Southworth, Maynard N. Box 36, Schoolcraft
Stewart, Wm. C., Jr. (A).....224 E. Cedar, Kalamazoo
Stiller, Anthony F Pinecrest Sanatorium, Kalamazoo
Stryker, Homer H. Borgess Hospital, Kalamazoo
Upjohn, E. G.
Upjohn Co., 301 Henrietta St., Kalamazoo
VanderVelde, Kenneth M.
320 Bronson Medical Center, Kalamazoo
Verhage, Martin D. 228 W. Cedar, Kalamazoo
Volderauer, John C. 458 W. South St., Kalamazoo
Warnke, Robert D. 252 E. Lovell, Kalamazoo
Westcott, Leo P. 420 John St., Kalamazoo
Wilbur, E. P. (E) 1730 Cambridge, Kalamazoo
Williamson, Edwin M.
315 Bronson Medical Center, Kalamazoo
Youngs, A. S. (E) 416 S. Burdick, Kalamazoo
Youngs, Cyril A. 416 S. Burdick, Kalamazoo
Zolen, Margaret H.....628 S. Park, Kalamazoo

KENT COUNTY

Adams, Frank A. ..526 Leonard St., N.W., Grand Rapids
Aitken, George T. Kendall Prof. Bldg., Grand Rapids
Albers, G. Donald 203 Paris Ave., S.E., Grand Rapids
Alfenito, Felix S. 608 Med. Arts Bldg., Grand Rapids
Allen, R. V. 1669 Plainfield, N.E., Grand Rapids
Anderson, Karl A. 3000 Monroe, N.E., Grand Rapids
Andre, Harvey M. 201 Med. Arts Bldg., Grand Rapids
Avery, Noyes L. ..309 Kendall Prof. Bldg., Grand Rapids
Baker, Abel J. (L) Ashton Bldg., Grand Rapids
Baert, George H. (E)..218 Kendall Bldg., Grand Rapids
Ballard, Milner S.
1516 Grand Rapids Nat. Bank Bldg., Grand Rapids
Balyeat, Gordon W. ..Blodgett Mem. Bldg., Grand Rapids
Beaton, James H.....1516 Wealthy St. S.E., Grand Rapids
Beeman, Carl B. ..509 Kendall Prof. Bldg., Grand Rapids
Beets, W. Clarence Loraine Bldg., Grand Rapids
Bell, Charles M.....Kendall Prof. Bldg., Grand Rapids
Benjamin, Howard G.
514 Medical Arts Bldg., Grand Rapids
Benson, Roland R. St. Mary's Hospital, Grand Rapids
Bergsma, Stuart (A).....Women's Christian Medical College, Luthiana, East Punjab, India
Bettison, William L.....68 Ranson N.E., Grand Rapids
Beukema, Marenus J. 6850 S. Division, Grand Rapids
Bignall, C. Rexford, ...736 Burton, S.E., Grand Rapids
Billings, Elton P. (L)....301 Gilbert Bldg., Grand Rapids
Blackburn, Henry M. Metz Bldg., Grand Rapids
Boelkins, Richard C. ..115 Fountain, S.E., Grand Rapids
Boersma, Donald 528 Med. Arts Bldg., Grand Rapids
Boet, Frank A. (L) 849 Scribner, N.W., Grand Rapids
Boet, John T. 503 Loraine Bldg., Grand Rapids
Bolt, Robert J. (A) University Hospital, Ann Arbor
Bond, George L. (L) Rapid City
Bosch, Leon C. 512 Med. Arts Bldg., Grand Rapids
Botting, A. J.....2554 Sherwood S.W., Byron Center
Boyce, D. C. 606 Loraine Bldg., Grand Rapids
Brace, F. C.....1498 Lake Drive S.E., Grand Rapids
Brayman, Charles W. (L) Cedar Spring
Brink, J. Russell 308 Metz Bldg., Grand Rapids
Brook, Jacob D. (L) Grandville
Brotherhood, James S. (L)
1749 Breton Rd., S.E., Grand Rapids
Browning, Eugene S.
303 Keith Theatre Bldg., Grand Rapids
Buist, S. J. 55 Sheldon, S.E., Grand Rapids
Bull, Frank L. 72 East Division, Sparta
Burleson, John S. 531 Greenwood, S.E., Grand Rapids
Burling, Wesley M.
758 Michigan St., N.E., Grand Rapids
Burroughs, Frank M., Jr.....11 Wilson, Grandville
Butler, Wm. J. 324 Med. Arts Bldg., Grand Rapids
Byers, Earle I.....410 Medical Arts Bldg., Grand Rapids

Byrd, Mary Lou..700 Kent Hills Dr., N.E., Grand Rapids
Campbell, Alexander M. (E)
Oakwood Manor, 345 Cherry St. S.E., Grand Rapids
Carpenter, Luther C. 604 Metz Bldg., Grand Rapids
Cayce, Wm...1420 Gd. Rap. Nat. Bk. Bldg., Grand Rapids
Chamberlain, Louis H. (L)
441 Crescent, N.E., Grand Rapids
Chandler, Donald 719 Ashton Bldg., Grand Rapids
Clawson, Carroll K. (M)
1144 Madison, S.E., Grand Rapids
Claytor, Robert W. ..142 Michigan, N.W., Grand Rapids
Clement, D. M. (A)....213 Hampton, S.E., Grand Rapids
Colvin, Walter G. 305 Loraine Bldg., Grand Rapids
Corbus, Burton R. (L) Metz Bldg., Grand Rapids
Crane, Harold D. 204 Med. Arts Bldg., Grand Rapids
Cronick, Anne B.....124 Michigan N.E., Grand Rapids
Currier, F. P. 626 Med. Arts Bldg., Grand Rapids
Dales, Ernest W.
1424 Grand Rapids Nat. Bank Bldg., Grand Rapids
Damstra, Harold J. 1115 Wealthy St., S.E., Grand Rapids
Davis, David B.
403 Med. Arts Bldg., 26 Sheldon Ave., S.E., Grand Rapids
Dawson, W. Douglas....408 Med. Arts Bldg., Grand Rapids
Dean, Alfred.....308 Med. Arts Bldg., Grand Rapids
DeBoer, Clarence J...423 Med. Arts Bldg., Grand Rapids
DeBoer, Guy W.....516 Med. Arts Bldg., Grand Rapids
DeMaagd, Gerald 143 Courtland, Rockford
DeMol, Richard J. 1414 Eastern, S.E., Grand Rapids
Denham, R. H. Metz Bldg., Grand Rapids
DePree, Isla G. Kendall Bldg., Grand Rapids
DePree, Joe.....Blodgett Med. Bldg., Grand Rapids
DeVel, Leon 739 Plymouth, S.E., Grand Rapids
DeVries, Daniel 1414 Eastern, S.E., Grand Rapids
Dewey, Kent A. 607 Med. Arts Bldg., Grand Rapids
DeYoung, Thies 35 East Division, Sparta
Dick, Mark W.
1508 Grand Rapids Nat. Bank Bldg., Grand Rapids
Diskey, Donald G.....634 Bridge N.W., Grand Rapids
Docter, Luebert L. ..312 Med. Arts Bldg., Grand Rapids
Doran, F. L. 314 Metz Bldg., Grand Rapids
Droste, James C. 72 Sheldon, S.E., Grand Rapids
DuBois, Wm. J. (L) Kaleva
Ducey, Edward F. ..St. Mary's Hospital, Grand Rapids 2
Dyer, David P. 62 Ransom, N.E., Grand Rapids
Eaton, Robert M. 12 Burton, S.E., Grand Rapids
Eggleston, H. R. 117 Page, N.E., Grand Rapids
Ellis, M. E. 409 Division, S., Grand Rapids
Fahlund, Geo. T. R...516 Med. Arts Bldg., Grand Rapids
Failing, John F. 502 Metz Bldg., Grand Rapids
Farber, Charles E. 68 Ransom, N.E., Grand Rapids
Faust, Lawrence W. ..425 Med. Arts Bldg., Grand Rapids
Fellows, Kenneth E. Metz Bldg., Grand Rapids
Ferguson, James A. 72 Sheldon, S.E., Grand Rapids
Ferguson, Lynn A. 72 Sheldon, S.E., Grand Rapids
Ferguson, W. S. (R).....Route 1, Ludington
Ferrand, Louis G. 3 N, Monroe, Rockford
Fitts, Ralph L. Metz Building, Grand Rapids
Flynn, J. Donald
240 Kendall Prof. Bldg., 12-18 Monroe, N.E., Grand Rapids
Fochtman, T. W. 72 E. Division, Sparta
Foshee, J. C. 602 Loraine Bldg., Grand Rapids
Fralick, E. Howard..Blodgett Med. Bldg., Grand Rapids
Frantz, Charles H...Blodgett Med. Bldg., Grand Rapids
Fuller, E. H., Jr.....702 Ashton Bldg., Grand Rapids
Fuller, W. J. 421 Medical Arts Bldg., Grand Rapids
Gadzikowski, Isabelle T. 700 Fuller N.E., Grand Rapids
Gamm, Kenneth E...1516 Wealthy St., S.E., Grand Rapids
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Gilbert, Ralph H. 509 Metz Bldg., Grand Rapids
Gillett, F. S.....68 Ransom N.E., Grand Rapids
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Gosling, Robert J. (M)....1941 S. Division, Grand Rapids
Grant, Lee O. J.....420 Med. Arts Bldg., Grand Rapids
Grant, Lucile R. Blodgett Med. Bldg., Grand Rapids
Grass, Edward J. 758 Cherry, S.E., Grand Rapids
Gray, Fred B.....622 Med. Arts Bldg., Grand Rapids
Graybiel, George P.....Cherry Valley C. E., Caledonia
Griffith, Lucian S. 505 Kendall Prof. Bldg., Grand Rapids
Haeck, William, Jr.....1414 Eastern S.E., Grand Rapids
Hagerman, D. B. 203 Med. Arts Bldg., Grand Rapids
Hamp, Arthur K. Kendall Prof. Bldg., Grand Rapids
Hardy, Faith F. 62 Ransom, N.E., Grand Rapids
Hayes, Lawrence W., Jr.....
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Hayes, L. W., Sr. (A).....Howard City
Heetderks, Dewey R...405 Med. Arts Bldg., Grand Rapids
Henry, James (E).....38 Monroe St. N.W., Grand Rapids
Herrick, Ruth 303 Med. Arts Bldg., Grand Rapids
Hill, A. Morgan 310 East Fulton St., Grand Rapids
Hill, Thomas B. 103 W. Main St., Lowell
Hodgen, John T. Blodgett Med Bldg., Grand Rapids
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Hoffs, Albertus J. ..522 Med. Arts Bldg., Grand Rapids
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Hoogerhyde, Jack 504 Loraine Bldg., Grand Rapids
Hudson, H. C. 456 Cherry St., S.E., Grand Rapids
Hufford, A. R. 260 Jefferson, S.E., Grand Rapids
Humphreys, James C...127 Fountain, N.E., Grand Rapids
Hunderman, E. D. ..538 Eastern Ave., S.E., Grand Rapids
Hyland, William A. Metz Bldg., Grand Rapids
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Jack, William W. Blodgett Med. Bldg., Grand Rapids
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Jarvis, Charles 1520 Plainfield, N.E., Grand Rapids
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Johns, Donald C.....
1508 Grand Rapids Nat. Bank Bldg., Grand Rapids
Johnston, William L. Metz Bldg., Grand Rapids
Jones, H. E. Metz Bldg., Grand Rapids
Jones, Horace C. ..Blodgett Mem. Hospital, Grand Rapids
Kelly, Edward F. 507 Loraine Bldg., Grand Rapids
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Lanning, N. E. 1200 Madison St., S.E., Grand Rapids
Lentini, Joseph R. 518 Metz Bldg., Grand Rapids
Lewis, G. H. 3425 Division Ave., S., Grand Rapids
Lieffers, Harry, ...400-2 Med. Arts Bldg., Grand Rapids
Lillie, W. I. Loraine Bldg., Grand Rapids
List, Carl F. 626 Med. Arts Bldg., Grand Rapids
Logie, James W. 321 Metz Bldg., Grand Rapids
MacDonell, James A.
Kendall Professional Bldg., Grand Rapids
MacIntyre, D. S. 300 E. Fulton, Grand Rapids
Marsh, John P. 509 Ashton Bldg., Grand Rapids
Martin, A. M.....225 Metz Bldg., Grand Rapids
Martinus, Martin.....525 Ooverbrook Lane, S.E., Grand Rapids
Maynard, Mason S.....445 Cherry St. S.E., Grand Rapids
McCandliss, Robert J. ..Butterworth Hosp., Grand Rapids
McCormick, John K.
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McDougal, Wm. J. 127 Fountain, N.E., Grand Rapids
McDongall, Clarice L. ..310 E. Fulton St., Grand Rapids
McKay, O. D. 207 W. Main, Lowell
McKenna, J. L. 508 Med. Arts Bldg., Grand Rapids
McKinlay, Leland M...604 Loraine Bldg., Grand Rapids
Meade, R. H., Jr. Blodgett Med. Bldg., Grand Rapids
Meeuwsen, Bernard....309 Med. Arts Bldg., Grand Rapids
Mehney, Gayle H. Med. Arts Bldg., Grand Rapids
Miller, J. Duane 6th Floor, Metz Bldg., Grand Rapids
Miller, John J. 1580 Water, Marne
Mitchell, W. B. 507 Med. Arts Bldg., Grand Rapids

Moen, Cornetta G. 53 Lafayette, S.E., Grand Rapids
Moleski, Joseph V. 628 Med. Arts Bldg., Grand Rapids
Moleski, Leo T.....628 Med. Arts Bldg., Grand Rapids
Moleski, S. L.....628 Med. Arts Bldg., Grand Rapids
Moll, Arthur M. 453 Powers Bldg., Grand Rapids
Montgomery, J. C. Blodgett Med. Bldg., Grand Rapids
Moore, Douglas P. 529 Metz Bldg., Grand Rapids
Morey, E. C.....557 E. Fulton St., Grand Rapids
Mouw, Dirk R.....1854 Division, S., Grand Rapids
Mulder, G. Arthur 68 Ransom, N.E., Grand Rapids
Mulder, J. D. 6850 Division Ave., S., Grand Rapids
Murphy, Miles J. 754 W. Fulton, Grand Rapids
Nanzig, Reinard P. 1516 Wealthy, S.E., Grand Rapids
Nickel, Kenneth C. ..626 Med. Arts Bldg., Grand Rapids
Noordewier, Albert (L).....
1518 Grand Rapids Nat. Bank Bldg., Grand Rapids
Northouse, Peter B.....418 Med. Arts Bldg., Grand Rapids
Notier, Victor A. 606 Med. Arts Bldg., Grand Rapids
Oates, Samuel M. (A)
28 Michigan, N.E., Grand Rapids
Oliver, Walter W. ..318 Med. Arts Bldg., Grand Rapids
Overbeck, E. L.....445 Cherry St., S.E., Grand Rapids
Paalman, R. J. 222 Med. Arts Bldg., Grand Rapids
Patterson, P. W. 1961-63 Division Ave., S., Grand Rapids
Payne, C. Allen Blodgett Mem. Hosp., Grand Rapids
Pearson, Glenn A. 312 Med. Arts Bldg., Grand Rapids
Pedden, John R., Jr.....445 Cherry St. S.E., Grand Rapids
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Posthuma, A. E. 616 Med. Arts Bldg., Grand Rapids
Postma, E. Y. 68 Ransom, N.E., Grand Rapids
Pott, A. L. 1011 E. Fulton, Grand Rapids
Ragsdale, L. V. Butterworth Hospital, Grand Rapids
Ralph, L. Paul 402 Metz Bldg., Grand Rapids
Rasmussen, R. A.....Blodgett Med. Bldg., Grand Rapids
Reed, Torrance.....304 Ashton Bldg., Grand Rapids
Repert, R. W. (A).....General Deliv., Durango, Colo.
Reus, William F. 24 Burton, S.E., Grand Rapids
Riekse, J. M. 1916 Division, S., Grand Rapids
Rigterink, John W. (E) Metz Bldg., Grand Rapids
Riley, G. L. 1419 Coit, N.E., Grand Rapids
Ringenberg, J. C.....420 Med. Arts Bldg., Grand Rapids
Robb, Charles S.....445 Cherry St., S.E., Grand Rapids
Robbert, J. H. 11 S. Wilson, Grandville
Roberts, M. E. (E) 516 Med. Arts Bldg., Grand Rapids
Robinson, H. C. 509 Med. Arts Bldg., Grand Rapids
Rodgers, William L. 616 Bridge, N.W., Grand Rapids
Rosenzweig, L. 1516 Wealthy St., S.E., Grand Rapids
Roth, Emil M. 55 Sheldon, S.E., Grand Rapids
Ryan, John A. 324 Med. Arts Bldg., Grand Rapids
Sanders, J. F. 226 Med. Arts Bldg., Grand Rapids
Schaubel, Howard J. 404 Loraine Bldg., Grand Rapids
Schermerhorn, L. J.
1508 Grand Rapids Nat. Bank Bldg., Grand Rapids
Schneider, G. R. Blodgett Med. Bldg., Grand Rapids
Schnoor, E. W. 216 Medical Arts Bldg., Grand Rapids
Schnute, Louise F.
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Schuitema, D. M. Blodgett Med. Bldg., Grand Rapids
Scott, William B. ..114½ Michigan, N.W., Grand Rapids
Sculley, Raymond E. 126 Burton, S.E., Grand Rapids
Sevensma, Elisha S. (L)
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Sevensma, Eugene S.
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Shellman, Millard W. Metz Bldg., Grand Rapids
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Sidell, Richard H. 312 E. Fulton, Grand Rapids
Siebers, Bernard H. ..616 Med. Arts Bldg., Grand Rapids
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1324 Logan St., S.E., Grand Rapids
Sluyter, J. S. 1034 Franklin, S.E., Grand Rapids
Smith, A. B. Metz Bldg., Grand Rapids
Smith, Austin H. Kent City
Smith, Edwin M...201 Kendall Prof. Bldg., Grand Rapids
Smith, Ferris.....Blodgett Med. Bldg., Grand Rapids
Smith, R. Earle 709 Ashton Bldg., Grand Rapids
Smith, Robert B. 125 Fountain, N.E., Grand Rapids
Smith, Robert O. (M) 16937 Log Cabin, Detroit
Snyder, C. H. 200 Med. Arts Bldg., Grand Rapids
Southwick, G. H. 55 Sheldon Ave., S.E., Grand Rapids
Steffensen, W. H. Blodgett Med. Bldg., Grand Rapids
Stonehouse, G. G. 408 Med. Arts Bldg., Grand Rapids
Stover, Virgil E. 1719 Madison, S.E., Grand Rapids
Stuart, Gerhardus J. (L) Metz Bldg., Grand Rapids
Sugg, Cullen E. 303 E. Fulton, Grand Rapids
Sugiyama Tetsuo.... Loraine Bldg., Grand Rapids
Swenson, H. C. 303 Loraine Bldg., Grand Rapids
Ten Have, John 806 Leonard, N.W., Grand Rapids
Tesseine, A. J. 242 Jefferson Ave., S.E., Grand Rapids
Teusink, J. H. Cedar Springs
Thompson, A. B. Blodgett Med. Bldg., Grand Rapids
Thompson, E. C. 522 Med. Arts Bldg., Grand Rapids
Thompson, F. D. Blodgett Med. Bldg., Grand Rapids
Tidey, Marcus B. 456 Cherry, S.E., Grand Rapids
Tiffany, Joseph C. 401 Metz Bldg., Grand Rapids
Torgerson, Wm. R. 321 Metz Bldg., Grand Rapids
Truog, C. Peter 201 Metz Bldg., Grand Rapids
Uthoff, Carl W. 68 Ransom Ave., N.E., Grand Rapids
Usndek, Harold E. 220 Med. Arts Bldg., Grand Rapids
VanBelois, H. J. 522 Med. Arts Bldg., Grand Rapids
VanBree, R. S. 204 Loraine Bldg., Grand Rapids
VandenBerg, A. R. 524 Med. Arts Bldg., Grand Rapids
VandenBerg, Henry J. (L)
Blodgett Medical Bldg., Grand Rapids
VanderMeer, Ray Mond.....
407 Med. Arts Bldgs., Grand Rapids
VanderPloeg, William H.
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VanDuine, Henry J. Med. Arts Bldg., Grand Rapids
Van't Hof, Albert Metz Bldg., Grand Rapids
Van Portfliet, Paul.....
505 Med. Arts Bldg., Grand Rapids
Van Solkema, Andrew A. 953 E. Fulton, Grand Rapids
Van Solkema, Arthur 64 State, W., Grandville
VanWoerkom, Daniel 750 W. Leonard, Grand Rapids
Van Zwalenburg, Benjamin R...Metz Bldg., Grand Rapids
Veldman, H. E. 222 Med. Arts Bldg., Grand Rapids
Venema, Jay R. 612 Med. Arts Bldg., Grand Rapids
Ver Meulen, John....2400 Wyoming, S.W., Grand Rapids
Ver Meulen, Peter 105 Baynton, N.E., Grand Rapids
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Vining, Keats K., Jr...305 Med. Arts Bldg., Grand Rapids
Vis, William R. 504 Med. Arts Bldg., Grand Rapids
Vyn, Jay D. 615 Ashton Bldg., Grand Rapids
Waterman, Donald F. 68 Ransom, N.E., Grand Rapids
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Wells, S. M., Jr.....407 Metz Bldg. Grand Rapids
Wenger, Aaron V. (E) ..302 Loraine Bldg., Grand Rapids
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1164 Griswold, S.E., Grand Rapids
Wiarda, Roy J. (M).....
1553 Plainfield, N.E., Grand Rapids 5
Wilkes, John B. 1810 Division, S., Grand Rapids
Williams, John R. Med. Arts Bldg., Grand Rapids
Willitts, Paul W. Blodgett Med. Bldg., Grand Rapids
Wilson, William E. (R)
37 Prospect Ave., N.E., Grand Rapids
Winfield, Emory D. 457 Burton, S.E., Grand Rapids
Winter, Garrett E. 1967 Godfrey, S.W., Grand Rapids
Wright, Thomas B. 1571 Wealthy, S.E., Grand Rapids
Wurz, John F. 412 Medical Arts Bldg., Grand Rapids
Yared, Jerome A. Gilbert Bldg., Grand Rapids
Yegge, J. P. Kent City

LAPEER COUNTY

Biggs, Robert A. North Branch
Burley, David H. (E) Almont
Chapin, Clarence D. Columbiaville
Dorland, Clarke Lincoln St., Lapeer
Doty, James R. Clay St., Lapeer
Leith, Dorothy L. Imlay City
McBride, John R. 915 Liberty St., Lapeer
Merz, Henry G. (E) Lapeer
Thomas, J. Orville (E) North Branch
Zemme, Harry B. Clay St., Lapeer
Zolliker, C. R. P.O. Drawer A, Lapeer

LENAWEE COUNTY

Benz, Carl A. 150 Toledo St., Adrian
Blair, Thomas H. National Bank Bldg., Adrian
Blanchard, L. E. 301½ W. Main St., Hudson
Blanden, Merwin R. Ford Bldg., Tecumseh
Claxton, W. T. 136 Chicago St., Britton
Dustin, Richard E. 103 E. Chicago, Tecumseh
Eddy, H. R. C. 114 National Bank Bldg., Adrian
Hamilton, J. D. 122 Toledo St., Adrian
Hammel, H. H.....2 S. Pearl St., Tecumseh
Harrison, R. E., 1st Lt. (M)
U.S.A.F. (MC), Base Hospital, F. E. Warren, A.F.B., Wyo.
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Heffron, Howard H. 231 N. Main St., Adrian
Helzerman, Ralph F. 112 S. Ottawa St., Tecumseh
Hinshaw, Warren V. 139½ N. Main St., Adrian
Hofstra, R. 119 W. Church St., Adrian
Huebner, R. J. Addison
Hunter, T. B. 201 National Bank Bldg., Adrian
Isley, Homer E. 115 W. Adrian St., Blissfield
Loveland, Horace H. (E) ..220 Chicago Blvd., Tecumseh
Marsh, R. G. B. 610 W. Logan St., Tecumseh
Miller, Perry L. 310 E. Maumee, Adrian
Morden, Esli T. (E) 109 E. Maumee St., Adrian
Parker, D. A. 635 W. Maumee St., Adrian
Patmos, Bernard 127½ E. Maumee St., Adrian
Raabe, E. C. 124 North St., Morenci
Rogers, John D. 146 Toledo St., Adrian
Sayre, P. P. 121 N. Main St., Onsted
Spalding, I. L. (E) Hudson
Stark, Emily S. 155 E. Maumee St., Adrian
Thompson, J. R., Jr.....106 E. Chicago Blvd., Tecumseh
Tubbs, R. V. 120 E. Adrian St., Blissfield
VanDusen, Chad A. R.F.D. No. 2, Blissfield
Whitehouse, Keith 118 W. Main St., Morenci
Wynn, G. H. 147 E. Church St., Adrian

LIVINGSTON COUNTY

Barton, Thomas A. 112 E. Grand River, Howell
Clarke, Niles A. 723 Spencer Rd., Brighton
Duffy, Ray M. 250 E. Main, Pinckney
Fidler, Wm. F.....Michigan State San., Howell
Glenn, Bernard H. Fowlerville
Hauer, R. Fred Fowlerville
Hendren, J. J. Fowlerville
Hill, H. C. 116 N. Michigan, Howell
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Meier, Walter E. 630 Godfrey, Monroe
Nicholas, Mildred V. Michigan Sanatorium, Howell
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Sigler, Hollis L. 110 N. Michigan, Howell
Walker, Enos G. 4485 Cordley Lake Rd., Lakeland
May, Louis E., Lt., MC, USNR (M)
U.S.S. Bausell, DD 845, c/o F.P.O., San Francisco, Calif.

LUCE COUNTY

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Gibson, Robert E. L.....Newberry
Hicks, R. P. 228 Newberry Ave., Newberry
Perry, Henry E. (E) Newberry
Purmort, William R.....Newberry
Streitwieser, Robert J. ..Newberry State Hosp., Newberry
Swanson, George F. VA Hospital, Beckley, W. Va.
Thompson, T. W. Newberry State Hospital, Newberry

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Banting, O. Fenton Richmond
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Croman, Joseph M., Jr. 117 Cass Ave., Mt. Clemens
Curatola, Victor St. Joseph Hospital, Mt. Clemens
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Dudzinski, Edmund J. New Baltimore
Engels, John A. Richmond
Goldman, B. J. ..409 Monitor Leader Bldg., Mt. Clemens
Hartmann, W. B. 1416 S. Gratiot, Mt. Clemens
Heine, Austin W. 99 S. Gratiot, Mt. Clemens
Henkin, W. A. 610 Monitor Leader Bldg., Mt. Clemens
Isbey, Edward K.....25020 Van Dyke, Centerline
Jewell, James H. 18215 Utica Rd., Roseville
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Maguire, A. J. 4875 Van Dyke Ave., Utica
Mattes, M. W. 610 Monitor Leader Bldg., Mt. Clemens
Moore, G. F. 410 Monitor Leader Bldg., Mt. Clemens
Mulligan, Philip T. 91 Cass St., Mt. Clemens
Reichman, J. J. ..312 Monitor Leader Bldg., Mt. Clemens
Reitzel, Rufus H. 199 S. Gratiot, Mt. Clemens
Reizen, Maurice S.....Memorial Hosp., Van Dyke
Revere, J. O. 192 S. Gratiot, Mt. Clemens
Rickman, L. D. 10 Howard St., Mt. Clemens
Rivard, Charles L. ..20825 Mack Ave., Grosse Pte. Woods
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Rothman, Arthur M. 22552 Gratiot, East Detroit
Ruedisueli, Clarence A. 18215 Utica Rd., Roseville
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Scher, Sydney 132 Cass Ave., Mt. Clemens
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Singer, Nelson 22422 Gratiot, East Detroit
Smith, Milton C. 50 S. Gratiot, Mt. Clemens
Stone, Elizabeth A. Romeo
Stryker, O. D. Macomb Co. Health Dept., Mt. Clemens

Test, Frederick C., II 91 Cass Ave., Mt. Clemens
Thompson, Alfred A. 126 Cass Avenue, Mt. Clemens
Ullrich, Russell W. 91 Cass Ave., Mt. Clemens
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Wilde, Maurice M.....5930 Chicago, Warren
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Zavela, Daniel 22644 Gratiot Ave., East Detroit

MANISTEE COUNTY

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Hansen, Earnest C. 78 Maple, Manistee
Konopa, John F. 57 Poplar St., Manistee
Lalime, Ruth E. Bear Lake
Lewis, Lee A. (E) 467 Second St., Manistee
Miller, Ernest B. 425 River St., Manistee
Oakes, Ellery A. 401 River St., Manistee
Ogilvie, Gordon D. 210 Savings Bank Bldg., Manistee
Osborne, M. G.
Health Dept., Savings Bank Bldg., Manistee
Osborn, Samuel, Jr.....90 Maple St., Manistee
Ramsdell, Homer A. Engelman Bldg., Manistee
Rowe, Robert E. (M) 326 18th St., Manistee
Schwarz, Marlowe L.....Onekama

MARQUETTE-ALGER COUNTIES

Acocks, J. R. Morgan Heights San., Marquette
Amolsch, Arthur L. St. Luke's Hospital, Marquette
Baron, Benzoin C. Munising
Bennett, A. K. (L) ..Union Nat. Bank Bldg., Marquette
Bennett, M. C. Union Nat. Bank Bldg., Marquette
Berry, Robert F. Bacon Bldg., Marquette
Bertucci, Joseph P. 114 S. First St., Ishpeming
Bolitho, T. B. St. Luke's Hospital, Marquette
Casler, W. L. 131 E. Ridge, Marquette
Cooperstock, Moses 418 W. Magnetic, Marquette
Corcoran, W. A. Anderson Bldg., Ishpeming
Elzinga, Eugene R. 315 N. Front St., Marquette
Erickson, Arvid W. Ishpeming Hospital, Ishpeming
Harkin, J. C. Marquette
Hirwas, C. L. Huetter Bldg., Marquette
Hornbogen, D. P. Hornbogen Bldg., Marquette
Howe, Lloyd W. Savings Bank Bldg., Marquette
Jaedecke, R. G. Ishpeming Hospital, Ishpeming
Keskey, George I. 105 S. Front, Marquette
Knutson, George O. Twin City Hospital, Negaunee
Lambert, W. C. Huetter Bldg., Marquette
LeGolvan, Celestin 221 W. Washington St., Marquette
Lyons, James W., Jr.....First National Bldg., Marquette
Matthews, Norman L. St. Luke's Hospital, Marquette
Mudge, William A. 314 Teal Lake Ave., Negaunee
Narotzky, Archie S. Odd Fellows Bldg., Ishpeming
Nicholson, J. B. Savings Bank Bldg., Marquette
Paine, Raymond Lee.....415 E. Case St., Negaunee
Schweinsberg, Sara D. Savings Bank Bldg., Marquette
Sicotte, Isaiah (L) Michigamme
Swinton, A. L. (E) Savings Bank Bldg., Marquette
Tearnan, Raymond A. Munising
Van Riper, Paul (L) Champion
Waldie, George M. Ishpeming Hospital, Ishpeming
Wickstrom, George B.....Madigan Bldg., Munising
Williams, R. G.....Ishpeming

MASON COUNTY

Bacon, Herbert G., Jr.....Scottville
Boldyreff, Ephraim B. Custer
Boon, A. F. 808 W. Court St., Ludington
Carney, John R. 202 N. Park, Ludington
Carney, Ruth V. C. 202 N. Park, Ludington
Goulet, Leo J. 222 S. James St., Ludington
Hoffman, Howard B. 121 Ludington Ave., Ludington
Martin, William S. 107 W. Ludington Ave., Ludington
Ostrander, Robert A. 121 Ludington Ave., Ludington
Paukstis, Charles A. 111 Court St., Ludington
Slaybaugh, James C. 101 W. Loomis St., Ludington

MECOSTA-OSCEOLA-LAKE COUNTIES

Anderson, Gordon H. 309 N. Michigan, Big Rapids
Bruggema, Jacob Evart
Chess, Leo F. Reed City
Franklin, Benjamin L. (L) Remus
Ivkovich, Paul Reed City
Kilmer, David Reed City
Kilmer, Paul B. Reed City
Kowaleski, Edward H.....Remus
Merlo, Frank A. 206 S. Michigan Ave., Big Rapids
Miller, Charles Scott
Traverse City State Hospital, Traverse City
Mitchell, H. C. 124 Mecosta Ave., Big Rapids
Nelson, Lorenzo R.....Baldwin
Peck, Louis K. (E) Barryton
Treynor, Thomas P. Fairman Bldg., Big Rapids
Van Auken, Edward W. Big Rapids
White, John A. 121 S. Michigan Ave., Big Rapids
Yeo, Gordon H. 126 Maple St., Big Rapids

MENOMINEE COUNTY

Brukardt, Herman R.....Electric Sq. Bldg., Menominee
DeWane, Francis J. 413 Tenth Ave., Menominee
DeWane, James N. 413 Tenth Ave., Menominee
Flanagan, Clarence B. 534 First St., Menominee
Glickman, L. Grant 958 First St., Menominee
Gonty, Arthur St. Joseph's Hospital, Menominee
Heidenreich, John R. Daggett
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Jones, W. S.....1146 10th Avenue, Menominee
Jones, W. S., Jr. 1146 10th Avenue, Menominee
Kaye, John T.....1005 10th Ave., Menominee
Kerwell, Karm C. Stephenson
Peterson, Allen R. Daggett
Sawbridge, Edward (E) Stephenson
Sethney, Henry T. Electric Sq. Bldg., Menominee
Sweany, S. K.....Pinecrest San., Powers
Towey, John W. Pinecrest San., Powers

MIDLAND COUNTY

Ballmer, Robert S. 144 W. Main, Midland
Bernier, J. A. Sanford
Blackhurst, R. T. Arcade Bldg., Midland
Bowsher, Robert E. 2719 Ashman St., Midland
Bulmer, Dan J. 402 E. Ellsworth, Midland
Buskirk, Maurice D. 201 Reinhart Bldg., Midland
Gordon, Harold L. Dow Chemical Co., Midland
Grewe, Norman C. 347½ E. Main St., Midland
Gronemeyer, William H. 127 MacDonald, Midland
Hautau, Emily R. Court House, Midland
High, C. V., Jr. (R).....2100 Isabella Rd., Midland
Howe, Irvin M. 217 Reinhart Bldg., Midland
Ittner, Martin J. 2912 Ashman St., Midland
Kilian, D. J. 3611 Jefferson, Midland
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Maynard, W. A. Coleman
Meisel, Edward H., Jr.....413 Lingle Lane, Midland
Pike, Melvin H. 209 Reinhart Bldg., Midland
Poznak, Leonard A. 220 W. Collins Ave., Midland
Sherk, Joseph H. Masonic Bldg., Midland
Towsley, W. D. Arcade Bldg., Midland

MONROE COUNTY

Ames, Florence D.....2 W. Noble Ave., Monroe
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Blakey, L. C. 222 N. Monroe St., Monroe
Bond, W. W. 4 East Front St., Monroe
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Freud, John W. 222 N. Monroe, Monroe
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Johnson, A. Esther 31 Washington Ave., Monroe
Kelso, S. Newton, Jr. 9 South Monroe St., Monroe
Laboe, Edward W. 424 Hollywood, Monroe
Lammers, Gerald P. Ida
Landon, Herbert W. (E) 512 Washington, Monroe
Long, Edgar C. 127 E. Front St., Monroe
Long, Sara J. 130 Maple Blvd., Monroe
McDonald, T. A. 7 East Front St., Monroe
McGeoch, R. W. 633 N. Macomb, Monroe
McMillin, John H.....423 E. Elm, Monroe
Newcomer, Sheldon R. 31 Washington, Monroe
Parmelee, O. E. Lambertville
Pinkus, Hermann K. B. 12 E. Fourth St., Monroe
Reisig, Albert H. 5 East Front St., Monroe
Sanger, Emerson J. J.....3 East Front St., Monroe
Van Dyke, Anne E.....31 Washington, Monroe
Wagar, Spencer H. 31 Washington St., Monroe
Williams, Robert J. 31 Washington St., Monroe
Williamson, George W. Dundee

MUSKEGON COUNTY

Anderson, A. J. 1371 Peck St., Muskegon
Anderson, Axel Lakewood Club, Twin Lake
Atkinson, Annie L.....525 Seventh, Muskegon
August, R. V. 72 E. Broadway, Muskegon Heights
Barnard, Helen S. Nedeau Bldg., Muskegon
Beers, C. W.....68 E. Broadway, Muskegon, Heights
Benedict, Arthur L. 22 W. Southern Ave., Muskegon
Bloom, C. J. 59 E. Larch St., Muskegon
Bolthouse, Robert E.....1214 Peck St., Muskegon Heights
Boyd, D. R. 1735 Peck St., Muskegon
Bradshaw, Park S. 1014 Jefferson, Muskegon
Busard, J. Max.....503 Musk. Bldg., Muskegon
Chapin, Wm. S. (A)..638 Sanford St., Muskegon Heights
Christophersen, J. W. Hackley Bank Bldg., Muskegon
Clapp, Henry W. 88 Strong Ave., Muskegon
Clark, Harry L. Hackley Hospital Lab., Muskegon
Closz, Harold F.
809 Hackley Union Bank Bldg., Muskegon
Cohan, Sol G. 1114 Second St., Muskegon
Dasler, A. F. (M) Cmdr. MC. USNR.....
Naval Training Center, Great Lakes, Ill.
Diskin, Frank.....410 Jackson Ave., Muskegon
Dykhuizen, Harold D.
710 Hackley Union Bank Bldg., Muskegon
Ellis, Nicholas J.....1883 Lake Shore Drive, Muskegon
Emerick, Robert W. 878 N. Second St., Muskegon
Engstrom, Albert.....Whitehall, Muskegon
Fillingham, Enid 870 N. Second St., Muskegon
Fleischmann, C. B.....250 W. Webster, Muskegon
Fleishman, Norman A. 1094 Jefferson, Muskegon
Gaikema, Everett W.....Muskegon Co. San., N. Muskegon
Garber, Frank W., Jr. 1178 Third St., Muskegon
Gillard, J. L.....208 Michigan Theater Bldg., Muskegon
Goltz, Martha H. Montague
Greene, Henry P. 764 Pint St., Muskegon
Griffith, Robert M. 1217 Fifth St., Muskegon
Hagen, William A. 1255 Palmer Blvd., Muskegon
Hanley, W. J. (A)..405 Hackley Union Bldg., Musekgon
Harryman, James E. 1129 Peck St., Muskegon
Hartwell, Shattuck W. ..452 W. Western Ave., Muskegon
Hennessy, Mary E.....1624 Peck St., Muskegon
Heneveld, Edward H. 1603 Peck St., Muskegon
Heneveld, John 1603 Peck St., Muskegon
Heneveld, Robert G., Capt. (M)
MC 01920986, C.P.S.A., A.P.O. 613 c/o P.M., San Francisco, Calif.
Holly, Leland E. 876 Second St., Muskegon
Holmes, Roy H. 316 Hackley Union Bldg., Muskegon
Jiroch, John T. (A).....
1426 E. Ninth St., Jeffersonville, Ind.
Joistad, Arthur H., Jr.....878 N. Second St., Muskegon
Kane, Thomas J. 179 Strong Ave., Muskegon
Kay, Cecelia S.....1533 Peck St., Muskegon
Keilin, Marie 403 Michigan Theater Bldg., Muskegon
Kerr, Howard J. 1441 Lakeshore Drive, Muskegon
LaFollette, P. S. 1075 Jefferson St., Muskegon
Lapham, Landon M. Whitehall
Lange, Eugene W. Hackley Hospital, Muskegon
Lauretti, Emil J. 815 Hackley Bank Bldg., Muskegon
Laurin, Vilda S. 804 Hackley Bank Bldg., Muskegon
LeFevre, Louis L.....450 W. Western Ave., Muskegon
LeFevre, William M. 289 W. Western, Muskegon
Loder, Leonel L. Hackley Union Bldg., Muskegon
Loomis, John L. (R)....French Village, Gatlinburg, Tenn.
Mandeville, C. B.
515 Hackley Union Bank Bldg., Muskegon
Maples, Douglas E. 402 Center St., North Muskegon
McNair, John N. 967 Second St., Muskegon
Medema, Paul E. 1017 Sanford, Muskegon
Meengs, Marvin B. 1725 Peck St., Muskegon
Miller, Philip L. 1755 Peck St., Muskegon
Mulligan, A. W. 1260 Jefferson St., Muskegon
Oden, Constantine L. A.
804 Hackley Union Bank Bldg., Muskegon
Powers, Lunette (E) 337 Morris Ave., Muskegon
Prentice, Edwin W. 1017 Sanford St., Muskegon
Price, Leonard 1282 Arthur St., Muskegon
Pyle, Henry J. 506 Muskegon Bldg., Muskegon
Risk, Robert D. 1160 Ransom St., Muskegon
Rooks, Wendell H.....100 Larch Ave., Muskegon

Scholle, Norbert W. 1001 Peck St., Muskegon Heights
Sears, Richard B. Court House, Muskegon
Shebasta, Emil M. 1075 Jefferson, Muskegon
Smith, M. Luther 840 Pine St., Muskegon
Swartout, W. C. (L)
514 Hackley Union Bank Bldg., Muskegon
Swenson, Leland L. 1724 Peck St., Muskegon
Teifer, Charles A. 407 Muskegon Bldg., Muskegon
Tellman, H. Clay Hackley Bank Bldg., Muskegon
Thieme, S. W. (L).....Ravenna
Thornton, Eugene S.
802 Hackley Union Bank Bldg., Muskegon
Toy, Charles M. 1067 Pine St., Muskegon
Tyler, William H. 1435 Peach St., Muskegon
Vanderlaan, John E. 1624 Peck St., Muskegon
Van Gelder, W. E. ..Hackley Union Bk. Bldg., Muskegon
Wagenaar, Edward H. 404 Muskegon Bldg., Muskegon
White, W. G., Jr.....1735 Peck St., Muskegon
Wiersma, Silas C. Hackley Union Bldg., Muskegon
Wildgen, Bernard C...416 Hackley Bank Bldg., Muskegon
Wilke, Carl A. Montague
Williams, E. V. 905 Jarman St., Muskegon Heights
Wilson, Pitt S. (L).....1377 Peck St., Muskegon

NEWAYGO COUNTY

Deur, Theodore R. Grant
Geerlings, Lambert J. 20 N. Division St., Fremont
Geerlings, Wills R.....20 N. Division St., Fremont
Harris, Dean W. 38 W. Dayton St., Fremont
Klein, J. Paul 16 W. Sheridan, Fremont
Masters, Brooker L. 43 W. Main, Fremont
Moore, Hugh R. 38 State St., Newaygo
O'Neill, John W.....351 E. Cherry St., Whitecloud
Tompsett, Arthur C. Hesperia

NORTH CENTRAL COUNTIES

Backe, John C. Box 434, Gaylord
Balice, F. W. 117 N. Third St., West Branch
Barstow, Richard G. Gaylord
Boehm, John D. (R) West Branch
Clippert, Clarence G. 308 Michigan Ave., Grayling
Coulter, Keith D. Gladwin
Egle, Joseph L. Northern Michigan TB San., Gaylord
Hasty, Earl A.....115 Burgess, West Branch
Hayes, Louis F. Grayling
Henig, B. Elmore.....308 Michigan Ave., Grayling
Hoenig, Andrew L. 1200 Cedar St., Cherokee, Ia.
Jardine, Hugh M. 109 S. Third St., West Branch
Keyport, Claude R. 308 Michigan Ave., Grayling
Kirker, F. O. Prudenville
Libke, Robert S. Gaylord
Martzowka, M. A. Roscommon
McKillop, G. L. Gaylord
Peckham, Richard C. Gaylord
Schaiberger, Geo. L. 707 W. Hought St., West Branch
Stealy, Stanley A. Box 485, Grayling
Timreck, Harold A. Gladwin

NORTHERN MICHIGAN MEDICAL SOCIETY

Albi, Robert J. Boyne City
Alm, Bernhard T. (M) 309½ E. Mitchell, Petoskey
Blum, Benjamin B. Petoskey
Burns, Dean C. 314½ Howard St., Petoskey
Conkle, Guy C. (E) Boyne City
Conti, Joseph B. Petoskey
Conway, William S. Burns Clinic, Petoskey
Crippen, Edward F. Mancelona
Drake, Gerald A. Petoskey
Grate, Lawrence E. 304 Mason St., Charlevoix
Hegener, A. J. Petoskey
Kirk, T. R. Petoskey
Lentini, Nicholas Cheboygan
Lilga, Harris V. 113 Howard St., Petoskey
Litzenburger, Albert F. Boyne City
Love, James M. Burns Clinic, Petoskey
Martin, R. G. Cheboygan
Matheskon, V. S. Burns Clinic, Petoskey
Mayne, Frederick C. Cheboygan
McClintock, Robert S.....211 Myrtle, Iowa City, Iowa
Parks, William H. Petoskey
Reus, Leonard W. Petoskey
Rodger, John R. Bellaire
Saltonstall, Gilbert B. 112 Clinton St., Charlevoix
Savory, John H.....East Jordan
Terr, Isaac.....Charlevoix
Van Dellen, Jerrian East Jordan
Weburg, Kathryn D. Petoskey
Wood, George H. Onaway

OAKLAND COUNTY

Abbott, James A.....Pontiac State Hospital, Pontiac
Abbott, Vernon C. 1405 Pontiac State Bldg., Pontiac
Adair, Robin 1016 N. Hunter Blvd., Birmingham
Adams, Frederick M. 322 Wabeek Bldg., Birmingham
Arnkoff, Harry 305 First Nat. Bank Bldg., Pontiac
Aulie, H. G. 307 W. Sixth, Royal Oak
Baker, Frederick A. 907 Pontiac State Bank, Pontiac
Baker, Robt. H. ..1110 Pontiac State Bank Bldg., Pontiac
Bannow, R. J. 704 Pontiac State Bank Bldg., Pontiac
Barefield, Alwin S. 20879 Bethlawn, Ferndale
Barker, Howard B. 1006 Riker Bldg., Pontiac
Bauer, Edward G. 101½ N. Saginaw, Pontiac
Bauer, Ernest W. 23005 John R St., Hazel Park
Beattie, W. G.....Professional Bldg., Ferndale
Beck, Otto O. 280 W. Maple, Birmingham
Bedwell, William L.....Pontiac State Hospital, Pontiac
Beebe, Willard E.....1411 Pontiac State Bank, Pontiac
Belknap, Warren F.....1809 S. Main Street, Royal Oak
Berg, Richard H.....2 S. Washington, Oxford
Berger, Charles J.....1413 S. Washington Ave., Royal Oak
Blakeney, James.....449 E. Pike Street, Pontiac
Blue, Jane.....218 Riker Bldg., Pontiac
Bonner, Hugh.....Pontiac General Hospital, Pontiac
Boucher, R. E...617 Washington Square Bldg., Royal Oak
Bullard, R. W., Jr.....20 S. Main Street, Clarkston
Burgess, Charles M.....23235 Woodward Avenue, Ferndale
Burke, Chauncey G.....1022 Riker Building, Pontiac
Butler, Samuel A. (L).....Pontiac State Hospital, Pontiac
Byberg, Robert A.....500 S. Washington, Royal Oak
Calhoun, Ethel T.....707 Lakeview, Birmingham
Campbell, Malcolm D.....216 Wash. Sq. Bldg., Royal Oak
Cefai, A. F.....412 People State Building, Pontiac
Cobb, Leon F.....83½ Saginaw, Pontiac
Cobb, Thomas H.....804 Riker Building, Pontiac
Collins, Edward F.....26½ Huron, West, Pontiac
Conrad, C. D.....3027 Woodward, Royal Oak
Cooley, Roy V., Jr.....159 Wesson Street, Pontiac
Cooper, Robert J.....622 Riker Building, Pontiac
Coucke, Henry O.....12475 San Jose Blvd., Birmingham
Crissman, H. C.....22748 Woodward Ave., Ferndale

Cudney, Ethan B.....Pontiac Motor Division, Pontiac
Dahlgren, Carl W.....
301½ Orchard Lake Road., Keego Harbor
Darling, C. G., Jr.....1025 Riker Bldg., Pontiac
Darmstaetter, A. A., Jr.....222 E. Maple, Birmingham
DeLawter, Hilbert H.....1072 Wimbleton, Birmingham
Deutsch, William L.....600 W. First, Huntington Woods
Dobski, Edwin J.....236 Riker Bldg., Pontiac
Dunlap, Gregg L.....
2925 Orchard Lake Ave., Keego Harbor
Dunn, Lewis E.....5876 Thomas, Berkley
Durocher, Normand E...605 Pontiac State Bank, Pontiac
Dustin, Robert L.....Pontiac General Hospital, Pontiac
Ekeland, Clifford T.....906 Riker Building, Pontiac
Endress, Z. F., Jr.....206 Oneida Drive, Pontiac
Evseeff, George S.....611 S. Washington, Royal Oak
Farnham, Lucius A. (L).....538 Riker Bldg., Pontiac
Ferris, Ralph G.....205 Hanna Bldg., Birmingham
Fink, L. Jerome.....1411 Pontiac State Bk. Bldg., Pontiac
Fitzpatrick, Francis J.....818 Peoples Bank Bldg., Pontiac
Flick, John R.....120 West Second, Royal Oak
Foust, Earl W.....233 Key Avenue, Eustis, Florida
Fox, Ralph M.....205 Wabeek Bldg., Birmingham
Furlong, Harold A.....932 Riker Bldg., Pontiac
Gaba, H. B.....21721 Dequindre, Hazel Park
Gadbaw, Joseph J.....23603 Farmington Rd., Farmington
Gaensbauer, Ferdinand.....932 Riker Building, Pontiac
Gariepy, Bernard F.....109 W. First Street, Royal Oak
Gates, E. M.....206-10 Riker Building, Pontiac
Gatley, C. R.....97 N. Perry Street, Pontiac
Gatley, L. Warren.....97 N. Perry Street, Pontiac
Gehringer, Norman F.....336 Riker Bldg., Pontiac
Geib, Ormond D.....Avon Building, Rochester
Gerls, Frank B.....602 Peoples State Bank Bldg., Pontiac
Gibson, James C. (E).....206 E. Commerce, Milford
Gibson, Wellington C.....216 Commerce Street, Milford
Gill, Matthew J.....324 Riker Building, Pontiac
Goode, Norman J., Jr.....109 E. Nine Mile, Ferndale
Gradolph, Paul L.....23338 Woodward Avenue, Ferndale
Grant, William A. (L).....Milford
Green, J. D.....
217 Briggs Bldg., 222 E. Maple, Birmingham
Green, William M.....1402 Pontiac State Bldg., Pontiac
Hackett, Daniel J.....1205 Peoples State Bldg., Pontiac
Haddock, D. A.....5780 Lakeview, Rt. 5, Pontiac
Hagman, George L.....Cranbrook School, Bloomfield Hills
Halsted, Lee H.....33311 Grand River, Farmington
Hammonds, E. E.....209 Wabeek Building, Birmingham
Han, Maolin.....3358 Auburn Rd., Auburn Heights
Hanna, Carl.....900 Baldwin Avenue, Pontiac
Hardy, George C.....
240 Oak Drive, Box 135-G, R. R. 2, Rochester
Harvey, Campbell.....832 Riker Bldg., Pontiac
Hasner, Robert B...617 Washington Sq. Bldg., Royal Oak
Hassberger, J. B.....316 Wabeek Bldg., Birmingham
Hathaway, Clarence L.....33 S. Broadway, Lake Orion
Hathaway, William S.....433½ Main St., Rochester
Heitch, William C.....Pontiac General Hospital, Pontiac
Henderson, James.....Pontiac General Hospital, Pontiac
Hendren, Owen S...1408 Pontiac State Bk. Bldg., Pontiac
Henry, Colonel R.....Professional Bldg., Ferndale
Hensley, C. B.....46 W. Flint St., Lake Orion
Hershey, Lynn N.....
Route 1, 31275 Franklin Blvd., Birmingham
Hoekman, Aben..1301 Pontiac State Bank Bldg., Pontiac
Howlett, E. V. (L).....538 Riker Bldg., Pontiac
Hoyt, Donald F...1203 Pontiac State Bank Bldg., Pontiac
Huber, Philip J...1106 N. Woodward Avenue, Royal Oak
Hubert, John R., Jr.....606 Riker Bldg., Pontiac
Hutchinson, W. G. (L)....1888 Bates Street, Birmingham
Kemp, Felix J.....1115 Peoples State Bank Bldg., Pontiac
Kemp, W. L.....450 Maple Road, Birmingham
Kendrick, H. F.....97 N. Perry, Pontiac
Klewicki, H. A.....125 W. Nine Mile, Ferndale
Koehler, William H.....629 Wash. Sq. Bldg., Royal Oak
Kozonis, M. C.....1006 Riker Bldg., Pontiac
Kuhn, Henry H.....817 E. Eight Mile Road, Hazel Park
Kuhn, R. E.....1706 West Blvd., Berkley
Lahti, Paul T.....325 Washington Sq. Bldg., Royal Oak
LaMarche, Norman O.....2827 Woodward, Berkley
Lambert, Alvin G.....2748 Woodward Ave., Ferndale
Lambie, John S.....280 Aspen Road, Birmingham
Laux, Philip J., Jr.....3027 N. Woodward, Royal Oak
Leaky, Etta Link.....600 11 Mile Road, Berkley
Lewis, S. M.....400 W. Nine Mile, Ferndale
Ling, Theodore W.....23603 Farmington Rd., Farmington
Lockwood, C. E.....107 Martha St., Holly
Lowery, A. J.....8124 S. Meadow, R. 5, Pontiac
MacKenzie, O. R.....128 Common St., Walled Lake
Margrave, Edmund D...306 W. Ten Mile Rd., Royal Oak
Markle, John G.....617 Washington Sq. Bldg., Royal Oak
Markley, John M.....849 W. Huron Street, Pontiac
Mason, Robert J.....308 N. Woodward Ave., Birmingham
McConkie, J. P.....311-2 Wabeek Bldg., Birmingham
McNeill, H. H.....83½ S. Saginaw, Pontiac
Mehas, C. P...Bloomfield Hosp., 2100 Woodward, Pontiac
Meinke, Herman A.....817 E. 8 Mile Road, Hazel Park
Meng, Ralph H.....6315 Livernois, Rochester
Mercer, Frank A...1401 Pontiac State Bk. Bldg., Pontiac
Merrrill, Lionel N...330 Washington Sq. Bldg., Royal Oak
Miller, Hazen L.....617 Washington Sq. Bldg., Royal Oak
Miller, Sidney.....391 Hamilton Ave., Birmingham
Moloney, J. Clark.....240 Daines, Birmingham
Monroe, John D...Oakland County Health Dept., Pontiac
Mumby, Clinton J.....Pontiac State Bank Bldg., Pontiac
Naz, John F.....Clarkston
Nessel, J. H., Lt. MC (M).....
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Newcomb, Arnold B.....P.O. Box 1036, Berkley
Norup, John.....2818 Coolidge Hwy., Berkley
Nosanchuk, Joseph I...1215 Pontiac St. Bk. Bldg., Pontiac
Olsen, Richard E.....St. Joseph Mercy Hospital, Pontiac
Palmer, Hayden D.....506 Riker Building, Pontiac
Pauli, Theodore H.....206 Riker Bldg., Pontiac
Payton, Charles F.....611½ S. Washington, Royal Oak
Pearce, James F.....114 S. Washington, Royal Oak
Pelletier, Charles J.....1914 Dusetta, Royal Oak
Petroff, George N...1301 Pontiac State Bk. Bldg., Pontiac
Porritt, Ross J.....304 Riker Bldg., Pontiac
Prather, Frank W.....Milford
Prevette, Isaac C.....215 First Nat. Bank Bldg., Pontiac
Quarton, Albert E., Jr.....3027 N. Woodward, Royal Oak
Raynale, George P. (L)....302 Wabeek Bldg., Birmingham
Read, James Allen.....612 E. Maple, Birmingham
Reid, Fred T.....Clawson State Bank Bldg., Clawson
Riggs, Harry L.....42½ S. Saginaw, Pontiac
Roker, Aaron D.....1012 Riker Bldg., Pontiac
Roehm, Harold R.....322 Wabeek Building, Birmingham
Rowley, Laurie G.....4400 Dixie Highway, Drayton Plains
Rupp, Edson C., Jr.....97 S. Edith Street, Pontiac
Russell, Vincent P...624 Washington Sq. Bldg., Royal Oak
Ruva, Joseph, Jr.....97 S. Edith Street, Pontiac
St. John, Harold A.....718 Riker Bldg., Pontiac
Schlecte, I. Rochester
Seaborn, A. J.....1412 S. Washington St., Royal Oak
Schuneman, Howard....23760 Woodward, Pleasant Ridge
Shadley, Maxwell L...1405 Pontiac St. Bk. Bldg., Pontiac
Sigler, Louis E., Jr.....920 James K. Blvd., Pontiac
Simpson, E. K.....804 Pontiac State Bank, Pontiac
Smith, Carleton A.....822 Riker Bldg., Pontiac
Smith, Donald S.....824 Riker Bldg., Pontiac
Smith, Ellen Brigar.....Pontiac State Hospital, Pontiac
Smith, George E.....629 Washington Sq. Bldg., Royal Oak
Spencer, Lloyd H.....1302 S. Washington, Royal Oak
Spoehr, Eugene L.....22832 Woodward, Ferndale
Spohn, Earl W.....201 S. Center Street, Royal Oak
Stageman, John C.....1203 Pontiac St. Bk. Bldg., Pontiac
Stahl, Harold F.....Oxford
Stanley, W. F.....1148 S. Woodward, Royal Oak
Starker, C. T. (L)....716 Com. Nat. Bk. Bldg., Pontiac
Steffes, Everette M.....3345 Coolidge Highway, Berkley
Steinberg, Norman N.....211 Wash. Sq. Bldg., Royal Oak
Stevens, John M.....Pontiac State Hospital, Pontiac
Stinson, Paul R.....94 Bloomfield Terrace, Pontiac
Stolpman, A. K.....306 Wabeek Bldg., Birmingham
Sutton, Palmer E.....629 Washington Sq. Bldg., Royal Oak

Swickle, Edward F.....17 S. Main, Clawson
Tauber, Abraham..1108 People Stats Bank Bldg., Pontiac
Tolle, Charles B.....202 Riker Building, Pontiac
Uloth, Milton J. (L).....Ortonville
VandenBerg, Kenneth.....640 Riker Building, Pontiac
Van Haltern, H. L.....Riker Building, Pontiac
Virga, George M.....12744 LaSalle, Huntington Woods
Wagley, P. V.....Pontiac State Hospital, Pontiac
Wagner, Ruth E.....201 First Street, Royal Oak
Wake, Douglas L.....1307 S. Washington, Royal Oak
Watson, Arthur M.....46 W. Flint Street, Lake Orio
Watson, Thomas Y.....313 Wabeek Building, Birminghai
Weisberg, William W...25201 Coolidge Hwy., Royal Oa
Wessels, Robert R.....302 Wabeek Building, Birminghai
Whitehouse, John D.....State Hospital, Pontia
Wigent, Ralph D.....171 Crestwood, Pontia
Williams, John P.....1102 Peoples State Bldg., Pontia
Willis, Maurice E...1107 Pontiac State Bk. Bldg., Pontia
Young, Arthur R.....906 Riker Building, Pontia
Zimmerman, Walter J.....2946 Bacon Street, Berkle

OCEANA COUNTY

Diehl, Clarence.....Shelby
Flint, Charles H.....315 State Street, Hart
Hasty, Willis A.....405 State St., Shelby
Hayton, A. R.....327 Michigan Avenue, Shelby
Heard, William H.....Pentwater
Munger, L. P. (E).....Hart
Nicholson, John H. (E).....Ha
Reetz, Fred A. (A).....Shelb
Robinson, Wm. G.....35 State Street, Hai
Vrbanac, John J.....315 State St., Hai
Wood, Merle G.....19 Courtland Street, Hai

ONTONAGON COUNTY

Hogue, H. B.....Ewen
Lahti, Carl R.....700 River Street, Ontonago
Strong, W. F.....Ontonagon

OTTAWA COUNTY

Beernink, E. H. 222½ Washington St., Grand Haven
Bloemendaal, D. C.....47 E. Main Street, Zeeland
Bloemendal, W. B.....300 Franklin Street, Grand Haven
Boersma, Vernon L. (M).....64 W. 14th Street, Holland
Boone, Conellious E.....101½ E. Main Street, Zeeland
Bulthuis, Jerry E.....Jamestown
Clark, Nelson H.....11 West Eighth Street, Holland
Cook, Carl S.....Holland
DeVries, H. G.....36 East Eighth Street, Holland
DeYoung F. W.....Spring Lake
Frieswyk, Melvin J.....241 E. Main, Zeeland
Groat, Frank L.....414 Franklin St., Grand Haven
Hager, Ralph.....Hudsonville
Hamelink, M. H.....Holland
Harms, H. P.....2 East Eighth Street, Holland
Kearney, Joseph B.....33 West Eighth Street, Holland
Kemme, Gerrit J.....Route 3, Zeeland
Kitchel, John H.....Grand Haven
Kitchel, Mary S.....414 Franklin Street, Grand Haven
Kools, William C.....14 W. 8th Strret, Holland
Kuipers, S. W.....Holland
Leenhouts, Abraham (E).....Holland
Long, C. E. (L).....Grand Have
Michmerhuizen, R. E.....408 Fulton, Grand Have
Moerdyk, William G.....132 E. 12th Street, Hollan
Nichols, Rudolph H.....33 W. 8th Street, Hollan
Nykamp, Russell.....Zeelan
Rypkema, W. M.....228½ Washington St., Grand Have
Stobbelaar, Robert.....107 S. 2nd Street, Grand Have
Schaftenaar, R. H.....210 River Street, Hollan
Ten Have, Ralph.....1016 Sheldon, Grand Have
Ten Pas, Henry.....Hamilto
Timmerman, E. C.....Coopersvill
Van Appleborn, C. J.....99 West 23rd Street, Hollan
Van Der Berg, E. E.....Hollan
Van der Velde, Otto.....35 W. 8th Street, Hollan
Van Kolken, P. J.....Grand Have
VerDuin, J. W.....223 Washington, Grand Have
Wells, Kenneth N. Spring Lak
Westrate, Warren K.....Hollan
Westrate, William.....Hollan
Winter, John K.....10 E. 10th Street, Hollan
Winter, William G., Jr.....Hollan
Yonkman, Frederick F...58 Pomery Road, Madison, N. J

SAGINAW COUNTY

Ackerman, G. L.....124 S. Jefferson Avenue, Saginaw
Albers, M. J.....715 Court Street, Saginaw
Anderson, William K.....404 S. Warren Ave., Saginaw
Bagley, Ulysses S.....1401½ Court Street, Saginaw
Beckett, M. B.....1500 Weiss Street, Saginaw
Berberovich, Thomas F.....2005½ N. Mich. Ave, Saginaw
Bishop, H. M.....515 S. Jefferson, Saginaw
Brender, Fred P.....Frankenmuth
Brock, W. H. (L).....9 Merrill Bldg., Saginaw
Bruggers, Lawrence.....1703 N. Michigan Ave., Saginaw
Bruton, Martin F.....315 S. Jefferson Ave., Saginaw
Bucklin, Robert V.....1447 N. Harrison, Saginaw
Bullington, Bert M...Room 213, Bearinger Bldg., Saginaw
Busch, F. J.....1731 N. Michigan, Saginaw
Butler, Milton G.....502 S. Jefferson, Saginaw
Cady, Frederick J.....402 S. Jefferson Ave., Saginaw
Cambridge, V. W.....400½ Potter Street, Saginaw
Cameron, A. K.....409 1st Sav. & Loan Bldg., Saginaw
Campbell, Lloyd A...405 1st Sav. & Loan Bldg., Saginaw
Catizone, Roy J.....Merrill
Caumartin, Hugh T.....1007 Congress, Saginaw
Chisena, Peter R.....6227 Dixie Highway, Bridgeport
Claytor, Archer A. 1000½ N. Third Avenue, Saginaw
Comer, Walter H.....701 2nd Nat. Bank Bldg., Saginaw
Cortopassi, Vital E.....324 S. Washington Ave., Saginaw
Cortopassi, Andre J.....324 S. Washington, Saginaw
Cory, Charles W.....611 1st Sav. & Loan Bldg., Saginaw
Curts, James H.....127 S. Washington, Saginaw
Durman, Donald C.....408 S. Jefferson Ave., Saginaw
DuVall, Dorothy V.....202 Kresge Bldg., Saginaw
Ely, Cecil W.....1820 Janes St., Saginaw
Ernst, Arthur R. (R).....443 S. Weadock, Saginaw
Fleschner, Thomas E.....Birch Run
Friedrick, David F.....615 Tuscola, Frankenmuth
Gage, David P.....514 First Savings & Loan, Saginaw
Galsterer, Edwin C.....
507-9 First Savings & Loan Bldg., Saginaw
Gamon, A. E.....514 First Savings & Loan, Saginaw
Gardner, J. H.....815 N. Michigan Ave., Saginaw
Gomon, Louis D.....308 Eddy Building, Saginaw
Grigg, Arthur P.....320 N. Michigan, Saginaw
Grigg, Arthur (E).....320 N. Michigan Ave., Saginaw
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Roggen, Ivan J.....611 First Savings & Loan, Saginaw
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Schmitt, Phillip E.....Yale
Selby, C. D.....1916 Military, Port Huron
Sites, Edgar C.....Michigan Nat'l Bank Bldg., Port Huron
Thomas, Charles F.....Sperry Bldg., Port Huron
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Townley, Charles O.....312 Sperry Bldg., Port Huron
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Wetzel, John O.....1012 N. Riverside Dr., St. Clair
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Fiegel, Samuel A. 500 Michigan, Sturgis
Fortner, Roscoe J. 137 Portage, Three Rivers
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Lepard, Olin L.....101 N. Maple, Sturgis
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O'Dell, C. W.....226 East Street, Three Rivers
O'Dell, J. H., Jr.....226 East Street, Three Rivers
Olney, Harold E.....Leonidas
Parrish, Marion F.....120 S. Nottawa St., Sturgis
Pennington, Harry C.....118 S. Kalamazoo, White Pigeon
Penzotti, S. C.....117 Spring, Three Rivers
Porter, C. G.....303 N. Main, Three Rivers
Shaw, George D.....117 Spring, Three Rivers
Sheldon, John P.....104 S. Clay, Sturgis
Slote, Leal K. (E).....157 S. Washington, Constantine
Sweetland, George J.....240 W. Second, Constantine
Tesar, Frank J.....104 W. Market, Centerville
Weisheit, H. R.....504 E. Chicago Road, Sturgis
Zimont, Raymond D.....100 S. Washington, Constantine

SANILAC COUNTY

Bennett, William G.....Brown City
Blanchard, Ernest W.....Deckerville
Cripps, James.....Marlette
Ford, Frances A.....Applegate
Gift, Weldon A.....Marlette
Hart, Robert K.....Howard Street, Croswell
McCrea, John W.....Marlette
McGunegle, K. T.....Sandusky
Muir, Neil.....Croswell
Seager, M. C.....Brown City
Tweedie, G. Evans.....Sandusky
Tweedie, S. Martin.....Sandusky

SHIAWASSEE COUNTY

Agin, L. J.....113 E. Williams, Owosso
Anderson, J. L. (A).....Memorial Hosp., Owosso
Arnold, Alfred L., Jr.....812 Bradley Street, Owosso
Austin, Eugene S.....113 E. Williams, Owosso
Brown, Richard C.....113 E. Williams Street, Owosso
Brown, Richard J.....113 E. Williams, Owosso
Buzzard, Walter D.....Chesaning
Chipman, E. M.....502 W. Williams, Owosso
Graves, James H.....511 W. Main Street, Owosso
Harkness, C. A.....113 E. Williams St., Owosso
Harroun, John E.....113 East Williams St., Owosso
Hoshal, Verne L.....Durand
Hume, Arthur M. (E).....224 N. Ball, Owosso
Janci, Julius S.....213 E. Mason, Owosso
Lieber, Robert W.....202 E. First Street, Perry
McKnight, Edwin R.....320 N. Washington Ave., Owosso
Merz, Walter L.....224 N. Ball St., Owosso
Pochert, Rolland C.....1254 N. Shiawassee, Owosso
Richards, Chester J.....Durand
Sahlmark, Joseph F.....812 Bradley, Owosso
Sheperd, W. F.....Matthews Building, Owosso
Weinkauf, William F.....Corunna
Weston, Claude L.....1306 N. Washington St., Owosso

TUSCOLA COUNTY

Adams, DeWitt C.....State Hospital, Caro
Ballard, James H.....Cass City
Barbour, Harry A.....Mayvolle
Dickerson, Willard W.....Caro State Hospital, Caro
Donahoe, Harold T.....Cass City
Elmendorf, Edward N.....Vassar
Flett, Richard O.....Millington
Gugino, Frank J.....Reese
Howlett, R. R.....624 W. Frank St., Caro
Kaven, G. H. (L).....Unionville
Merrill, Elmer H.....South State Street, Caro
Morris, Frank L.....Cass City
Nigg, Herbert L.....Caro
Pelczar, W. E.....Unionville
Savage, Lloyd L.....General Delivery, Caro
Starmann, Bernard.....Cass City
Von Renner, Otto (L).....Vassar

VAN BUREN COUNTY

Boothby, Carl F.....Hartford
Boothby, F. M.....Lawrence
Boothby, Paul R.....Lawrence
Bope, William P. (E).....Decatur
Buckborough, M. W.....South Haven
Copeland, Evan L.....Decatur
Diephuis, Bert.....South Haven
Dillon, Thomas J.....R..F.D. 3, Paw Paw
Gano, Avison.....Bangor
Giffen, John R. (E).....Bangor
Greenman, Newton H. (R) Decatur
Hoyt, W. F. (E).....Paw Paw
Itzen, J. F.....South Haven
Kleber, John A.....South Haven
Penoyar, C. L.....South Haven
Ralyea, John R.....Paw Paw
Spalding, R. W.....Gobles
Staggs, Adelbert L.....Hartford
Steele, Arthur H.....Paw Paw
Hen Houten, Charles.....Paw Paw
Terwilliger, Edwin H.....
Bank of South Haven Bldg., South Haven
Urist, Martin J.....South Haven
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Range, R. L. (A).....3031 Eye St., Sacramento, Calif.
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Raphael, Theophile ..University Health Serv., Ann Arbor
Rapp, Robert (A).....University Hosp., Ann Arbor
Ratliff, Rigdon K. ..St. Joseph's Mercy Hosp., Ann Arbor
Reid, J. R. (A) University Hospital, Ann Arbor
Riecker, H. H. St. Joseph's Mercy Hosp., Ann Arbor
Riggs, Harold W. St. Joseph's Mercy Hosp., Ann Arbor
Rekshan, W. R. Beyer Mem. Hospital, Ypsilanti
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Robinson, William D. University Hospital, Ann Arbor
Rogers, R. J. (A).....108 Mill St., Vickburg
Ross, C. Howard 715 University Ave., N., Ann Arbor
Rottschaefer, William (A) ..University Hosp., Ann Arbor
Ruchie, W. H. (A).....St. Mary's Hospital, Racine, Wisc.
Ryan, Rlaph W. (A).....University Hospital, Ann Arbor
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Schneider, R. C. University Hospital, Ann Arbor
Schoch, Henry K., (A).....
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Seime, Reuben I. 11 N. Hamilton St., Ypsilanti
Seltzer, H. S. (A) University Hospital, Ann Arbor
Sheldon, John M. University Hospital, Ann Arbor
Shoecraft, Harriet L.....326 Liberty, Ann Arbor
Singleton, E. B. (A) University Hospital, Ann Arbor
Sink, Emory W. 725 N. University, Ann Arbor
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Spears, Clarence W. 302 W. Cross St., Ypsilanti
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Steenrod, W. J., Jr. (M)..110 W. Cushman, Three Rivers
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Tappan, Wm. M. (A)....University Hospital, Ann Arbor
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Thompson, G. R. (A) University Hospital, Ann Arbor
Thompson, R. F. (M).....
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Towsley, Harry A. University Hospital, Ann Arbor
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Westerberg, Martha R. University Hospital, Ann Arbor
Westover, Charles J. ..982 W. Ann Arbor Trail, Plymouth
Wetterstroem, R. G. 501 W. Dunlap St., Northville
Whitehouse, Walter M. University Hospital, Ann Arbor
Wile, Udo J. 511 First Nat. Bank Bldg., Ann Arbor
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Williamson, Frederick B. 319 W. Michigan, Ypsilanti
Willison, C. H. (A) University Hospital, Ann Arbor
Wilson, Frank N.. (A) 1945 Burdon Rd., Stockbridge
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Wisdom, Inez R. 705 N. University, Ann Arbor
Wollum, Arnold University Hospital, Ann Arbor
Woods, J. J. 19 N. Washington, Ypsilanti
Worth, Melissa H. C.....15 N. Adams St., Ypsilanti

Wright, P. E. Leland Sanitorium, Ypsilanti
Wright, Walter J. (E) 133 W. Michigan, Ypsilanti
Wylie, William C. (L) Dexter
Yoder, O. R. Ypsilanti State Hospital, Ypsilanti
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Adelson, Sidney L. 16221 Schoolcraft, Detroit
Adler, Sidney 872 Fisher Bldg., Detroit
Agnew, George, H. 559 Fisher Bldg., Detroit
Aiuto, James J.....660 Cadieux Rd., Grosse Pointe
Akroyd, Cecil 3841 Junction, Detroit
Albrecht, Herman F. 877 Chicago Blvd., Detroit
Alderman, R. F. 16880 Gilchrist St., Detroit
Aldrich, E. Gordon 14239 Chandler Park Dr., Detroit
Alexander, Eugene J. Henry Ford Hospital, Detroit
Alford, E. S., Lt. Col. (M)
Base Hospital, Landley Air Force Base, Va.
Allen, John V. 1336 Southfield, Detroit
Alles, Russell W. 968 Fisher Bldg., Detroit
Allison, Herbert C. 80 Kercheval, Grosse Pte. Farms
Alper, Louis 20401 Schaefer Highway, Detroit 35
Alpern, Elliott B. 2840 W. 7 Mile Rd., Detroit
Alpiner, Sam 2850 E. 7 Mile Rd., Detroit
Altman, Raphael 1052 Maccabees Bldg., Detroit
Altshuler, Abraham M. 508 Fox Theater Bldg., Detroit
Altshuler, C. H. Wayne Co. General Hospital, Eloise
Altshuler, Ira M. 512 Fox Theater Bldg., Detroit 1
Altshuler, S. S., Major (M)
Veterans Hospital, Tuscon, Ariz.
Amos, Thomas G. 201 Curtis Bldg., Detroit
Anderson, Bruce (E)....2579 Silver Lake Rd., Pontiac 17
Anderson, C. P.....334 Bates, Detroit
Anderson, James O. 641 David Whitney Bldg., Detroit
Anderson, Walter L. 5902 Jos. Campau, Detroit
Anderson, Walter T. 923 David Whitney Bldg., Detroit
Anderson, William H. (M)....c/o A. M. Anderson, Ewen
Andries, George H.....853 Fisher Bldg., Detroit
Andries, R. C. 1737 David Whitney Bldg., Detroit
Ankley, Jerome W. 8331 Mack Ave., Detroit
Anslow, Robert E. 10 Peterboro St., Detroit 1
Appelman, H. B. 1014 David Broderick Tower, Detroit
Archambault, Henry A.....1076 Maccabees Bldg., Detroit
Archambault, R. F. 35550 Michigan Ave., Wayne
Arehart, Burke W. 17600 Harper Ave., Detroit
Arent, J. G. 12600½ Grand River Ave., Detroit
Arminski, Thomas C.....1066 Fisher Bldg., Detroit
Armstrong, Arthur G. 530 Fisher Bldg., Detroit
Armstrong, M. J. 15125 Grand River, Detroit
Arnold, Effie E.....10 Peterboro, Detroit
Aronstam, Noah E. (E)....654 Maccabees Bldg., Detroit
Arrington, Robyn J. 7811 Oakland, Detroit
Ascher, Meyer S. 942 Maccabees Bldg., Detroit
Ashe, Robert M.....6838 Park Ave., Allen Park
Ashe, Stilson R. 8031 W. Vernor Highway, Detroit
Ashley, L. Byron 113 Martin Place, Detroit
Ashton, F. B. (L) 18 Winona Ave., Highland Park 3
Asselin, D. R. 1208 David Whitney Bldg., Detroit
Asselin, Regis F. 14935 E. Warren, Detroit 24
Atler, L. R. 681 W. Forest, Detroit
Atler, LeRoy L. 4847 Third Ave., Detroit
Athay, Roland M.....Wayne Co. Gen'l. Hosp., Eloise
Auble, Max E. 2501 W. Grand Blvd., Detroit 8
August, Harry E. 1242 Maccabees Bldg., Detroit 2
Auld, Douglas Dev.....275 W. Grand Blvd., Detroit 16
Avrin, Ira 9105 Hamilton, Detroit
Axelrod, A. R. 15920 Linwood, Detroit
Axelson, A. U. 7310 Grand River Ave., Detroit 4
Babcock, Kenneth B. Grace Hospital, Detroit 1
Babcock, Lloyd K. 16420 Schoolcraft, Detroit
Babcock, Myra E. 7 Poplar Park, Pleasant Ridge
Babcock, Warren W. 868 Fisher Bldg., Detroit
Bach, Walter F. 5419 Livernois, Detroit 10
Bachman, Morris E. 569 Fisher Bldg., Detroit 2
Bacon, Vinton A. 4819 W. Fort St., Detroit 9
Bader, Benjamin H. 5210 Third Ave., Detroit 2
Baeff, Michael A. (R) 15435 Stahelin, Detroit 23
Baer, George J. 707 David Whitney Bldg., Detroit 26
Baer, Raymond B. 7815 E. Jefferson, Detroit 14
Bagley, Harry E. 7541 Oakman Blvd., Dearborn
Bailey, Carl C. 9203 Grand River, Detroit 4
Bailey, Don A. 3300 Woodstock Drive, Detroit 21
Bailey, L. J. 620 Vinewood Ave., Birmingham
Bailey, William A.....630 Telegraph Rd., Dearborn
Baker, Clarence (L) 19182 Patton Ave., Detroit 19
Baker, H. A. (M) U.S.S. Baltimore, F.P.O., N. Y.
Bakst, Joseph H.....10 W. Warren, Detroit 1
Balaga, Frank T. 9701 Jos. Campau, Detroit 12
Balberor, Harry 1404 David Broderick Tower, Detroit
Balcerski, Matthew A. 10 Peterboro, Detroit 1
Ballard, C. S. (R) 370 Chalmers Ave., Detroit
Ballard, Donald R. 10149 Michigan Ave., Dearborn
Baltz, James I. Henry Ford Hospital, Detroit 2
Balser, Charles W. 13931 Gratiot, Detroit 5
Barak, Lewis R.....7448 W. Seven Mile Rd., Detroit
Baranowski, A. W. 15841 W. Warren, Detroit 10
Barbaglia, L. C. 16378 Harper, Detroit
Barber, Radivoj 504 S. Main St., Plymouth
Barenholtz, Benjamin 674 Maccabees Bldg., Detroit
Barland, Oscar L. 8703 Oakland, Detroit 11
Barnes, Donald J. 564 Fisher Bldg., Detroit 2
Barnes, Van D. Veterans Hospital, Dearborn
Barnett, Louis L.....1806 David Broderick Tower, Detroit
Barnett, Morton 1527 David Stott Bldg., Detroit 26
Barone, C. G.....13535 Woodward, Detroit
Bartemeier, Leo H. ..8-259 General Motors Bldg., Detroit
Barrett, Wyman D. ..311 David Whitney Bldg., Detroit 26
Bethea, J. Hardee 1005 Kales Bldg., Detroit 26
Barnett, Dewin Dwight
Columbia University, 600 W. 168th St., New York 32, N. Y.
Barron, William H. 14938 Livernois, Detroit
Barron, James Henry Ford Hospital, Detroit
Barton, Joseph R. 7503 W. Warren, Detroit 10
Bassett, Louis H.....8100 E. Jefferson, Detroit
Batchelor, M. T.....7600 John R, Detroit
Bates, G. S.....1144 David Whitney Bldg., Detroit 26
Bauer, Benedict J. 7615 Dexter Blvd., Detroit 6
Bauer, A. Robert 19268 Grand River, Detroit 23
Bauer, Lester Eugene 859 Fisher Bldg., Detroit
Baumer, Moe 701 Kales Bldg., Detroit
Baumgarten, Elden C. 8045 E. Jefferson, Detroit
Beach, Watson 742 Maccabees Bldg., Detroit
Beam, A. Duane 85 Kercheval, Detroit 30
Beamer, George D. 13810 Michigan Ave., Dearborn
Beattie, Robert (L) 1229 David Whitney Bldg., Detroit
Beaver, Donald C. 432 E. Hancock, Detroit 1
Beavers, Robert 2043 McDougall, Detroit 7
Becker, A. 1414 David Broderick Tower, Detroit 26
Becklein, Clarence L. ..14351 E. Warren Ave., Detroit 13
Beckwith, Carl C. 15625 Twelfth St., Detroit 3
Beckwitt, Morris C. 865 Fisher Bldg., Detroit 2
Bedell, Archie A. 15643 Mack Ave., Detroit
Beecher, A. J. 20390 Harper, Detroit
Beeuwkes, L. E. 12922 W. Warren, Dearborn
Behn, Claud W. 1546 David Whitney Bldg., Detroit
Beigler, Sydney K. 513 David Whitney Bldg., Detroit
Beitman, Max R 510 Kales Bldg., Detroit 26
Belanger, Ernest E. 10593 W. Jefferson, Detroit
Belanger, Henri (E) 10593 W. Jefferson, River Rouge
Belanger, W. G. 522 Fisher Bldg., Detroit 2
Belisle, John A. Wayne County Hospital, Eloise
Bell, J. Kenner....1654 First Nat. Bank Bldg., Detroit 26
Benjamin, William O. 1037 Green Ave., Detroit 9
Bennett, Germany E. 5144 Hastings, Detroit 11
Bennett, Harry B. 942 Maccabees Bldg., Detroit 2

Bennett, Sanford A. 17904 John R St., Detroit 3
Bennett, William E.....12897 Woodward Ave., Detroit
Bennett, Zina B.
Michigan Mutual Hospital, 2730 E. Jefferson St., Detroit 7
Benson, Clifford D. 1515 David Whitney Bldg., Detroit
Benson, Davis A. 3706 Sturtevant, Detroit 6
Benson, Paul J.....2900 S. Fort Street, Detroit
Benson, Virginia M.....16238 Snowden Ave., Detroit 27
Bentley, Frederick E. 861 Penniman Bldg., Plymouth
Bentley, Neil I. (L)
1166 David Whitney Bldg., Detroit 26
Berge, Clarence A. 14309 E. Jefferson, Detroit 15
Berger, Edwin L. Cadillac Motor Car Div., Detroit 32
Bergman, Murray Stewart 4400 Livernois, Detroit 10
Bergman, Theodore I. 16455 Woodward, Detroit 3
Bergo, Howard L. (M)
Berke, Sydney S.....3333 E. Jefferson, Detroit
Berlien, Ivan C. 1753 Guardian Bldg., Detroit 26
Berman, Lawrence 1516 St. Antoine St., Detroit 26
Berman, Robt. ..1304 David Broderick Tower, Detroit 26
Berman, Sidney L. 60 W. Hancock, Detroit 1
Bermel, J. M. (M) 13130 Tireman, Detroit
Bernard, Walter G. 13002 E. Jefferson Ave., Detroit 15
Bernbaum, Bernard 17320 Livernois, Detroit
Bernstein, Albert E.....9 Burlingame, Detroit 2
Bernstein, Samuel S. 18200 Wyoming, Detroit
Berry, Jos. E. 18268 Grand River, Detroit 23
Besancon, J. H. 1510 Broderick Tower, Detroit
Best, T. H. Edward 9221 E. Jefferson, Detroit
Bethea, John H.....1005 Kales Bldg., Detroit
Bicknell, Edgar A. 13641 Wyoming, Detroit 21
Bicknell, Frank B. 938 David Whitney Bldg., Detroit
Bielawski, John G. 1042 Maccabees Bldg., Detroit 2
Billingslea, Thomas H.....2175 E. Willis, Detroit
Birch, John R. 1010 Maccabees Bldg., Detroit 2
Bird, H. Waldo, Jr.....1865 Guardian Bldg., Detroit
Birkelo, Carl C.
Herman Kiefer Hospital, Taylor & Hamilton, Detroit 2
Birmingham, John R. 2331 Ardmore, Royal Oak
Birndorf, Leonard.....18004 John R, Detroit
Bittker, Isadore Irving ..616 Professional Bldg., Detroit 1
Bittrich, Norbert M.
Providence Hospital, 2500 W. GD. Blvd., Detroit 8
Bjork, Floyd J. 14447 W. Seven Mile Road, Detroit
Black, Perry S. 19431 Van Dyke, Detroit 12
Blain, Alexander W. 2201 E. Jefferson St., Detroit 7
Blain, Alexander W., III 2201 E. Jefferson, Detroit
Blain, James H., Jr. 119 Kercheval, Grosse Pte.
Blaine, Max 654 Maccabees Bldg., Detroit
Bleier, Alfred 13015 E. Warren Ave., Detroit 13
Bleier, Joseph 7504 Dexter Blvd., Detroit 6
Bloch, Abraham 2935 E. Milwaukee, Detroit 11
Blodgett, James B. 606 Kales Bldg., Detroit 26
Blodgett, Wm. E. (L) 602 Kales Bldg., Detroit 26
Blodgett, William H. 603 Kales Bldg., Detroit
Bloom, Arthur R. 1058 Maccabees Bldg., Detroit 2
Blumenthal, Franz L. 466 Fisher Bldg., Detroit 2
Boccaccio, John L. 16383 Harper, Detroit 13
Boccia, J. J. 15761 E. Warren, Detroit
Boddie, Arthur W. 2737 Chene, Detroit 7
Bogucki, C. J. (M) 36450 Mound Rd., Warren
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Bogusz, Ladislaus Wayne Co. General Hospital, Eloise
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Bohne, A. W. Henry Ford Hospital, Detroit
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Boland, J. R. 2229 East Jefferson, Detroit
Bolstad, Donald S. Henry Ford Hospital, Detroit 2
Bolton, Russell P., Jr.....19566 Grand River, Detroit
Bockmyer, R. H. 17198 Oak Drive, Detroit 21
Bookstein, Abraham M. 1475 Colton, Detroit 3
Bornstein, Sidney 12710 Appoline, Detroit
Bott, Edmund T. 3152 Biddle St., Wyandotte
Botvinick, Isadore 13701 W. 7 Mile Rd., Detroit 21
Boutrous, T. A. 15801 W. McNichols Rd., Detroit 25
Bovill, E. G. 17555 James Couzens Hwy., Detroit 35

Bower, Donald W. 1336 Southfield, Lincoln Park
Bower, F. T.....10 Kenningston Blvd., Pleasant Ridge
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Bradley, Geo. T. 1201 David Whitney Bldg., Detroit 26
Bradshaw, William H. 4715 St. Antoine, Detroit 1
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Bramigk, F. W. 509-11 Professional Bldg., Detroit 1
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Breitenbecher, Edward R. 13973 Woodward, Detroit 3
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Brent, Morris S. 13503 Northlawn Ave., Detroit 4
Brey, Norman 1202 Maccabees Bldg., Detroit 2
Briggs, William J. 1202 Maccabees Bldg., Detroit 2
Brines, O. A. 1512 St. Antoine, Detroit
Bringard, Elmer L. 16889 James Couzens, Detroit 21
Brisbois, Harold J. 893 W. Ann Arbor Trail, Plymouth
Brisson, Joseph C. D.....9191 Whittier, Detroit 24
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Broadman, Sylvan A. 16401 Grand River, Detroit 27
Brooks, Charles W. 2033 E. Davison Ave., Detroit
Bromme, William 10 Peterboro, Detroit 1
Bronson, W. W. 22128 Grand River, Detroit 19
Brooks, Clark D. (L) 113 Martin Place, Detroit 1
Brooks, Nathan 1001 Kales Bldg., Detroit
Brosius, William L. Harper Hospital, Detroit
Broudo, Philip H. 316 Professional Bldg., Detroit 1
Brough, Glen A. 1402 David Whitney Bldg., Detroit
Brown, A. G. 12065 Wyoming, Detroit
Brown, Audrey O. 742 Maccabees Bldg., Detroit
Brown, C. F. 1229 David Whitney Bldg., Detroit 26
Brown, Charles H. 3152 Biddle Ave., Wyandotte
Brown, Frances 1940 Lincolnshire, Detroit
Brown, Gordon T. 11146 Gratiot, Detroit 5
Brown, Harvey F. 3714 W. McNichols Rd., Detroit 21
Brown, Henry S.....9101 Hamilton Ave., Detroit
Brown, John R. 702 Maccabees Bldg., Detroit 2
Brown, Robert A. 11299 W. Jefferson, Detroit 18
Brown, Samuel M. 6315 Ellsworth Ave., Detroit 21
Brown, Stanley H. 8544 W. McNichols Rd., Detroit 21
Brown, Thomas A. 5430 W. Warren Ave., Detroit
Brownell, Paul G. 18916 Woodward Ave., Detroit 3
Bruehl, Richard A. 471 Fisher Bldg., Detroit
Bruer, E. L. 1495 Fort St., Wyandotte
Bruer, Edgar S. 11299 W. Jefferson, River Rouge
Brunk, C. F. Route 1, Traverse City
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Brush, Brock Edwin 2799 W. Grand Blvd., Detroit
Bryan, Donald I. 1050 Fisher Bldg., Detroit
Bryce, John D. 696 W. Kirby, Detroit 2
Buchanan, Wm. Paul ..11751 Grand River Ave., Detroit 4
Budson, Daniel 1080 Fisher Bldg., Detroit 2
Buell, John H. 1306 David Whitney Bldg., Detroit 26
Buller, H. L. 4120 Fenkell Ave., Detroit 21
Buerki, Robin C. Henry Ford Hospital, Detroit
Burhans, D. C. 13700 Woodward Ave., Highland Park
Burke, Ralph M. 742 Maccabees Bldg., Detroit 2
Burnham, David C.....
13700 Woodward Ave., Highland Park
Burns, Robert T. 16101 Harper Ave., Detroit 24
Burnstine, Julius Y. 45 Owen Ave., Detroit
Burnstine, Perry P. 434 W. Palmer, Detroit 2
Burton, D. T. 54 Arden Park, Detroit
Burton, Irving F. 14624 East 7 Mile Rd., Detroit
Burr, George C. 1706 David Whitney Bldg., Detroit 26
Burr, H. Leonard 168 Fisher Rd., Grosse Pointe
Burroughs, R. G. 1449 David Whitney Bldg., Detroit
Burrows, Howard 10423 W. Warren, Dearborn
Burstein, Harry S. 2950 W. Grand Blvd., Detroit 2
Burstein, I. Marvin 2950 W. Grand Blvd., Detroit 2

Burstein, Morris M. 2950 W. Grand Blvd., Detroit 2
Bush, Glendon J. 7704 Dexter Blvd., Detroit 6
Bush, Lowell M. 18950 Woodward, Detroit
Butler, Harry J. (L) 33 Waverly, Highland Park 3
Butler, J. Payne 3403 W. Warren, Detroit 8
Butler, Lawrence H. 7005 Harper Ave., Detroit
Butler, Volney N. 28 W. Adams, Detroit 26
Butler, John D. 1308 Broadway, Detroit 26
Butterworth, H. K. 719 Liberty Ave., Lincoln Park
Buttrum, Edward J. 14755 Fenkell, Detroit 27
Byers, Dudley W. 8934 Oakland Ave., Detroit
Byington, Garner M. 1151 Taylor Ave., Detroit

Cadieux, Henry W. (L) 103 E. Grand Blvd., Detroit 7
Cahalan, Joseph L. 1447 David Whitney Bldg., Detroit
Caldwell, J. Ewart 10 Peterboro, Detroit 1
Caldwell, George L. 12017 Jos. Campau, Detroit 2
Calkins, H. N. 14970 Robson Ave., Detroit
Callaghan, Thomas T. 312 Professional Bldg., Detroit
Cameron, D. A. 1405 Kales Bldg., Detroit
Campau, George H. 393 W. Grand Blvd., Detroit 16
Campbell, Charles A. 12922 West Warren, Dearborn
Campbell, Duncan 9203 Grand River, Detroit 4
Campbell, Duncan A. (E)
1613 David Whitney Bldg., Detroit 26
Campbell, Kenneth N. Blaine Hospital, Detroit
Campbell, Malcolm D.....10 Peterboro, Detroit
Campbell, Thelma Wygant.....22375 Garrison, Dearborn
Candler, C. L...20040 Mack Ave., Grosse Pte. Woods 30
Canter, Allie L. 13700 Woodward Ave., Detroit 5
Canter, G. E. 13732 Woodward Ave., Detroit 3
Cantor, Meyer O. 666 Maccabees Bldg., Detroit 2
Cantow, L. A. 1123 David Whitney Bldg., Detroit 26
Capano, Oreste A. 16234 Cruse, Detroit 27
Caputo, Joseph M. 22575 Nona Avenue, Dearborn
Caraway, Jas. E. 355519 Norris St., Wayne
Carbone, Louis A. 9317 Gratiot, Detroit 13
Carey, Cornelius (L) 9667 Gratiot Ave., Detroit 13
Carleton, Lawrence H. 750 Fisher Bldg., Detroit 2
Carlson, Harold W. 18070 Wildemere, Detroit 21
Carmichael, Edward K. 7815 E. Jefferson, Detroit 14
Carp, Joseph 8839 Mt. Elliott, Detroit 11
Carpenter, Claire H. 18700 Meyer Rd., Detroit 21
Carpenter, C. J. 3835 Biddle St., Wayne
Carpenter, G. B. ..1416 David Whitney Bldg., Detroit 26
Carpenter, Wm. S...1317 David Whitney Bldg., Detroit 26
Carr, J. G. 5181 Van Dyke, Detroit
Carroll, Elmer H. 9920 Stoepel Ave., Detroit 4
Carroll, Lona B. 1066 Maccabees, Bldg., Detroit 2
Carrick, Lee 1515 Kales Bldg., Detroit 26
Carson, Herman J. 7745 Puritan, Detroit 21
Carstens, H. R. 3706 Manor Rd., Chevy Chase 15, Md.
Carter, John M. 613 David Whitney Bldg., Detroit 26
Carter, L. F. 613 David Whitney Bldg., Detroit 26
Casey, Byron L., Jr.....1865 Guardian Bldg., Detroit
Cassidy, Wm. J.....1737 David Whitney Bldg., Detroit 26
Castle, Maurice 761 Fisher Bldg., Detroit
Castrop, Charles W. 10149 Michigan Ave., Dearborn
Catherwood, A. E. ..1337 David Whitney Bldg., Detroit 26
Caton, Dorothy F. 17144 Oak Drive, Detroit 21
Caughey, A. F., Jr.....16889 James Couzens, Detroit 35
Caughey, Edgar H. 11301 Whittier, Detroit 24
Caumartin, Fred E. 15361 Plymouth Rd., Detroit 27
Cavell, Roscoe W.
Vets. Readjustment Center, Univ. Hosp., Ann Arbor
Cellar, Frank A. 944 Maccabees Bldg., Detroit
Ceravolo, Albert J. 1420 St. Antoine, Detroit 26
Ceresko, A. R. 18650 W. Warren Ave., Detroit 10
Cetlinski, C. A.....11838 Joseph Campau, Hamtramck
Cetnar, E. J. (M) 6684 Baldiven, Detroit 13
Chabut, V. George 206 W. Dunlap, Northville
Chall, Henry G. 2941 W. McNichols, Detroit 21
Chapin, Sidney E. 10149 Michigan Ave., Dearborn
Chapman, Aaron L. 2550 Atkinson, Detroit 6
Chapman, Paul T. 1151 Taylor Ave., Detroit 2
Chapnick, H. A. 506 Kales Bldg., Detroit
Charleston, R. A. 15174 Lasher Rd., Detroit 23
Charnas, Sidney 542 Maccabees Bldg., Detroit 2
Chase, Clyde H. 1002 David Whitney Bldg., Detroit 26
Chase, John D. 1512 St. Antoine, Detroit 26
Chason, Jacob L. Veterans Admin. Hospital, Dearborn
Chatel, Arthur N.....4927 Cadillac Avenue, Detroit
Check, Frank E. 3439 Iroquois, Detroit 14
Cheng, James T. 1800 Tuxedo, Detroit 26
Chesluk, H. M.....1312 David Broderick Tower, Detroit
Chester, William P. 5057 Woodward, Detroit 2
Childs, George M. 6505 Hamilton, Detroit 2
Chipman, W. A. 14920 Grand River Ave., Detroit 27
Chittenden, G. E. 7815 E. Jefferson Ave., Detroit 14
Chostner, G. C. 13715 Gratiot Ave., Detroit
Christensen, C. A. 10149 Michigan Ave., Dearborn
Christensen, R. C. Henry Ford Hospital, Detroit 2
Christopher, James G.
Holy Cross Hospital, 4777 East Outer Drive, Detroit
Chrouch, Laurence A. 18456 Grand River, Detroit 23
Church, A. S. 10 Peterboro, Detroit
Cioffari, M. S. 19363 James Couzens Hwy., Detroit
Ciprian, Joseph E. 1775 E. Grand Blvd., Detroit
Clapper, Muir 1512 St. Antoine, Detroit
Clark, Benjamin W. (M).....Address Unknown
Clark, Charles J. Ford Motor Co., Dearborn
Clark, Clarence M. 2605 Holbrook, Detroit 12
Clark, Donald V. 15400 Plymouth Rd., Detroit 27
Clark, George E. (E)
Michael House, Thedford, Ont., Canada
Clark, Harold E. 17198 Oak Drive, Detroit 21
Clark, Harry G. 15361 Plymouth Rd., Detroit 27
Clark, Ronald E. 15537 Centralia, Detroit 23
Clark, William P. 15044 Harrison, Allen Park
Clarke, Norman E. 2501 W. Grand Blvd., Detroit 8
Clarke, Robert B. 1112 Kales Bldg., Detroit
Clifford, C. H. 10 Peterboro, Detroit 1
Clifford, J. E. 10 Witherell, Detroit 26
Clifford, Robert H.....Henry Ford Hospital, Detroit
Clifford, T. P. 1802 David Whitney Bldg., Detroit 26
Clippert, J. C. (E) Dearborn Inn, Dearborn
Clunas, V. F., Lt. (jg) (M).....
(MC) USNR, 4709 S. Chelsea, Bethesda, Md.
Coan, Glenn L. 114 Maple, Wyandotte
Coates, Carl Amos 21576 Michigan Ave., Dearborn
Cobane, John H. 10 Peterboro, Detroit 1
Cochrane, Edgar G. 12805 Hamilton, Detroit 3
Coffman, E. W. 14807 W. McNichols Rd., Detroit
Cohen, H. Herbert 12700 W. 7 Mile Rd., Detroit 21
Cohen, Lewis 16861 Wyoming Ave., Detroit
Cohn, Daniel E. 409 Fox Bldg., Detroit 1
Cohoe, Don A. 13535 Woodward, Detroit 3
Cole, Albert B. 2208 Broderick Tower, Detroit
Cole, F. H.....1757 David Whitney Bldg., Detroit 26
Cole, James E. 344 Glendale, Detroit 4
Cole, Wyman C. C. 1077 Fisher Bldg., Detroit 2
Coleman, Margarete W. 58 W. Adams Ave., Detroit 26
Coleman, William G. 20526 Grand River, Redford 19
Collings, M. R. 9201 W. Outer Dr., Detroit 19
Collins, James E. 13103 W. Chicago Blvd., Detroit 29
Colvin, Leslie T. 474 Fisher Bldg., Detroit 2
Colyer, Raymond G. 601 Piquette, Detroit
Comfort, Milton D. 28754 Seneca, Flat Rock
Comstock, Lawrence A. P.O. Drawer L, Trenton
Condon, Stanley.....
1477 Lochmoor Blvd., Grosse Pointe Woods
Conley, L. C. M. 99 Tuxedo, Detroit 3
Connelly, R. C. 1645 David Whitney Bldg., Detroit 26
Conner, Edward D. 15778 Birwood, Detroit
Connolly, Frank 5149 Joy Rd., Detroit 4
Connolly, John P. 5149 Joy Rd., Detroit 4
Connolly, Paul J. 113 Martin Place, Detroit 1
Connors, J. J. 3546 Trumbull, Detroit
Conrad, Elmer R. 716 Kales Bldg., Detroit 26
Cook, James A.....1860 Ford, Wyandotte
Cook, James C. Harper Hospital, Detroit 1
Cooksey, Warren B. 62 W. Kirby, Detroit
Coolidge, M. B. (L)..808 Barrington Rd., Grosse Pte. Pk.
Cooper, Benjamin F. 10053 Gratiot St., Detroit 13
Cooper, James B. ..1241 David Whitney Bldg., Detroit 26
Cooper, Edmond L. 414 David Whitney Bldg., Detroit
Cooper, Ralph R.....1515 David Whitney Bldg., Detroit 26

Corbeille, Catherine, ...1050 Fisher Bldg., Detroit
Coseglia, Robert P. 7962 Kercheval, Detroit 14
Costello, Russell T. 630 Fisher Bldg., Detroit 2
Cotant, John F. 8935 Fenkell, Detroit 21
Cotruro, Louis D. 3640 McDougall, Detroit 7
Cotton, Schuyler O. 2332 Carson Ave., Detroit 9
Coulter, William J. 5258 Chatsworth, Detroit 24
Courville, Charles J. 1202 Maccabees Bldg., Detroit 6
Cowan, Wilfrid 6135 Chalmers, Detroit 13
Cowen, Leon B. 1038 Maccabees Bldg., Detroit 2
Cowen, Robert L. 907 Stroh Bldg., Detroit 26
Coyle, J. E. 573 Fisher Bldg., Detroit
Coyne, Douglas Ruthven....7376 Grand River, Detroit 4
Crawford, A. S.....Thaver Hosp., Waterville, Maine
Crews, Thomas H. 772 Fisher Bldg., Detroit 2
Croll, Leo J. 1326 Maccabees Bldg., Detroit 2
Croll, Maurice M.....1326 Maccabees Bldg., Detroit 2
Crook, Charles L. 47 W. Grand Ave., Highland Park
Cross, Harold E. ..499 Sunningdale, Grosse Pte. Woods 30
Crossen, H. F. 902 David Whitney Bldg., Detroit 26
Crossen, R. J. 902 David Whitney Bldg., Detroit 26
Croushore, James E. 573 Fisher Bldg., Detroit 2
Cruikshank, A. (E) 228 E. Grand Blvd., Detroit 7
Curhan, Jos. Howard 18709 Meyer Rd., Detroit 21
Curtis, Frank E.....10 Peterboro, Detroit 1
Curtiss, William P. 3181 E. Jefferson, Detroit 9
Cushing, Russell G. 13424 Gratiot Ave., Detroit 5
Cusick, Paul L. 1108 Stroh Bldg., Detroit 26

Dale, Edward C.
Vets. Admin., Mental Hygiene Clinic, 9th Floor, Guardian Building, Detroit 26
Dale, Esther H. 1512 St. Antoine, Detroit 26
Dale, Mark.....728 Maccabees Bldg., Detroit 2
Daly, Byrne M. 120 McLean, Detroit 3
Danforth, James C., Jr.
20175 Mack Ave., Grosse Pointe Woods
Danforth, James C., Sr.
20175 Mack Ave., Grosse Pointe Woods
Danforth, M. E. (L) 1311 Cadillac Blvd., Detroit 14
Daniels, Lewis E.....458 Fisher Bldg., Detroit
Darling, Charles E. 673 Fisher Bldg., Detroit
Darling, Milton A. 673 Fisher Bldg., Detroit 4
Darpin, Peter H. 6602 W. Fort St., Detroit 9
Davidson, David M. 1055 Fisher Bldg., Detroit 2
Davidson, Harry O. Henry Ford Hospital, Detroit
Davies, R. H. 1633 David Whitney Bldg., Detroit 26
Davies, T. S. 15425 Kercheval, Grosse Pointe
Davies, Windsor S. 1302 Stroh Bldg., Detroit 26
Davis, George H. (M)
2252 Washington Ave., Silver Spring, Md.
Davison, L. E. (M) 9257 Parkway, Grosse Ile
Davison, William T. 312 Sperry Bldg., Port Huron
Dawson, W. A. 25951 Avondale Rd., Inkster
Day, Andrew J. 710 David Whitney Bldg., Detroit
Day, J. Claude 703 David Whitney Bldg., Detroit
Deering, Robert J. 1392 Coolidge Hwy., River Rouge
Defever, Cyril R. 15124 Kercheval, Grosse Pointe
Defnet, William A. 1302 Stroh Bldg., Detroit 26
DeJongh, Edwin
Diesel Eng. Div., General Motors Corp., 13400 W. Outer Drive, Detroit 23
Delaini, Stella M. 760 Fisher Bldg., Detroit 2
Delaney, J. R. 1020 David Whitney Bldg., Detroit 26
DeLawrence, Betty J. 10149 Michigan, Dearborn
DeLawrence, Thomas 10149 Michigan, Dearborn
Demaray, John F. 15312 Burt Rd., Detroit 23
DeNike, A. J. (L)....1479 E. Jefferson Ave., Detroit 7
Denison, Louis L. 4026 W. McNichols Rd., Detroit 21
Dennis, M. S. 14001 Greenfield, Detroit
DePonio, Sylvester A. 20249 Van Dyke, Detroit 12
Deresz, Alphonse R. 6609 Van Dyke, Detroit
Derleth, Paul E. 562 W. Oakridge, Ferndale
DeRosier, Joseph L.....10944 Wilshire, Detroit
Derr, J. W. 702 Maccabees Bldg., Detroit
DeSmyter, George C. 15527 E. Warren, Detroit
de Spelder, Ray E.....2970 W. Grand Blvd., Detroit 11
DeTomasi, Rome Q. 1098 E. Grand Blvd., Detroit
Deuby, O. J. 14477 W. 7 Mile Rd., Detroit
Devine, H. W.....22101 Moross Rd., Detroit 26
Dibble, Harry F. 1313 David Whitney Bldg., Detroit 26
Dickson, B. R. 337 W. Grand Blvd., Detroit 16
Dickson, Elias L., Jr.....7716 Oakland, Detroit 11
Dickson, Leon A.....5119 Milford, Detroit
Diebel, Nelson W. 660 Cadieux, Detroit 30
Dietzel, H. O. 1024 W. Seven Mile Rd., Detroit
Dill, Hugh L. 16114 E. Warren, Detroit 24
Dill, J. Lewis 2799 W. Grand Blvd., Detroit 2
DiLoreto, Panfilo C. 4345 Harvard Rd., Detroit
Dimond, G. E. 6853 Orchard, Dearborn
Dinnen, Wm. J. (M)
Dittmer, Edwin F. 14320 E. Jefferson, Detroit 15
Dixon, Fred W. 530 N. Telegraph Rd., Dearborn
Dixon, Ray S. 5001 Van Dyke Ave., Detroit 13
Dixon, Robert K. 2501 W. Grand Blvd., Detroit 8
Dodds, J. C. (L)....1355 David Whitney Bldg., Detroit 26
Dodenhoff, Chas. F. 791 E. Grand Blvd., Detroit 7
Dodrill, F. D. 641 David Whitney Bldg., Detroit
Doering, Wendell R.....968 Fisher Bldg., Detroit 2
Doerr, Louis E., Jr. 16401 Grand River, Detroit 27
Dolgoff, Sidney 7301 Schaefer, Dearborn
Dolega, Stanley F. 12870 E. Jefferson, Detroit 14
Domzalski, Casimer A. 5361 McDougall, Detroit 11
Donald, Douglas 7815 E. Jefferson, Detroit 7
Dondanville, Joseph M. Henry Ford Hospital, Detroit
Donovan, Daniel R., Jr. 8378 Grand River, Detroit 4
Donovan, Eugene T. 13365 Michigan, Dearborn
Donovan, Richard S. 968 Fisher Bldg., Detroit 2
Dorman, Jack 18245 Warrington Drive, Detroit
Dorsey, John M. 65 Moss St., Highland Park 3
Doty, Chester A. ..1735 David Whitney Bldg., Detroit 26
Doub, Howard P. Henry Ford Hospital, Detroit
Douglas, Clair L. 405 David Whitney Bldg., Detroit
Dovitz, Benj. W. 95 Martin Place, Detroit
Dowdle, Edward F.....2501 W. Grand Blvd., Detroit 8
Downer, Ira G. 8445 E. Jefferson Ave., Detroit
Downes, George O. 8007 Harper, Detroit 13
Doyle, George H. 5543 W. Warren, Detroit 10
Drake, Ellet H. Henry Ford Hospital, Detroit 2
Draves, Edward F. 19647 Joy Rd., Detroit 28
Drazek, Joseph A. 809 Kales Bldg., Detroit
Drews, Robert S. 12500 Broadstreet, Detroit 4
Drinkhaus, H. I. 14827 E. Jefferson, Detroit 15
Droock, Victor 10 Peterboro, Detroit 1
Dryer, Clyde K. 3152 Washington St., Wayne
Dubin, Joseph J. 10401 W. Chicago Blvd., Detroit 4
Dubnove, Aaron 2115 W. Grand Blvd., Detroit 8
DuBois, Paul W. 1708 Broderick Tower, Detroit 26
Dubpernell, Karl (E) 3525 28th St., Detroit 10
Dubpernell, Martin S. 4019 Gilbert, Detroit 10
Dubpernell, Robert O. 9125 Meyers Rd., Detroit 28
Dudek, J. J. 16401 Grand River, Detroit 27
Duncan, James R.....311 East Warren, Detroit
Dundas, Edward M. 4700 Schlaff, Dearborn
Dunlap, Henry A. 7815 E. Jefferson Ave., Detroit 14
Dunlap, Samson F.....9100 Oakland, Detroit
Dunn, Cornelius E. 11107 Mack Ave., Detroit
Durham, Everett W.....904 S. Military, Dearborn
Durocher, Edmund J. (L) 4158 W. Jefferson, Ecorse
Duwe, Frank A. 25296 Fenkell, Detroit
Dwaihy, Paul J.....14530 E. Warren, Detroit
Dwyer, Francis W.....7448 Linwood, Detroit
Dziuba, John F. 8559 W. Jefferson, Detroit 17

Eades, Charles C. 863 Fisher Bldg., Detroit 2
Eadie, G. A.....16083 Southampton, RFD 5, Plymouth
Eakins, Frederick J.
Vets. Administration Guardian Bldg., Dearborn
Easterly, Robert L. 9 Salliotte Rd., Ecorse
Eaton, Crosby D. 462 Fisher Bldg., Detroit 2
Eckhous, Arthur W.....1015 Kales Bldg., Detroit
Eder, Samuel J. 1116 Maccabees Bldg., Detroit 2
Edgar, Irving I. 712 Maccabees Bldg., Detroit 2
Edmonds, Gerald W. 44200 W. 10 Mile Rd., Northville
Edmonds, W. N. 10 Peterboro, Detroit 1
Edmondson, Robert B.....18501 Mack Ave., Detroit 24
Edwards, Gilbert Lloyd 1841 E. Davison, Detroit 3

Eisman, Clarence H. 1025 E. Forest Ave., Detroit
Eldredge, Edward F. 412 Kales Bldg., Detroit
Ellias, Elmer P. 4330 Fullerton, Detroit 6
Elliott, William G. 4101 Fenkell, Detroit 21
Elman, Meyer J. 14002 Woodward, Detroit
Elvidge, Robert J. 2900 W. Grand Blvd., Detroit
Emmert, Herman C. (L) 7303 Grandmont, Detroit 10
Engel, E. H. 114 Maple St., Wyandotte
English, Leo Victor, Jr. 4533 W. Warren, Detroit
Eno, Laurel S. 1001 David Whitney Bldg., Detroit 26
Ensign, Dwight C. Henry Ford Hospital, Detroit
Ensing, Osborn 758 Fisher Bldg., Detroit 2
Epperson, John W. W. 1512 St. Antoine, Detroit 26
Epstein, S. G. 6438 Van Dyke, Detroit 13
Erickson, Eldon W. 2900 S. Fort St., Detroit 26
Erkfitz, Arthur W. ..545 David Whitney Bldg., Detroit 26
Eschbach, Jos. W. 936 S. Military, Dearborn
Estabrook, Bert U. (L).....850 Virginia Park, Detroit 2
Ettinger, Clayton J. 18734 Woodward, Detroit 3
Evans, Joseph M.....10500 E. Warren Ave., Detroit
Evans, Leland S. 20953 Grand River, Redford 19
Evans, W. A., Jr. 552 Fisher Bldg., Detroit 2
Evison, Emerson O.
1003 Hawthorne Rd., Grosse Pointe Woods 30
Ewing, C. H. 16545 E. Warren, Detroit 24
Eyres, A. E. 1064 Fisher Bldg., Detroit

Fagin, Irving D. 1214 Maccabees Bldg., Detroit 2
Falick, Mordecai Louis, ...960 Fisher Bldg., Detroit
Falk, Ira E. 7925 W. Verner Highway, Detroit 9
Fallis, Lawrence S. Henry Ford Hospital, Detroit 2
Fandrich, Theodore S. ..1004 Maccabees Bldg., Detroit 2
Farbman, Simon S. 13300 Fenkell, Detroit 27
Farbman, Aaron A. 14515 Kercheval, Detroit 15
Fauman, D. H. ..3200 Boston Blvd., Apt. 201, Detroit 6
Faunce, Sherman P. 8300 Kercheval, Detroit 14
Felcyn, W. George 2091 West Grand Blvd., Detroit 8
Feldkamp, Lee E. 9545 Grand River, Detroit
Feldman, N. L. 17338 Woodingham, Detroit
Feldstein, Martin Z. 907 Kales Bldg., Detroit 26
Feicks, W. J. (M) 2960 Heather Pl., Harrisburg Penna.
Feld, David 520 Maccabees Bldg., Detroit
Feldman, Paul 19136 Indiana, Detroit
Fellers, Ray L. 6505 Grand River, Detroit 8
Fenton, Edwin H. 15125 Grand River Ave., Detroit 27
Fenech, Harold B. 324 Professional Bldg., Detroit
Fenton, Meryl M. 8830 W. McNichols Rd., Detroit
Fenton, Russell F., ..15125 Grand River Ave., Detroit 27
Fenton, Stanley C. 15310 E. Warren St., Detroit 24
Fenner, William G. 12454 E. Outer Drive, Detroit 24
Ferrera, Louis V. 13805 Parkgrove Ave., Detroit 5
Ferrara, Virginia M. 18422 Woodward Ave., Detroit 3
Ferris, G. N. 15400 Plymouth, Detroit
Fettig, Carl A. (E) 6154 W. Fort St., Detroit 9
Fill, Leon 1506 David Broderick Tower, Detroit
Finch, Alvis D.....17555 James Couzens, Detroit
Finch, F. Sinclair 21303 Gratiot, East Detroit
Fine, Edward 1112 Kales Bldg., Detroit 26
Finkelstein, M. B. 612 Kales Bldg., Detroit 26
Fischer, Frederick J. 474 Fisher Bldg., Detroit 2
Fisher, G. S. 1310 David Broderick Tower, Detroit 26
Fisher, James M. 79 Kercheval, Grosse Pointe
Fisher, O. O. 2475 Iroquois Ave., Detroit 14
Fisher, Ralph L. 8445 Jefferson, East, Detroit
Fitzgerald, James M. 2536 W. Grand Blvd., Detroit 8
Flaherty, H. J. 15865 Wyoming, Detroit 21
Flaherty, Norman W. 10573 W. Jefferson, River Rouge
Fleming, L. N. 6150 W. Fort St., Detroit 9
Flower, J. A. 14140 Puritan, Detroit 27
Flora, William Robert 8100 E. Jefferson, Detroit 14
Fogt, Herbert E. 7835 E. Forest, Detroit 13
Fogt, Robert G. 7835 E. Forest, Detroit 13
Folberg, Irving I.....9246 Grand River, Detroit 4
Foley, Hugh S. 22255 W. Michigan, Dearborn 23
Foley, Joseph M. ..1429 David Whitney Bldg., Detroit 26
Font, Anthony J.....710 Kales Bldg., Detroit
Foote, James A. 1336 Southfield Rd., Lincoln Park 25
Ford, George A. (L) 803 Stroh Bldg., Detroit 26
Ford, Sylvester 1010 Stroh Bldg., Detroit 26
Ford, Walter D. (E) 4866 Third Ave., Detroit 11
Fordell, F. S. 441 S. Oakwood, Lincoln Park 25
Forgrave, E. G. 14001 Greenfield, Detroit 21
Forsythe, John R. 19566 Grand River, Detroit 23
Foster, E. Bruce 853 Fisher Bldg., Detroit 2
Foster, Linus J. 10 Peterboro, Detroit 1
Foster, Owen C. ..1015 David Whitney Bldg., Detroit 26
Foster, Wallace M. 13700 Woodward Ave., Detroit 3
Foster, William L. 2567 W. Grand Blvd., Detroit 8
Fowler, Melvin E. 247 E. Warren, Detroit
Fox, Leonard 3152 Biddle St., Wyandotte
Fox, Morris Edward 10 Peterboro, Detroit 1
Fraiberg, Paul L. 13001 W. Chicago, Detroit 27
France, C. J. 3401 Burns Ave., Detroit 14
Franjac, M. J. 25447 Plymouth Rd., Detroit 28
Franklin, John T. W. 73 Orchester Place, Detroit
Franzen, Nils A. 19566 Grand River, Detroit 23
Frazer, Mary Margaret 812 Kales Bldg., Detroit 26
Frederickson, G. C. 3919 John R, Detroit
Free, Harry W. 952 Fisher Bldg., Detroit 2
Freedman, John..4853 Second Blvd. at Warren, Detroit 1
Freedman, Milton 18626 Santa Barbara St., Detroit 21
Freeman, D. K. 881 Chalmers, Detroit 15
Freeman, Mable 1316 Broderick Tower, Detroit 26
Freeman, Michael W. 1810 Wallesley Drive, Detroit 3
Freeman, Thelma 1055 Knox St., Birmingham
Freeman, Wilmer 940 E. Seven Mile Rd., Detroit 3
Freier, Morton L. 1503 Kales Bldg., Detroit 26
Fremont, J. C. 1202 David Whitney Bldg., Detroit 26
Freund, Hugo A. (L) 62 West Kirby Ave., Detroit 2
Frey, James L. 422 W. Golden Gate, Detroit
Freid, Samuel 16850 Joy Rd., Detroit
Friedlaender, Alex S. 905 Kales Bldg., Detroit 26
Friedlaender, Sidney 905 Kales Bldg., Detroit 26
Friedman, David 2429 E. Milwaukee Ave., Detroit 11
Friedman, I. H. 3773 2nd Ave., Detroit 1
Fritz, G. E. 912 Kales Bldg., Detroit 26
Frothingham, George E. (E)
707 David Whitney Bldg., Detroit
Fryfogle, James D. 655 Fisher Bldg., Detroit 2
Fulgenzi, Andrew A. 7445 Mack Ave., Detroit
Fuller, Hugh M. ..1257 David Whitney Bldg., Detroit 26
Fullenwider, Allan C. 22128 Grand River, Detroit 19
Fulton, Wm. J.....3-204 General Motors Bldg., Detroit 2

Gaber, Ben 12244 Dexter, Detroit
Gagliardi, Raymond 2900 South Fort, Detroit
Gaberman, D. B...908 David Broderick Tower, Detroit 26
Gaffney, J. Mitchell 13600 Ohio St., Detroit 6
Galantowicz, Henry C. 7433 Michigan, Detroit 10
Galdonyi, Laslo 1406 Broderick Tower, Detroit 26
Galdonyi, Nicholas.....8001 W. Jefferson, Detroit 17
Galerneau, D. B. 25005 Van Dyke, Center Line
Galvin, Paul P.....7416 Twelfth Street, Detroit
Gannan, Arthur M. 4515 Trumbull, Detroit 8
Ganschow, John H.....1840 Holbrook, Detroit 12
Gardner, Lawrence W...6071 W. Outer Drive, Dertoit 21
Gardner, Max L. 812 Kales Building, Detroit
Gariepy, Louis J.....16401 Grand River Ave., Detroit 27
Gass, H. Harvey.....815 Kales Building, Detroit
Gaston, Herbert B.....871 Fisher Bldg., Detroit 2
Gates, Nathaniel.....10 Peterboro, Detroit 1
Gaydos, Leonard M.....311 David Whitney Bldg., Detroit
Gaynor, Alex.....1326 E. Seven Mile Road, Detroit 3
Gehring, Harold W.....767 Fisher Bldg., Detroit 2
Geib, Ledru O.....3528 Van Dyke St., Detroit 14
Geitz, William A.....7234 E. Forest Avenue, Detroit 13
Gelbach, Philip D.....2900 S. Fort St., Detroit 25
Gellert, I. S. (L)..1229 David Whitney Bldg., Detroit 26
Gemeroy, J. C.....664 Fisher Bldg., Detroit 2
Gerisch, Robert A...1217 David Whitney Bldg., Detroit 26
Gerondale, Edmond J.....750 Fisher Bldg., Detroit 2
Gibson, Dunbar P.....8550 Oakland Avenue, Detroit 11
Giese, Douglas.....602 Doctors Building, Detroit
Giese, F. W.....18526 Schoolcraft, Detroit
Gigante, Nicola.....10 Peterboro, Detroit
Gigliotti, David.....Providence Hospital, Detroit
Gilbert, H. R.....13146 Phelps, Wyandotte
Gillespie, Stephen M.....1011 Haigh St., Dearborn

Gillman, R. W. (E).....61 Peterboro, Detroit 1
Gilpin, W. A....4560 Niagara Lane, Route 1, Birmingham
Ginsberg, Harold I.....1328 Maccabees Bldg., Detroit
Gitlin, Charles.....Marygrove Medical Service, Detroit
Gitlin, Julius R.....6502 Chene, Detroit
Gittins, Perry C.....732 Maccabees Bldg., Detroit 2
Glazer, Walter S.....60 W. Hancock, Detroit 1
Glassman, Samuel.....60 W. Hancock, Detroit 1
Glasgow, Gordon K.....575 Lodge Drive, Detroit 14
Gleason, John E. (L)..1061 D. Whitney Bldg., Detroit 26
Glees, John L.....11631 Mack, Detroit
Glemet, Raymond B. 3314 Bagley, Detroit 16
Glowacki, B. F.....1144 Maccabees Bldg., Detroit 2
Goerke, Elmer A.....3663 Goddard Road, Romulus
Goetz, Angus G.....710 David Whitney Bldg., Detroit 26
Goins, W. F.....6675 Tireman, Detroit 10
Goldberg, Arthur 340 E. 8 Mile Road, Detroit 3
Goldberg, Harry H.....514 Fox Theater Bldg., Detroit 1
Goldberg, Nathan H.....514 Fox Theater Bldg., Detroit 1
Goldin, M. I.....632 Maccabees Bldg., Detroit 2
Goldman, Abe A.....1013 Kales Building, Detroit
Goldman, Aubrey.....909 Kales Bldg., Detroit 26
Goldman, Perry.....1318 Maccabees Bldg., Detroit 2
Goldstein, Abe S.....2260 LaSalle Gardens, Detroit
Goldstone, R. R.....10 Peterboro, Detroit 1
Gollman, Maurice D.....918 Maccabees Bldg., Detroit 2
Gonne, William S.....619 David Whitney Bldg., Detroit 26
Goodman, H. L.....1512 St. Antoine, Detroit 26
Goodrich, Benjamin E.....Henry Ford Hospital, Detroit
Gordon, John W. (R).....12700 Mendota, Detroit
Gordon, W. E., Jr.....14820 Rosemont, Detroit
Gordon, William H...1102 Dav. Whitney Bldg., Detroit 26
Gore, Ira.....Henry Ford Hospital, Detroit
Gorelick, Martin J.....23901 Michigan Ave., Dearborn
Gorning, Raymond P.....857 Marlborough, Detroit 15
Goryl, Stephen V.....9953 E. Forest, Detroit 13
Gostine, Edmond..9758 Chalmer Ave. at Longv'w, Detroit
Gottschalk, Fred W.....1314 Maccabees Bldg., Detroit 2
Goudie, F. D.....18900 Sorrento Avenue, Detroit
Gould, S. Emanuel.....Eloise Hospital, Eloise
Gourley, E. V.....16901 James Couzens, Detroit
Goux, Raymond S...545 David Whitney Bldg., Detroit 26
Grace, Joseph M.....17505 Parkside, Detroit
Graff, J. M.....7305 Joseph Campau, Detroit 11
Graham, John G., Jr.....7815 E. Jefferson, Detroit 14
Grain, Gerald O.....Henry Ford Hospital, Detroit 2
Grajewski, Leo E.....2201 E. Jefferson Ave., Detroit 7
Gramley, William.....13328 E. Jefferson Ave., Detroit 15
Granger, Francis L.....14160 Gratiot Ave., Detroit 5
Granger, G. R.....2243 Iroquois Avenue, Detroit 14
Grant, Abraham H.....18024 Sorrento, Detroit
Grant, Heman E. (L).....Lewiston
Gratton, Henri L.....1301 Kales Bldg., Detroit 26
Gravelle, Lawrence J...1036 D. Whitney Bldg., Detroit 26
Gray, Jacques Pierce.....1415 Parker, Detroit 14
Greenlee, William Tate.....15053 Maddelein, Detroit 5
Grifenstein, F. E.....1512 St. Antoine, Detroit 26
Greek, Louis M.....12901 Gratiot, Detroit 5
Green, Ellis R.....5172 Scotten Ave., Detroit 10
Green, Lewis.....13000 Grand River, Detroit 27
Green, Louis M.....14636 E. Seven Mile Road, Detroit 5
Green, Nelson W.....15819 Wyoming, Detroit 21
Green, Simpson W.....
2631 Woodward Ave., Suite 202, Detroit, 1
Greenberg, Jack R.....15743 W. 7 Mile Road, Detroit 19
Greenberg, Julius J...1211 Dav. Brod. Tower, Detroit, 26
Greenberg, M. Z.....9105 Van Dyke, Detroit
Greene, John B.....2730 Hastings St., Detroit 1
Greenidge, Robert I.....4839 Beaubien St., Detroit 1
Greenslit, Frank S.....310 E. Jefferson St., Detroit 26
Greifenstein, Ferdinand E.....1512 St. Antoine, Detroit
Greiner, Bert A.....13739 Gratiot, Detroit 5
Grekin, John N.....7441 W. 7 Mile Road, Detroit 21
Griffiths, Sidney 15400 Plymouth Road, Detroit 27
Griffith, Arthur J.....14049 Warwick Rd., Detroit
Grimaldi, G. J.....2983 Seminole, Detroit
Grinstein, Alexander..18700 Woodingham Dr., Detroit 21
Grob, Otto.....651 Fisher Bldg., Detroit 2
Gross, Louis.....18937 Van Dyke, Detroit
Grossman, Sol.....538 Maccabees Bldg., Detroit 2
Grotz, Genevieve A.....Wayne Co. Health Dept., Eloise
Gudes, David S.....1080 Fisher Bldg., Detroit
Guerrero, Jose.....13535 Woodward, Detroit
Guimaraes, A. S.....7301 Shaefer Highway, Dearborn
Guinam, G. E.....35551 Ford Road, Wayne
Gulick, Arthur E...1429 David Whitney Bldg., Detroit 26
Gurdjian, E. S.....840 David Whitney Bldg., Detroit 26
Curskis, Eugenia.....504 Kales Bldg., Detroit
Gutov, Benj. R.....602 Maccabees Bldg., Detroit
Gutterman, Meyer A.....1007 Kales Bldg., Detroit 26

Haefele, Leslie P.....29108 Ford Road, Garden City
Haitinger, Kalmon S.....7850 E. Jefferson, Detroit
Haking, Leonard.....9661 Gratiot, Detroit 13
Hale, Arthur S.....1501 David Whitney Bldg., Detroit
Hall, E. Walter.....10 Peterboro, Detroit 1
Hall, James A. J.....28 W. Adams Street, Detroit 26
Hall, Ralph E.....10 Peterboro, Detroit 1
Hall, Robert J.....6014 W. Fort St., Detroit 9
Hall, Winthrop D.....3000 Schaefer Road, Dearborn
Hallen, Leonard J.....14001 Greenfield, Detroit
H'Amada, Norman K.....904 Maccabees Bldg., Detroit 2
Hamburger, A. C...1512 Dav. Broderick Tow., Detroit 21
Hamil, Brenton M.....Henry Ford Hospital, Detroit
Hamilton, Norman C.....14555 Wyoming, Detroit 21
Hamilton, W. F. (L).....
58 W. Adams Ave., Suite 310, Detroit 26
Hamilton, William 13836 Woodward Ave., Detroit 3
Hammer, Edwin J.....16616 Mack, Detroit 24
Hammer, Roy W.....16620 E. Warren, Detroit
Hammond, Arthur E...1863 Dav. Whit. Bldg., Detroit 26
Hammond, J. L.....25520 Goddard Road, Taylor Center
Hand, Fordus V.....81 East Kirby, Detroit 2
Hank, E. J. (M).....3237 Ave. "F", Council Bluffs, Iowa
Hansen, Frederick E.....16854 Baylis, Detroit
Hanser, Joshua (L).....2730 E. Jefferson, Detroit
Hardstaff, R. John.....1201 Stroh Building, Detroit 26
Harelik, E. W.....614 Maccabees Bldg., Detroit
Harkaway, Roman W.....19125 Van Dyke, Detroit 34
Harley, Garth H.....834 N. York, Dearborn
Harley, Louis M.....660 Maccabees Bldg., Detroit 2
Harm, Winfred B.....5884 West Vernor Hwy., Detroit 9
Harper, Jesse T.....1248 David Whitney Bldg., Detroit 26
Harrington, Frank L.....8935 Fenkell, Detroit 21
Harris, Harold H.....8011 W. Vernor Highway, Detroit
Harris, Ivor David..1536 Dav. Whitney Bldg., Detroit 26
Harrison, Wesley, Jr.....4847 Iroquois, Detroit 13
Harrison, W. L., Cap. (M).....
5th General Hospital, APO 36, New York, N. Y.
Hart, Charles E.....9341 Moffat Ave., Detroit
Hart, John Clarence.....9341 Moffat, Detroit
Hartkop, H. H.....18332 Woodward Ave., Detroit
Hartman, F. W.....Henry Ford Hospital, Detroit 2
Hartquist, Capt. R. J. (M).....Armed Forces, Ex Station
4 NW Washington St., Spokane, Wash.
Hartzell, John B.....7815 Jefferson Ave. East, Detroit 14
Hasley, Clyde K.....1429 David Whitney Bldg., Detroit 26
Hasley, Daniel E.....1516 St. Antoine Street, Detroit 26
Hassig, W. W.....3631 McClellan, Detroit
Hastings, Orville J.....15132 Harper, Detroit 26
Hathaway, Hubert R.....Ford Motor Co., Dearborn
Hause, Glen E.....16401 Grand River, Detroit 27
Hauser, I. Jerome.....7411 Third Avenue, Detroit 2
Hauser, John E.....671 Fisher Bldg., Detroit 2
Hauser, Maurice J.....7411 Third Avenue, Detroit
Havers, Howard.....1032 Maccabees Bldg., Detroit 2
Hawkins, James W.....8527 Quincy Ave., Detroit 6
Heath, Leonard P...1457 David Whitney Bldg., Detroit 26
Heavner, Lyle E.....119 Kercheval, Detroit
Hecht, Manes S.....773 Fisher Bldg., Detroit 2
Hedges, Frank W.....10363 Greensboro, Detroit 14
Heenan, Theophilus H.....
1409 David Whitney Bldg., Detroit 26
Heideman, Louis E.....12244 Dexter Blvd., Detroit
Heldt, Thomas J.....Henry Ford Hospital, Detroit 2
Hellems, Harper Kieth....Wayne University Col. of Med.
1512 St. Antoine, Detroit

Hendelman, Manuel H.....14350 Harper, Detroit 13
Henderson, Allison B.....5320 John R, Detroit 2
Henderson, Arthur B.....10452 Mack, Detroit
Henderson, Charles W.....853 Fisher Building, Detroit
Henderson, Harold.....852 Fisher Bldg., Detroit 2
Henderson, Hugh W.....308 Professional Building, Detroit
Henderson, J. L.....11339 St. Aubin Avenue, Detroit 12
Henderson, John C.....3919 John R, Detroit
Henderson, Leslie T.....13038 E. Jefferson, Detroit 15
Henderson, William E.....5349 VanDyke Ave., Detroit 13
Henrich, Lawrence E.....2501 W. Grand Blvd., Detroit 8
Herbst, Harold B.....17300 Schaefer Road, Detroit 21
Herkimer, Dan R.....1802 Buckingham, Lincoln Park 25
Herrold, Rose E.....1277 E. Grand Blvd., Detroit 11
Herschelmann, Roy F.....
3343 Gratiot Ave. at Mack, Detroit 7
Herwick, John T.....Henry Ford Hospital, Detroit 2
Hess, Murray W.
13732 Woodward Avenue, Highland Park 3
Hesslschwerdt, D. W.....3919 John R, Detroit 1
Hertzler, Jack H.....307 David Whitney Bldg., Detroit
Hewitt, Leland V.....917 David Whitney Bldg., Detroit 26
Hewitt, Robert S.....2255 Fort Street, Lincoln Park
Heyner, Stanley A.....3424 Oakman Blvd., Detroit 4
Hickey, Joseph.....6004 W. Fort St., Detroit 9
Hicks, Fred G.....7301 Schaefer Road, Dearborn
Higbee, Arthur L.....429 E. Grand Blvd., Detroit 7
Hileman, S. Lee.....4043 W. Jefferson, Ecorse
Hill, E. J., Jr.....1515 David Whitney Bldg., Detroit
Hill, Gerald.....752 Book Building, Detroit
Hill, Welford T.....2405 Joseph Campau, Detroit
Hillenberg, Sidney J.....20215 W. Seven Mile Rd., Detroit
Hillenbrand, Alfred E.....14321 Kercheval, Detroit 15
Hiller, Glenn I.....13700 Woodward Avenue, Detroit 3
Hillier, Leland G.....13544 Woodward, Detroit
Hilton, William E.....13902 Mack, Detroit 15
Hinko, E. N.....434 S. Wayne Road, Wayne
Hiratzka, Tomiharu 1512 St. Antoine, Detroit
Hirschfield, A. H.....829 Fisher Building, Detroit
Hirschman, L. J. (E)....2619 Munson Ave., Traverse City
Hoagland, Thomas V.....81 E. Kirby, Detroit
Hochman, Morton M...16633 Plymouth Road, Detroit 27
Hodges, Jason.....
1200 S. Oxford Road, Grosse Pointe Woods 30
Hodgkinson, C. P.....Henry Ford Hospital, Detroit
Hoffman, E. S.....766 Fisher Bldg., Detroit 2
Hoffman, Edward A.....10125 Tireman, Dearborn
Hoffman, Harry Y...15085 E. Seven Mile Rd., Detroit 13
Hoffman, Henry A.....10015 E. Outer Drive, Detroit
Hoffman, Harry Y.....15085 E. Seven Mile Rd., Detroit 5
Hoffman, Martin H...1311 Dav. Whitney Bldg., Detroit 2
Holcomb, August A.....117 W. Wing St., Northville
Holcomb, Clayton E.....22203 Grand River, Detroit 19
Holdredge, Jean M.....2514 Biddle, Wyandotte
Hollander, A. J.....8026 Michigan Ave., Detroit 10
Hollis, Henry B.....7439 W. Warren, Detroit 10
Holman, Herbert H.....
2010 David Broderick Tower, Detroit 26
Holmes, Alfred W.....8802 Michigan, Detroit 10
Honhart, Fred L.....3240 Gratiot, Detroit 7
Honor, William H. (L) 2966 Biddle, Wyandotte
Hookey, John A.....2918 Biddle, Wyandotte
Hooper, Norman L.....6 Port Drive, Detroit
Hoops, George B. (E).....754 Fisher Bldg., Detroit
Hopkins, J. E.....6381 W. Fort St., Detroit 9
Horkins, Harold A.....893 Lakewood, Detroit
Horny, Hugo O.....11600 Whittier, Detroit 24
Horton, Reece H.....938 David Whitney Bldg., Detroit 26
Horvath, Louis O.....9122 W. Fort St., Detroit 9
Horwitz, John B.....
1208 David Broderick Tower, Detroit 26
Hotchkiss, Loris M.....33220 W. 7 Mile Road, Farmington
Howard, Austin Z...825 David Whitney Bldg., Detroit 26
Howard, Philip J.....Henry Ford Hospital, Detroit 2
Howard, W. L.....Maybury San., Northville
Howell, Bert F.....10800 Whittier, Detroit 24
Howell, James T.....Henry Ford Hospital, Detroit 2
Howes, Homer A.....1515 David Whitney Bldg., Detroit
Howes, Willard Boyden.... 1800 Tuxedo, Detroit 6
Howlett, Howard T.....868 Fisher Bldg., Detroit 2
Hromadko, Louis.....1075 Fisher Bldg., Detroit 26
Hubbard, John P.....1130 E. Grand River, Detroit 7
Hubbard, Ralph G.....14800 Prevost, Detroit 27
Hudson, J. Stewart.....
17443 E. Jefferson Ave., Grosse Pointe
Hudson, William A...602 David Whitney Bldg., Detroit 26
Huegli, Wilfred A.....16840 E. Warren, Detroit 24
Hull, LeRoy W.....1701 David Whitney Bldg., Detroit 26
Hulme, A. W., Lt. jg, U.S.N.R. (M).....2nd Med. Bat.,
2nd Marine Division, Lejeune, N. C.
Huminski, T. S.....19244 VanDyke, Detroit 34
Hummel, Arthur R.....8045 E. Jefferson, Detroit
Hunt, T. H.....19431 Van Dyke, Detroit 12
Hunt, Verne G.....723 David Whitney Bldg., Detroit 26
Hunter, Basil H.....13341 Livernois, Detroit
Hunter, Elmer N.....7615 W. Vernor Highway, Detroit 9
Husband, Chas. W.....3810 Northwestern Ave., Detroit 6
Husband, R. C.....3810 Northwestern, Detroit 6
Hyatt, Jarvis M.....22340 Michigan, Dearborn
Hyde, Frederick W...6104 W. Vernor Highway, Detroit 9
Hyde, Frederick W., Jr.....Grace Hospital, Detroit 1
Hyland, John R.....13030 Mack Ave., Detroit 15
Hyman, Samuel J.....27342 Michigan Avenue, Inkster

Iacobell, Peter H.....19300 Van Dyke, Detroit 34
Igna, Eli J.....1109 Kales Building, Detroit
Ignatius, A. A.....1915 E. 9 Mile Road, Ferndale
Irvin, Earle Albert....1341 Buckingham Road, Detroit 30
Irwin, William A.....Providence Hospital, Detroit 8
Isaacson, Arthur.....2921 E. Davison Ave., Detroit 12
Iseri, Lloyd T.....Wayne University, Detroit
Israel, Barney B.....1424 Maccabees Bldg., Detroit
Israel, Joseph G.....870 Maccabees Bldg., Detroit 21
Iwata, Herbert T. (M).....7611 Patton Ave., Detroit 28

Jacobson, Samuel D.....2435 Oakman Blvd., Detroit 4
Jaeger, Grove A.....1802 E. Grand Blvd., Detroit 11
Jaekel, C. N.....1086 E. Grand Blvd., Detroit 7
Jaffar, Donald J.....734 Maccabees Bldg., Detroit 2
Jaffe, J. L.....7465 Harper, Detroit 13
Jaffe, Jacob.....501 Fox Theater Bldg., Detroit 1
Jaffe, Louis.....1605 David Broderick Tower, Detroit 26
Jahsman, William E.....Henry Ford Hospital, Detroit 2
Jamieson, Thomas J.....1310 Warwick, Lincoln Park
Janicki, Natalia J.....Wayne Co. General Hospital, Eloise
Jarre, Hans A.....Grace Hospital, Detroit
Jarvis, Harold F. 14110 Gratiot Avenue, Detroit
Jarsen, Frank J.....817 Beechmont, Dearborn
Jaynes, Richard V.....25296 Fenkell, Detroit
Jeffries, Benjamin.....1753 Guardian Bldg., Detroit 26
Jasion, Lawrence J. 16853 Harper, Detroit 24
Jend, W. J. (L).....3598 Mitchell, Detroit 7
Jenkins, Elwood A. 514 Kales Bldg., Detroit
Jennings, Charles G. 7815 E. Jefferson, Detroit 14
Jennings, Elmer R. Alexander Blain Hospital, Detroit
Jentgen, Chas. J.....22101 Moross Rd., Detroit 8
Jentgen, L. G. 7338 Woodward, Detroit 2
Jeremias, Robert C. 1330 Livernois, Detroit 4
Jewell, F. C.....7220 Gratiot Avenue, Detroit 13
Jocz, M. W. 945 Trombley Rd., Grosse Pointe Park
Jodar, E. O. 15760 Mack, Detroit 24
John, Hubert R. 650 Maccabees Bldg., Detroit 2
Johnson, Homer L. Henry Ford Hospital, Detroit 2
Johnson, Ralph A. 7815 E. Jefferson, Detroit 14
Johnson, Thomas D.....20526 Grand River, Detroit
Johnson, Vernon P. 10445 Kercheval, Detroit 14
Johnson, Vincent C. 10 Peterboro, Detroit
Johnson, W. H. M. 7159 Michigan, Detroit 10
Johnston, Charles G. 1512 St. Antoine, Detroit
Johnston, E. V. 3919 John R., Detroit
Johnston, John L. 1950 W. McNichols Rd., Detroit 3
Johnston, Joseph A. Henry Ford Hospital, Detroit
Johnston, William E. 1071 Fisher Bldg., Detroit 21
Johnstone, B. I. 555 Fisher Bldg., Detroit 2
Joinville, E. V. 1202 Stroh Bldg., Detroit 26

Jones, Adrian R.....15309 Mack Avenue, Detroit
Jones, Arthur J. (L) 5760 Burns Ave., Detroit 13
Jones, Edna M. Maybury Sanatorium, Northville
Jones, L. F. 1800 Tuxedo Ave., Detroit 6
Jones, Roy D.....15720 James Couzens Hwy., Detroit 21
Jones, W. J. 2514 Biddle, Wyandotte
Jordan, Prescott 1209 Kales Bldg., Detroit
Jordan, R. Gerald 7759 Harper Ave., Detroit 13
Joyce, Stanley J. 1078 Fisher Bldg., Detroit 2
Juliar, B. 1004 David Broderick Tower, Detroit 21
Jurow, Harry N. 771 Fisher Bldg., Detroit 2
Jury, Donald B. 18800 Woodward, Detroit 3

Kalayjian, Bernard S. Womans Hospital, Detroit 1
Kalder, Ned Block 6071 W. Outer Drive, Detroit 35
Kallet, Herbert I. 944 Maccabees Bldg., Detroit 2
Kallman, David 5725 Cass, Detroit 2
Kallman, Leo 5725 Cass, Detroit 2
Kallman, R. R.....2632 Woodward Ave., Rm. 202, Detroit
Kamin, Louis E. 4642 Second Blvd., Detroit
Kaminski, Zeno L. 3504 24th St., Detroit 8
Kamperman, George A. (L)
1807 David Whitney Bldg., Detroit 26
Kanter, Herman 13127 West 7 Mile Rd., Detroit 21
Kapetansky, N. J. 4790 W. Fort St., Detroit 9
Kapetansky, A. J. 1728 Clairmont, Detroit 6
Kaplita, Walter A. 5087 Caniff, Hamtramck 12
Karch, Saul 26114 W. Six Mile Rd., Detroit 6
Kasabach, Harry Y. 1067 Fisher Bldg., Detroit
Kasabach, V. Y. 523 Book Tower Bldg., Detroit 26
Kasper, Joseph A. Bon Secour Hosp., Grosse Pointe 30
Kaspor, Albert J. 16715 Harper Ave., Detroit
Kass, Arnold 1316 David Stott Bldg., Detroit
Katzman, I. S. 412 Fox Theater Bldg., Detroit 1
Kaufman, Jack M. 1113 David Whitney Bldg., Detroit
Kaump, Donald H. Providence Hospital, Detroit 8
Kauppinen, J. A.....15400 Plymouth Rd., Detroit
Kawecki, Lucian 10734 Hart Ave., Huntington Woods
Kay, Edward W.....12004 Joseph Campau, Hamtramck
Kazdan, Louis L. 1027 David Stott Bldg., Detroit 26
Kazdan, Morris.....4619 Allen, Allen Park
Keane, William E. (L)
1737 David Whitney Bldg., Detroit 26
Keating, Thomas F.....20936 Grand River Ave., Detroit
Kehoe, Henry J. 15252 Gratiot, Detroit 5
Keim, H. L. 1110 David Broderick Tower, Detroit 26
Keith, Kelly 106 West Davison, Detroit 3
Kelley, Frank James 3919 John R. St., Detroit
Kelmenson, Victor A. 7356 12th St., Detroit 6
Kelson, Malcolm J. 119 Kercheval, Detroit
Kelly, Edward W. 156 Harmon, Detroit 2
Kemler, Walter J. 4045 W. Jefferson, Ecorse 18
Kennary, James M. 4900 Cadieux Rd., Detroit
Kennedy, Chas. S. 10 Peterboro, Detroit 1
Kennedy, Donald J. 1220 Livernois, Detroit
Kennedy, R. B...2108 David Broderick Tower, Detroit 26
Kennedy, William Y. 10 Peterboro, Detroit 1
Kenning, John C. (A)
526 N. Crescent Dr., Beverly Hills, Calif.
Kennison, Warren S. 1103 Kales Bldg., Detroit
Kernkamp, Ralph F. 1204 Broderick Tower, Detroit
Kernick, M. O. 13700 Woodward Ave., Detroit
Kersten, Werner 3100 Gratiot, Detroit 7
Kerzman, Joseph H. 850 Maccabees Bldg., Detroit 21
Keshishian, Sarkis K. 13544 Woodward Ave., Detroit 3
Keyes, Eugene Charles 4840 Maple St., Dearborn
Keyes, John W. Henry Ford Hospital, Detroit
Kibzey, Ambrose T. 4651 Braden, Detroit
Killins, C. G.
Detroit Med. Hosp., 7850 E. Jefferson Ave., Detroit 14
Kimberlin, Kenneth K. 16101 Harper, Detroit 24
King, Edward D. 5455 W. Vernor Hwy., Detroit 9
King, Melbourne J. 5455 W. Vernor Hwy., Detroit 9
Kingsley, J. W., Jr. 2201 E. Jefferson, Detroit 7
Kingswood, Roy C. 90 E. Warren Ave., Detroit 1
Kinsley, George 909 Kales Bldg., Detroit
Kitzmiller, John L. 15819 Wyoming Ave., Detroit 21
Klebba, Paul A. 161 Grixdale, Detroit 31
Klein, Alfred A.....13000 Grand River Ave., Detroit 27
Klein, Howard A.....1838 David Whitney Bldg., Detroit
Klein, Jacob E. 987 E. Jefferson, Detroit 7
Klein, Sander P. 1312 David Broderick Tower, Detroit
Klein, William 2288 Webb, Detroit
Kleinman, Shmarya.....2909 W. Grand Blvd., Detroit
Kliger, David 7756 Southfield, Detroit 10
Klosowski, Joseph 8222 E. Outer Drive, Detroit
Knaggs, Charles W. (L) 12244 Gratiot, Detroit 5
Knaggs, Earl J. 3164 Biddle, Wyandotte
Knapp, Floyd B. 16565 Birwood, Detroit 21
Knapp, W. L. (M) 2331 Biddle Ave., Wyandotte
Knapp, Byron S. 10909 W. Jefferson, River Rouge 18
Knobloch, Edmund J. 5933 Chene, Detroit 11
Knoch, Hubert S. 14149 E. Jefferson, Detroit 15
Knox, Ross M.....9 Saliote, Ecorse
Knutsen, Arne.....2101 Court St., Sioux City, Iowa
Koebel, R. H. 14504 Mack Ave., Detroit 24
Koerber, Edward J. 4876 Lakeview Ave., Detroit 13
Kogut, C. S. 10627 Puritan, Detroit
Kokowicz, Raymond J. ..1056 Maccabees Bldg., Detroit 2
Kolasa, W. B. 1910 E. Grand Blvd., Detroit 11
Kopel, Joseph O. 10 Peterboro, Detroit 11
Koren, Louis 1214 Griswold St., Rm. 610, Detroit 26
Korum, Lyle W. 18585 E. Warren, Detroit
Koschnitzke, Herman K. 2900 S. Fort, Detroit
Kossayda, Adam W. 5605 Michigan Ave., Detroit 10
Koster, Koert 1001 Merton Rd., Detroit 3
Kovach, Emery P. 14149 E. Jefferson, Detroit 15
Kovan, Dennis D.....16965 Hamilton, Highland Park
Koven, Abraham.....10 Peterboro, Detroit
Kozlinski, Anthony E. 5359 Chene, Detroit 11
Kozlow, Louise E. Ange.....863 Fisher Bldg., Detroit 2
Kraft, Raymond B. 9300 Mack Ave., Detroit 14
Kraft, Ruth M. 972 Fisher Bldg., Detroit 2
Krass, Edward W. 11088 Gratiot Ave., Detroit 5
Kraus, John J. 16840 E. Warren, Detroit
Krebs, William T. 16419 E. Warren, Detroit 24
Kreinbring, George E. 4229 Mt. Elliott, Detroit 14
Kretzschmar, John C. 535 E. Grand Blvd., Detroit 7
Krieg, Earl G. M...1842 David Whitney Bldg., Detroit 26
Kritchman, M. J. 2314 David Brod. Tower, Detroit 26
Krieger, Harley L. 11390 Strathmore, Detroit 27
Kroha, Lawrence A. 15124 Kercheval, Detroit 30
Krohn, Albert H. 5137 Second Ave., Detroit 2
Kruidenier, Bastian 9964 Gratiot Ave., Detroit
Krynicki, Francis X. 1044 Maccabees Bldg., Detroit 2
Kubanek, Joseph L. 23134 Myrtle St., Dearborn
Kucmierz, Francis S. ..12181 Joseph Campau, Detroit 12
Kuhn, Albert Arthur 90 E. Warren, Detroit 1
Kuhn, Richard F. 1700 Junction, Detroit 9
Kulaski, Chester H. 9309 Jos. Campau, Detroit 12
Kullman, Harold J. F...Veterans Admin. Hosp., Dearborn
Kurtz, H. C. ..833 Barrington Rd., Grosse Pointe Park 30
Kurcz, Joseph A. 7433 Michigan, Detroit 10
Kurtz, I. J. 503 Fox Theatre Bldg., Detroit 1
Kurtz, Leonard D. 2208 Broderick Tower, Detroit
Kutsche, John D. 2057 W. Jefferson, Trenton
Kwasiborski, Stanley A. 2300 Oak St., Wyandotte
Kyprie, H. M. 414 Kales Bldg., Detroit

LaBerge, James M. 114 Maple St., Wyandotte
LaBine, Alfred C. 8-259 General Motors Bldg., Detroit
La Ferte, A. D. 1401 David Whitney Bldg., Detroit 26
LaHood, M. J. 17555 James Couzens, Detroit 35
Lake, R. C. 10700 Balbour Rd., Detroit 24
Lakoff, Charles 5057 Woodward, Detroit 2
Lam, Conrad R. Henry Ford Hospital, Detroit 2
Lamberson, Frank A. 19001 Grand River, Detroit 23
Lammy, James V. 644 Maccabees Bldg., Detroit 2
Lampman, H. H. 675 Fisher Bldg., Detroit 2
Landers, Maurice B., Sr.
950 David Whitney Bldg., Detroit 26
Laning, G. M. 1217 David Whitney Bldg., Detroit 26
Lang, E. F. Harper Hospital, Detroit
Lang, Leonard W. 17400 Schaefer, Detroit 21
Langdon, Edward Henry Ford Hospital, Detroit 2
Lange, Anthony H. 364 E. Grand Blvd., Detroit 7

Lange, William A. 3919 John R, Detroit
Lansky, Mandell 14427 Mack Ave., Detroit
Lapham, Fred E. 12583 Livernois, Detroit 4
Large, A. M. 10 Peterboro, Room 210, Detroit
Larned, Richard I. 14182 Gratiot, Detroit
Larsson, Bror. H. (L)
Doctors Bldg., Suite 401, 3919 John R St., Detroit
Lasichak, Andrew G. 908 Kales Bldg., Detroit
Lasley, James William ..1026 Maccabees Bldg., Detroit 2
Lathrop, Philip L. 415 Book Bldg., Detroit 26
Laupee, E. H. 1650 David Whitney Bldg., Detroit 26
Lauppe, F. A. 1801 David Whitney Bldg., Detroit 26
Latteier, Karl K. 10 Peterboro, Detroit 1
Laurisin, Eugene 5290 W. Chicago, Detroit
Lawson, John W. 18456 Grand River Ave., Detroit 23
Lazar, Morton R. 3008 David Stott Bldg., Detroit 26
Leach, David 865 Fisher Bldg., Detroit 2
Leacock, R. C. 10619 E. Jefferson, Detroit
Leader, L. R. 1129 David Whitney Bldg., Detroit 26
Leaver, L. Ross 757 Lakewood, Detroit 15
Lebamoff, Alexander T. 6586 Allen, Allen Park
Leckie, G. C. 1355 David Whitney Bldg., Detroit 26
Lecklider, A. F.
Fisher Body Division, Piquette and St. Antoine, Detroit
Lee, Harry E. 9247 Mack Ave., Detroit 14
LeGallee, G. M. 18520 W. Seven Mile Rd., Detroit 27
Leibinger, Henry R. 511 Barrington Rd., Grosse Pointe
Leipsitz, Louis S. 3566 Cass, Detroit 1
Leiser, Rudolf Wayne Co. General Hospital, Eloise
Leiter, Forrest C. 22375 W. Garrison, Dearborn
Leithauser, D. J. 14540 E. Warren, Detroit
Leland, Sol 6563 Grand River, Detroit 8
Lemley, Clark F.....553 Fisher Bldg., Detroit 2
Lemmer, J. A., Jr.....9300 Mack Ave., Detroit
Lemmon, C. E. 1337 David Whitney Bldg., Detroit 26
Lemmon, C. W. 10537 W. Jefferson, River Rouge 18
Lemon, Bruce K. 716 Kales Bldg., Detroit 26
Lentine, James J. 3485 Audubon, Detroit
Lenz, Willard R. 418 Moran Rd., Grosse Pointe 30
Lepard, C. W. 1025 David Whitney Bldg., Detroit 26
Lepley, Fred O. 13302 Kercheval, Detroit 15
Lerman, S. E. 23700 Van Dyke, Van Dyke
L'Esperance, Simon P. (R)
1104 David Broderick Tower, Detroit 26
Leszynski, J. S.
517 Professional Bldg., Peterboro and Woodward, Detroit 1
Leucutia, Traian 10 Peterboro, Detroit
Levagood, Floyd B.....14056 Artesian, Detroit
Levant, Arthur B.....14828 E. Warren, Detroit
Levin, David M. 8819 Dexter Blvd., Detroit 6
Levin, Herbert G. 17300 Schaefer, Detroit
Levin, Michael M. 616 Maccabees Bldg., Detroit
Levin, Samuel J. 469 Fisher Bldg., Detroit 2
Levine, S. S. 8233 W. Chicago, Detroit
Levitt, Edward J. 840 Maccabees Bldg., Detroit 2
Levitt, Irving 19214 Santa Barbara, Detroit
Levitt, Nathan 607 Kales Bldg., Detroit
Levy, David B.....Harper Hospital, Detroit
Levy, Marvin B. 13906 Woodward, Detroit 3
Lewis, Charles T. 5050 Joy Rd., Detroit 4
Lewin, H. 2457 Woodward Ave., Suite 702, Detroit 1
Lewis, J. Hugh 2956 Biddle, Wyandotte
Lewis, L. A. 2730 E. Jefferson, Detroit 7
Lewis, Wilfred John 404 Professional Bldg., Detroit 1
Libbrecht, Robert V. 6540 Park, Allen Park
Lichtwardt, Harry E. 413 Professional Bldg., Detroit
Lichtwardt, Hartman A. 432 Hancock Ave., E., Detroit
Lichter, M. L. 2900 Oakwood, Melvindale 25
Liddicoat, A. G. 20125 Fenkell, Detroit 23
Lieberman, B. L.....19212 Woodward, Detroit 8
Lightbody, J. J. 501 David Whitney Bldg., Detroit 26
Lignell, R. W. 16259 James Couzens Hwy., Detroit
Lilly, Charles J. 2950 Puritan Ave., Detroit 21
Linkner, Leonard S.....738 Maccabees Bldg., Detroit 2
Linn, H. J.
Detroit Memorial Hospital, 1420 St. Antoine, Detroit
Linton, James R. Wayne Co. General Hospital, Eloise
Lipinski, Stanley L. 7540 Michigan Ave., Detroit 10
Lipkin, Ezra 5715 Michigan Ave., Detroit 10
Lipschutz, Louis S. 4741 Fullerton Ave., Detroit 4
Lipton, Raymond F. 10 Peterboro, Detroit 1
Little, James W.....2050 Beverly Rd., Berkley
Littlejohn, David....Wayne County Bd. of Health, Eloise
Litsky, Abraham D.....1183 E. Grand Blvd., Detroit 11
Lockwood, B. C. 723 David Whitney Bldg., Detroit 26
Lofstrom, James E. 1420 St. Antoine, Detroit 26
Loggins, James E. Henry Ford Hospital, Detroit 2
Long, Earle C. 2626 Rochester, Detroit 6
Long, John J. 12421 Monica, Detroit 4
Longo, Salvatore St. Mary's Hospital, Detroit
Longyear, Harold W. 706 Maccabees Bldg., Detroit 2
Loranger, C. B. 20825 Mack, Detroit
Lookanoff, V. A. 17145 Fairfield, Detroit
Loranger, Guy L. 250 Rayson St., Northville
Lorber, J. H. 16558 Northlawn Ave., Detroit 21
Lorentzen, Edwin H. 11702 Grand River, Detroit 4
Lovas, William S. 7702 W. Fort, Detroit
Love, W. Thomas 231 E. Warren, Detroit 1
Lowe, Adolf W. 3338 W. Davison, Detroit
Lowe, Townsend G.....9430 Oakland, Detroit 11
Lowrie, William L., Jr. Henry Ford Hospital, Detroit 2
Lowry, George L. 11601 E. Jefferson, Detroit 14
Lublin, Anna.....5926 Harvard, Detroit
Luce, Henry A. 629 David Whitney Bldg., Detroit 26
Lukas, John R. 7068 Michigan, Detroit 10
Lumpkin, John G., Jr. 243 East Warren, Detroit
Lutz, Earl F. 13-204 General Motors Bldg., Detroit 2
Lyford, John Henry Ford Hospital, Detroit 2
Lynch, John M. (M)
F. A. Surgeon (R) F. E. H. Unit, U. S. Public Health Service, Bethesda 14, Md.
Lynn, David H. 2900 S. Fort St., Detroit
Lynn, Harvey D. 2900 South Fort St., Detroit 25
Lyons, James H. 15651 Woodland Drive, Dearborn
Lyons, William Harrington ..1012 Kales Bldg., Detroit 26
Lytle, Robert P. 1069 Fisher Bldg., Detroit

Maben, Hayward C., Jr. 9342 Oakland, Detroit 11
Mabley, J. D. 1139 David Whitney Bldg., Detroit 26
MacArthur, Robert A. 95 Martin Place, Detroit 11
MacCracken, Frances L. 3752 Gladstone, Detroit 6
MacDougall, O. P. 13700 Woodward, Detroit
MacFarlane, H. W..1105 David Whitney Bldg., Detroit 26
MacGregor, William W.
1904 David Broderick Tower, Detroit 26
Mack, Harold C. 955 Fisher Bldg., Detroit 2
MacKenzie, Earle D. 81 E. Kirby, Detroit
MacKenzie, Edward P. 12801 E. Jefferson, Detroit 14
MacKenzie, F. M. ..641 David Whitney Bldg., Detroit 26
MacKenzie, John W. 289 Rivard Blvd., Grosse Point 30
Mackersie, W. G. 18205 Roselawn, Detroit 21
MacMillan, F. B.....920 David Whitney Bldg., Detroit 26
MacPherson, K. C. 8100 E. Jefferson, Detroit 2
MacQueen, M. D. ..1654 1st Nat. Bank Bldg., Detroit 26
Maczewski, John E. 9535 Jos. Campau, Detroit 12
Madsen, Martha E.....3245 E. Jefferson, Detroit
Magnell, Ralph C. 8825 Puritan, Detroit
Maguire, C. E. 536 David Whitney Bldg., Detroit 26
Mahoney, Hugh M. 214 David Whitney Bldg., Detroit
Maibauer, Frederick P. 2966 Biddle, Wyandotte
Maino, Linus J. 2501 W. Grand Blvd., Detroit 8
Maire, Edward D. 15224 E. Jefferson, Grosse Pointe
Mair, Harold U. 10 Peterboro, Detroit 1
Malachowski, B. T. 2501 W. Grand Blvd., Detroit 8
Malik, Edward A. 11302 Chalmers, Detroit 5
Malik, Nur M. 585 E. Grand Blvd., Detroit 7
Malina, Stephen 15126 Heyden, Detroit 19
Malone, Richard S.....8445 E. Jefferson, Detroit
Maloney, John A. 1338 Maccabees Bldg., Detroit 2
Maltzer, Joseph H. 14306 Gratiot Ave., Detroit
Mancuso, Vincent S. 962 E. Grand Blvd., Detroit 7
Mann, Andrew D.....16715 Harper, Detroit
Manning, Morey H. 824 E. State Fair, Detroit
Landa, Marshall 1760 St. Clair, St. Paul, Minn.

Marcotte, Oliver J.....2890 W. Grand Blvd., Detroit 2
Marcus, Daniel B. 1122 Maccabees Bldg., Detroit 2
Marinus, C. J. 303 David Whitney Bldg., Detroit 26
Mark, Jerome 903 Kales Bldg., Detroit 26
Markey, Alexander P. 13810 Michigan Ave., Dearborn
Markey, Frank R. 631 Selden, Detroit 1
Markoe, Rupert C. L. 4102 Brush St., Detroit 1
Marks, Ben 902 Industrial Bank Bldg., Detroit 26
Marks, Bert W.....20048 Mark Twain, Detroit 21
Marks, Morris H.....8233 W. Chicago Blvd., Detroit
Marsden, T. B. (R) 2460 Edison, Detroit
Marsh, Alton R. 1218 Maccabees Bldg., Detroit 2
Marshall, James R. 14528 E. Jefferson, Detroit 15
Martin, Elbert A. ..1151 David Whitney Bldg., Detroit 26
Martin, J. B., Jr. 449 E. Elizabeth, Detroit 1
Martin, L. R. 2000 Second Blvd., Detroit 26
Martin, Peter A. 17185 Muirland, Detroit 21
Martin, Richard D. (M)
A-19638, 2789 Base Medical Com., AMC, Brookley Air Base, Ala.
Martin, Wilbur, C. 7440 W. Jefferson, Detroit 17
Martinez, Pedro O. 1439 Bagley, Detroit 16
Martmer, Edgar E.
526 Prof. Bldg., Woodward at Peterboro, Detroit
Marwil, T. B. 16965 Hamilton, Highland Park
Mateer, John G. Henry Ford Hospital, Detroit 2
Mathes, Charles J.....24414 Farmington Rd., Farmington
Mattson, Theodore 3919 John R, Detroit
Mattman, P. E. (A) Receiving Hospital, Detroit 26
Maun, Mark E. 1551 David Whitney Bldg., Detroit
Maxwell, J. Harvey 2415 W. Grand Blvd., Detroit 2
May, Earl W. (A)
Star Route No. 1, East Grand Lake, Alpena
May, Frederick T.....608 Kales Bldg., Detroit 3
Mayer, E. V.....16525 Woodward Ave., Detroit 3
Mayer, Willard D. 510 Kales Bldg., Detroit 26
Maynard, F. M.....6525 Park, Allen Park
McAfee, F. W. 6828 Vinewood Ave., Detroit 8
McAlonan, William T. 10 Peterboro, Detroit 1
McAlpine, Gordon S. 658 Fisher Bldg., Detroit 2
McBroom, Russell E. 10 Peterboro, Detroit 1
McCadie, James 13700 Woodward, Detroit 3
McCain, French H. 970 Fisher Bldg., Detroit
McClellan, Robert J., II.....
906-8 Michigan Theatre Bldg., Detroit
McClellan, Robert J., Sr. (L)
906 Michigan Theatre Bldg., Detroit 26
McClelland, Rachel 461 Fisher Bldg., Detroit 2
McClendon, James J. 503 E. Warren Ave., Detroit 1
McClintock, J. J. 14255 Greenfield, Detroit 27
McClure, R. W. 1306 David Whitney Bldg., Detroit 26
McClure, William R. 954 Fisher Bldg., Detroit 2
McColl, Charles W. 2826 Biddle, Wyandotte
McColl, Clarke M. Henry Ford Hospital, Detroit 2
McColl, Kenneth M. 18520 E. Warren, Detroit 24
McCollum, E. B. 761 David Whitney Bldg., Detroit 14
McCord, Cary P.
University Hosp., 111 Maternity Bldg., Ann Arbor
McCormick, Colin C. 222 Shaefer Bldg., Dearborn
McCullough, Lester E.....
521 David Whitney Bldg., Detroit
McDonald, Angus L. 13856 Gratiot Ave., Detroit 5
McDonald, G. O. 20025 Ward, Detroit
McDonald, Peter W. 3005 First St., Wyandotte
McDougall, B. W..16190 James Couzens Hwy., Detroit 21
McDowell, D. B. Wayne Co. General Hospital, Eloise
McEvitt, W. G.....1713 David Whitney Bldg., Detroit 26
McFadyen, Hugh A.....10 Peterboro, Detroit 1
McGarvah, A. W. 7310 Grand River Ave., Detroit 4
McGillicuddy, Walter E. 511 Kales Bldg., Detroit 26
McGhee, Richard S. 20254 Northlawn, Detroit
McGlaughlin, Nicholas D. ..2312 Biddle Ave., Wyandotte
McGinnis, Daniel H. 1025 E. Forest, Detroit 7
McGough, Joseph M. 14202 Fenkel Ave., Detroit 2
McGraw, Arthur B. Henry Ford Hospital, Detroit 1
McGuire, M. Ruth 763 Fisher Bldg., Detroit 21
McIntyre, W. B. 1533 David Whitney Bldg., Detroit
McKean, G. T. 1515 David Whitney Bldg., Detroit 26
McKean, R. M. 1515 David Whitney Bldg., Detroit 26
McKeever, G. E. 15880 Greenlawn, Detroit
McKeever, Robert J. 16157 Indiana, Detroit
McKenna, Charles J. 1130 E. Grand Blvd., Detroit 11
McKinnon, John D. 106 W. Davison, Detroit 3
McKnight, Robert E.....
10030 W. McNichols Rd., Detroit 21
McLane, Harriet E. 4350 Oregon, Detroit 4
McLean, Don W. 1066 Fisher Bldg., Detroit 2
McLean, Harold G. 10 Peterboro, Detroit 1
McMorrow, Kathryn J.....16861 Wyoming, Detroit
McPherson, R. J. 12626 Meyers Rd., Detroit 27
McQuiggan, Mark R. 1050 Fisher Bldg., Detroit 2
McRae, Donald H. 275 W. Grand Blvd., Detroit 16
Meek, Stuart F.....13020 Kilbourne, Detroit
Mellen, Hyman S. 622 Maccabees Bldg., Detroit 2
Mendelssohn, R. J. 14427 Mack, Detroit 24
Merkel, Charles C. 85 Kercheval, Grosse Pointe 30
Merrill, William O. 958 Fisher Bldg., Detroit 2
Mersky, Charlotte I. 16209 Baylis, Detroit 21
Merritt, Earl G. 10 Peterboro, Detroit 1
Meinecke, H. A. 1912 David Brod. Tower, Detroit 26
Melnik, M. P. (A) 19479 Burlington Dr., Detroit 3
Menagh, Frank R. Henry Ford Hospital, Detroit 2
Metes, John S. 15252 Gratiot, Detroit 5
Peebles-Meyers, M. H. 5320 John R, Detroit 2
Meyers, M. P. 2204 David Broderick Tower, Detroit 2
Meyer, Ruben 938 Maccabees Bldg., Detroit 2
Meyers, Sidney 19635 Mack Ave., Detroit
Meyers, Solomon G. 1320 Maccabees Bldg., Detroit 2
Michael, Michael J. 703 Mutual Bldg., Detroit
Michels, Julius 9424 Mack Ave., Detroit 14
Mihay, Benjamin 13349 Michigan Ave., Dearborn
Miley, H. H. 8710 W. Davison, Detroit 4
Millard, Glenn E. 2900 W. Grand Blvd., Detroit 2
Miller, Daniel H. 8011 W. Vernor Hwy., Detroit 9
Miller, Elmer B. 10 Peterboro, Detroit 1
Miller, G. F. Saginaw General Hospital, Saginaw
Miller, Karl L.....1101 David Whitney Bldg., Detroit
Miller, Myron H. 8120 W. McNichols Rd., Detroit 21
Miller, M. M. 902 Balfour, Grosse Pointe 30
Miller, R. B. 1419 David Whitney Bldg., Detroit 26
Miller, T. H. 1305 David Whitney Bldg., Detroit 26
Miller, William Ernest 10 Peterboro, Detroit 1
Mills, C. C. 16190 James Couzens Hwy., Detroit 21
Mills, Georgia V. 1102 N. Maple, Royal Oak
Mintz, Edward I. 7401 Third Ave., Detroit 2
Mintz, Morris J. 16895 Livernois, Detroit 21
Miral, Solomon P. 4858 E. Davison, Detroit 12
Mishelevich, Sophie 3008 W. Grand Blvd., Detroit 2
Mitchell, Augustus W. 314 Visger Rd., River Rouge
Mitchell, C. Leslie Henry Ford Hospital, Detroit 2
Mitchell, D. P. 7713 Oakland, Detroit 11
Mitchell, Gertrude F. 650 W. Bethune, Detroit 2
Mosee, W. Jones.....5205 Hastings, Detroit
Muellenhagen, Walter J.....603 Boulevard Bldg., Detroit
Mitchell, Ralston S. 243 E. Warren, Detroit
Moehlig, Robert C. 964 Fisher Bldg., Detroit 2
Mogill, George 3150 Second Ave., Detroit 6
Moisides, V. P. 1205 Stroh Bldg., Detroit 26
Moll, Clarence D. 10 Peterboro, Detroit 1
Molnar, S. K. 4525 S. Telegraph, Dearborn
Molner, Joseph G. 334 Bates St., Detroit
Mond, E. 1812 David Broderick Tower, Detroit 26
Montante, Joseph R. 14103 Fenkel, Detroit
Monto, Raymond W. Henry Ford Hospital, Detroit 2
Monson, Robert C. 16404 E. Warren, Detroit 24
Montgomery, John C. 773 Fisher Bldg., Detroit 2
Mopper, Coleman..2901 Holbrook, Suite 302, Detroit 12
Morand, Louis J. ..641 David Whitney Bldg., Detroit 26
Morgan, D. N. 1807 David Whitney Bldg., Detroit 26
Moriarty, George J. 770 Fisher Bldg., Detroit 2
Morin, J. B. (L) 14416 Buch Rd., Detroit 23
Moritz, H. C. 1053 David Whitney Bldg., Detroit 26
Morley, Harold V. 205 Professional Bldg., Detroit 1
Morley, James A. 10520 Plymouth Ave., Detroit 4

Moroun, S. J. 8045 E. Jefferson, Detroit 14
Morris, Harold L. 1069 Fisher Bldg., Detroit 2
Morse, Plinn F. Harper Hospital, Detroit 1
Morton, David G. 16901 W. McNicholls, Detroit 19
Morton, John B. E. 90 E. Warren, Detroit 1
Mosen, Max M. 8015 Harper, Detroit 13
Moss, Ervin B. 1907 Pingree, Detroit 6
Moss, Nathan H. 2847 Trumbull, Detroit 16
Moss, Selma S. 469 Fisher Bldg., Detroit 2
Mossman, J. D. 1052 Maccabees Bldg., Detroit
Mott, Carlin P. 2395 W. Grand Blvd., Detroit 8
Moulton, C. W. (A) 731 S. Ott Rd., Columbia, S. C.
Munson, Henry T. E. 14344 E. Jefferson, Detroit
Murphy, D. J. 10 Peterboro, Detroit 1
Murphy, Eugene J. 18248 Joy Rd., Detroit 28
Murphy, John M. 710 David Whitney Bldg., Detroit
Murphy, Robert T. 113 Martin Place, Detroit 1
Murphy, Scipio G. 603 E. Forest, Detroit 1
Murphy, W. M. 10500 Warren East, Detroit 14
Murray, Thomas H. ..19345 West McNicholls, Detroit 19
Murray, William A. 11841 Ohio Ave., Detroit 4
Muske, Paul H. 5605 Michigan Ave., Detroit 10
Musselman, Merle M.
Wayne Co. Gen. Hospital, Dept. of Surgery, Eloise
Myers, D. W. 224 Professional Bldg., Detroit 1
Myers, Gordon B. 1512 St. Antoine, Detroit

Nagle, John W. 114 Maple, Wyandotte
Nahigan, Russell 8830 W. McNicholls Rd., Detroit 21
Nahoun, Antoine 2201 E. Jefferson, Detroit
Naud, Henry J. 18456 Grand River Ave., Detroit 23
Nawotka, Edward E. 4808 Tarnow, Detroit
Naylor, A. H. 10033 Tireman, Dearborn
Naylor, Archibald E. 10 Peterboro, Detroit 1
Neeb, Walter G. 16840 E. Warren, Detroit
Neill, Edwin J. 8045 E. Jefferson, Detroit 14
Nelson, Darwin M. 153 W. Grand Blvd., Detroit 16
Nelson, Harry M. 1067 Fisher Bldg., Detroit 2
Nelson, Victor E. 7345 Fenkell, Detroit
Newbarr, Arthur A. 1060 Fisher Bldg., Detroit 21
Newman, M. K. 16861 Wyoming Ave., Detroit
Nichamin, Samuel J. 672 Maccabees Bldg., Detroit 2
Nickels, Albert W. 471 Fisher Bldg., Detroit 2
Nickerson, I. Dean
604 Medical Arts Bldg., 13700 Woodward, Detroit
Nielsen, Aage E. 10 Peterboro, Detroit 1
Nigro, Norman D. 10 Peterboro, Detroit 1
Nill, John B. 6030 Grandy, Detroit 11
Nill, William F. 6030 Grandy, Detroit 11
Noble, William C. 4045 W. Jefferson, Ecorse 18
Nolan, Bernard E. 932 Maccabees Bldg., Detroit 2
Nolte, E. C. 3919 John R, Detroit
Nolting, Wilfred S. H. 15850 E. Warren, Detroit 24
Norconk, A. A. 859 Fisher Bldg., Detroit 2
Norcott, Edith Slipson....8909 E. Jefferson, Detroit 14
Norris, Edgar H. 607 Lakepointe, Grosse Pointe 30
Norton, A. B. 1076 Maccabees Bldg., Detroit
Norton, Charles S. (L) 3503 14th St., Detroit 8
Novy, R. L. 858 Fisher Bldg., Detroit 2
Nowicki, Joseph A. 3841 Junction, Detroit 10
Nunn, James W. 106 W. Davison, Detroit 3

O'Brien, E. J. 307 David Whitney Bldg., Detroit 26
O'Brien, G. M. 2501 West Grand Blvd., Detroit 8
O'Connor, Katheryn L.
14301 Grand River Ave., Detroit 27
O'Donnell, C. H. 10 Peterboro, Room 504, Detroit
O'Donnell, D. H. (E) 2501 W. Grand Blvd., Detroit
O'Donnell, D. H., Jr.....2501 W. Grand Blvd., Detroit
Oetting, E. M.....8045 E. Jefferson, Detroit 14
Ohmart, Galen B. 8721 E. Jefferson, Detroit 14
Ohrt, Harold F.....285 E. Grand Blvd., Detroit 7
Okun, Milton H. 3261 Sherbourne Rd., Detroit 21
Olechowski, Comdr. Leo. W. (M)
U.S.N. Naval Hospital, Oakland, Calif.
Olen, Alex 13100 Harper, Detroit 13
O'Linn, Francis P. 1055 Fisher Bldg., Detroit 2
Olmsted, George S. 1060 Fisher Bldg., Detroit 2
Olmsted, William R. (L)
219 Broadway Mkt. Bldg., Detroit 26
Olson, James A. Henry Ford Hospital, Detroit 2
Oman, Cyrus F. 12608 Wyoming Ave., Detroit 4
Oppenheim, J. M. 506 Kales Bldg., Detroit 6
Orecklin, Leo 914 Maccabees Bldg., Detroit 2
Organ, Fred W. 10304 Woodward Ave., Detroit 2
Ormond, John K. Henry Ford Hospital, Detroit 2
Ornstein, Charles 19504 Kelly Rd., Detroit 24
O'Rourke, P. V. 307 David Whitney Bldg., Detroit 26
O'Rourke, R. M. 7384 Twelfth St., Detroit 6
Ortiz, Augusto 15744 Harper, Detroit 24
Osius, Eugene A.....901 David Whitney Bldg., Detroit 26
O'Sullivan, Girardin S...18428 Fitzpatrick Ct., Detroit 28
Ott, Harold A. 706 Maccabees Bldg., Detroit 2
Ottaway, J. P. 1337 David Whitney Bldg., Detroit 26
Owen, Clarence I. 4160 John R, Detroit 1
Owen, James A. 67 E. Forest, Detroit 1

Palevich, Matthew D. 8733 Joseph Campau, Detroit
Palmer, Alice E. 3919 John R, Detroit 1
Palmer, R. J. (E) 1466 Chicago Blvd., Detroit 30
Panic, Stephen M. 3341 E. Davison, Detroit 12
Pangburn, L. E. 7 Avalon, Detroit
Parker, Benjamin R. 17306 W. 7 Mile Rd., Detroit 19
Parker, W. R. (E) 1025 David Whitney Bldg., Detroit
Parnell, John W.
1297 Lochmoor Blvd., Grosse Pointe Woods 30
Parr, Robert W.....8-265 General Motors Bldg., Detroit 2
Parsons, J. P.....808 Grand Marais, Grosse Pointe Park 30
Pasternacki, Nobert T. 6203 Chene, Detroit 11
Paterson, Walter G. (L) 471 Fisher Bldg., Detroit 3
Patton, T. B. 1209 Kales Bldg., Detroit 26
Pawlowski, Jerome I. 2009 East Grand, Detroit
Payne, Eugene
P.O. Box 118, Roosevelt Park Annex, Detroit 32
Paysner, Harry A. 13700 Woodward Ave., Detroit 3
Peabody, Charles W. 474 Fisher Bldg., Detroit
Pearce, Arthur J. Wayne Co. General Hospital, Eloise
Pearman, Charles L. R. 1509 Kales Bldg., Detroit
Pearlman, Jack 14146 Bramell, Detroit 28
Pearse, Harry A. 852 Fisher Bldg., Detroit
Pedersen, Herbert E. 1209 Kales Bldg., Detroit
Peggs, George F. 5419 Livernois, Detroit 10
Penberthy, G. C.....1515 David Whitney Bldg., Detroit 26
Pendy, G. V. 1808 David Broderick Tower, Detroit
Pensler, Leslie 8844 Joy Road, Detroit
Pensler, Meyer M. 8844 Joy Rd., Detroit
Pendy, J. M. 1401 David Whitney Bldg., Detroit 26
Pequegnot, C. F. (L) ...6283 W. Outer Drive, Detroit 21
Perdue, Grace M. 762-63 Fisher Bldg., Detroit 2
Perkin, Frank S. 970 Fisher Bldg., Detroit 2
Perlis, H. L. 1036 Maccabees Bldg., Detroit 2
Peterman, E. A. 801-2 Med. Arts Bldg., Highland Park
Petix, Samuel C. 19207 Schaefer, Detroit 21
Petoskey, Edward A. 6004 West Fort, Detroit 9
Pett, Robert G. Address Unknown
Petty, Thomas A. (M) 6434 Oakman Blvd., Dearborn
Pevin, Pauline 18709 Meyers Rd., Detroit 21
Peven, Philip S. 18709 Meyers Road, Detroit
Pfeiffer, Rudolph L. 469 E. Grand Blvd., Detroit 7
Picard, J. D. 13349 Michigan Ave., Dearborn
Phillipson, Chester 7411 Third Avenue, Detroit
Piccone, Louisa 10605 W. Warren, East Dearborn
Pichette, J. Walton 15146 Michigan Ave., Detroit
Pickard, Orlando W. 952 Fisher Bldg., Detroit 2
Pierce, Frank L. (L) 9262 Grand River Ave., Detroit 4
Pierson, Max J. 1030 Maccabees Bldg., Detroit
Pietraszewski, A. W. 10338 Jos. Campau, Detroit 12
Pinckard, Karl G. 932 Mason St., Dearborn
Pink, Rose M. 11413 Jos. Campau, Detroit
Pinney, L. J. 28 W. Adams Ave., Detroit
Pino, Ralph H.....208 David Whitney Bldg., Detroit 26
Piper, Ralph R. 1530 McKinstry Ave., Detroit 7
Pittman, J. E. 1613 David Whitney Bldg., Detroit 26
Plaggemeyer, H. W. (L)
1701 David Whitney Bldg., Detroit 26
Platz, Carol K. 11368 Kelly Rd., Detroit

Pliskow, Harold 1022 Maccabees Bldg., Detroit 2
Podezwa, J. W. 9300 Joseph Campau, Detroit
Podolsky, Harold M. 2785 S. Fort, Detroit 25
Poirier, Ralph A. 1405 Mutual Bldg., Detroit 26
Polentz, Charles P. 10 Peterboro, Detroit 1
Pollack, John J. 18200 Wyoming Ave., Detroit 21
Ponka, Joseph L. Henry Ford Hospital, Detroit 2
Pool, Walter D. 14320 E. Jefferson, Detroit
Poos, Edgar E. 554 Fisher Bldg., Detroit 2
Porretta, Anthony C. 11146 Gratiot, Detroit 5
Porretta, F. S. 1076 Maccabees Bldg., Detroit 2
Portnoy, Harry 4253 Leslie, Detroit
Posch, J. L. 1410 Kales Bldg., Detroit
Posner, Irving 12901 W. 7 Mile Rd., Detroit 21
Pratt, Jean P. 18910 Fairway Drive, Detroit 21
Pratt, Lawrence A.
Doctors Bldg., Suite 800, 3919 John R, Detroit
Prendergast, John J. 341 Massachusetts, Detroit
Preston, Ruth E. 460 Fisher Bldg., Detroit 2
Priborsky, Benjamin H. ..742 Maccabees Bldg., Detroit 2
Price, Alvin E. 313 David Whitney Bldg., Detroit
Price, A. Hazen 62 W. Kirby, Detroit 2
Priddle, Harold 1512 St. Antoine, Detroit 26
Priest, R. J. Henry Ford Hospital, Detroit
Procailo, A. B. 29627 Ford Rd., Garden City
Proctor, Bruce 1419 David Whitney Bldg., Detroit 26
Proud, Robert H. 26151 Huron River Dr., Flat Rock
Pugh, Howard C...1165 David Whitney Bldg., Detroit 26
Pugh, Richard G.....212-214 Schaefer Bldg., Dearborn
Pugliesi, Benedetto 2650 Arndt St., Detroit 7
Purcell, F. H.....1808 David Broderick Tower, Detroit 26
Purves, William H. L. 18501 Snowden, Detroit

Quigley, Eugene H. 22340 Michigan, Dearborn
Quigley, William G. 742 Maccabees Bldg., Detroit
Quinn, Edward L. Henry Ford Hospital, Detroit 2

Rahm, Lambert P. 14411 E. Jefferson, Detroit 19
Raiford, Frank P. 1308 Broadway, Detroit 26
Raiford, Frank P., Jr. 1308 Broadway, Detroit 26
Randall, David S. 7815 E. Jefferson, Detroit
Rasi, Howard B. 1713 David Whitney Bldg., Detroit
Raskin, Morris 987 E. Jefferson, Detroit
Rastello, Peter B. 6307 W. Fort St., Detroit 9
Ratigan, Carl S. 22276 Garrison, Dearborn
Rau, Frederick, W. 113 Martin Place, Detroit
Ray, K. J., Lt. (jg) (M)
1754 Sixth Avenue, N., St. Cloud, Minn.
Raynor, Harold F. 1340 Maccabees Bldg., Detroit 2
Reberdy, George J. 2080 W. McNichols Rd., Detroit
Rebuck, John W. Henry Ford Hospital, Detroit
Redfern, William E. Henry Ford Hospital, Detroit 2
Reed, E. H. (A)
1033½ Cadieux Rd., Grosse Pointe Park 30
Reed, H. Walter 8150 Grand River Ave., Detroit 4
Reed, Ivor E. 305 David Whitney Bldg., Detroit 26
Reed, Joseph O., Jr. Harper Hospital, Detroit
Rees, Howard C. 15700 Mack Ave., Detroit 24
Reichling, R. J., Jr. ..18514 Mack, Grosse Pte. Farms 30
Reid, J. G. 1337 David Whitney Bldg., Detroit 26
Reid, Wesley G. 974 Fisher Bldg., Detroit 2
Reiff, Morris V. 10241 Joy Rd., Detroit
Reinbolt, Charles A. (L)
33570 Quaker Valley Rd., Farmington
Reinsh, Ernest R. 18674 Muirland Ave., Detroit
Reisman, Nathan J. 1122 Maccabees Bldg., Detroit 2
Reisman, S. G. 1078 Maccabees Bldg., Detroit
Rennell, Leo P. 2567 West Grand Blvd., Detroit 8
Renton, George W. 1530 Seward, Apt. 209, Detroit
Reveno, William S. 958 Fisher Bldg., Detroit 2
Rexford, W. K.....1314 David Whitney Bldg., Detroit 26
Reyner, C. E. Henry Ford Hospital, Detroit 2
Reynolds, Lawrence 10 Peterboro, Detroit 1
Reynolds, R. P. 858 Fisher Bldg., Detroit 2
Rezanka, H. J. 952 Westchester Rd., Grosse Pointe 30
Rhoades, Francis P.....970 Maccabees Bldg., Detroit 2
Rice, Harold B.
Rice, Meshel 10 Peterboro, Detroit 1
.....2415 W. Grand Blvd., Detroit 8

Richardson, Allan L. 651 Fisher Bldg., Detroit 2
Richardson, Robert P. 3714 Monroe Ave., Wayne
Richardson, Robert P., Lt. (jg) (M).....
Cur-Des-Pac., San Diego, Calif.
Rick, Paul J. 4227 Mt. Elliott, Detroit
Ridge, Ralph W. 114 Maple St., Wyandotte
Rieckoff, George G. ..14905 E. Jefferson Ave., Detroit 15
Rieden, J. A. 2567 W. Grand Blvd., Detroit
Rieg, John F. 5695 W. Vernor Highway, Detroit 9
Rieger, John B. 1265 David Whitney Bldg., Detroit 26
Rieger, Mary H. 746 Pallister, Detroit
Riethmiller, Robert F.....12400 E. 7 Mile Rd., Detroit 5
Rinkel, Robert W. 6586 Allen Rd., Allen Park
Riseborough, E. C. 90 E. Warren, Detroit 1
Ritter, George 28420 Sunset Drive, Birmingham
Rizzo, Frank 1379 Berkshire Rd., Grosse Pointe Park
Robb, Edward L. 17380 Livernois, Detroit
Robb, Herbert F. 381 S. Main St., Belleville
Robb, James M. 641 David Whitney Bldg., Detroit 26
Roberts, Arthur J. 1310 Warwick, Lincoln Park
Robertson, Stanley B. 962 Fisher Bldg., Detroit 2
Robertson, T. H. 962 Fisher Bldg., Detroit
Robins, Samuel C. ..18963 Jas. Couzens Hwy., Detroit 21
Robinson, F. L. 13530 Michigan, Dearborn
Robinson, G. W. (L)....1701 E. Grand Blvd., Detroit 11
Robinson, H. A. 987 E. Jefferson, Detroit 7
Robinson, Howard 953 Fisher Bldg., Detroit
Robinson, J. H., Jr. 1553 W. Grand Blvd., Detroit 8
Robinson, R. G. 3751 31st St., Detroit 10
Roeglin, O. F. 14320 E. Jefferson, Detroit
Rohde, Paul C. 912 Maccabees Bldg., Detroit 2
Rom, Jack 903 Kales Bldg., Detroit 26
Roman, Stanley J. 742 Maccabees Bldg., Detroit 2
Rogin, James R. 3027 David Stott Bldg., Detroit 26
Rogers, James D. 2966 Biddle Ave., Wyandotte
Rogers, G. E. B. 2108 David Brod. Tower, Detroit 26
Rogers, Aaron Z.....20451 Mack Ave., Grosse Pte. Woods
Rogoff, Abraham S. 1328 Maccabees Bldg., Detroit 2
Ronayne, J. J. 16116 W. McNicholls Rd., Detroit
Roney, Eugene H. 17187 Schaefer Hwy., Detroit
Rosbolt, Oscar P. 8505 Plymouth Road, Detroit
Rosefield, John L. 630 Maccabees Bldg., Detroit
Rosen, Theodore S. 18700 Meyers Road, Detroit
Rosen, T. S. 18700 Meyers, Detroit
Rosenbaum, Herbert 19776 Snowden Ave., Detroit 35
Rosenbloom, Alvin B.....Wayne Co. General Hosp., Eloise
Rosenthal, Louis H. 1318 Maccabees Bldg., Detroit
Rosenthal, Samuel A. 16350 Hamilton, Detroit
Rosenwach, Felix F. 20429 W. Seven Mile Rd., Detroit
Rosenzweig, Saul....2114 David Broderick Tower, Detroit
Rosen, Harold M. 8830 W. McNichols, Detroit 21
Rose, Bernard 65 W. Hancock, Detroit
Ross, Ben C. 4493 14th Street, Detroit
Ross, Donald G. 654 St. Clair, Detroit
Ross, Hyman 19149 Joy Road, Detroit
Rotarius, E. M. 5800 Courville, Detroit 24
Roth, Edward T. 640 E. Grand Blvd., Detroit 7
Roth, Theodore I. 60 W. Hancock, Detroit
Rothbart, Harold B. 773 Fisher Bldg., Detroit 2
Rothman, Emil D. 722 Maccabees Bldg., Detroit 2
Rothman, H. R. 20171 Canterbury, Detroit 21
Rowda, Michael S. 2001 E. Grand Blvd., Detroit 11
Rottenberg, Leon 13419 Fenkell, Detroit 27
Rucker, Julian J. 668 Farnsworth Ave., Detroit 2
Ruedemann, A. D...1633 David Whitney Bldg., Detroit 26
Ruedemann, Albert D., Jr.
1633 David Whitney Bldg., Detroit
Rueger, Milton J. 708 Kales Bldg., Detroit 26
Rueger, Ralph C. 9149 E. Jefferson, Detroit 14
Runge, Edward F. 14 Abbot Lane, Dearborn
Rupp, J. R. 7056 W. Fort St., Detroit 26
Rupprecht, Emil F. 5525 W. Chicago Blvd., Detroit
Rutzen, Arthur C. 871 Fisher Bldg., Detroit 2
Russell, John C. (L) 2934 Davison St., E., Detroit 3
Ruskin, S. H. 1306 David Broderick Tower, Detroit 26
Rush, Alva D. 341 Massachusetts Ave., Detroit
Ryan, Charles F. 13960 Montrose, Detroit
Ryan, James M. 19207 Schaefer Rd., Detroit 35

Ryan, W. D. 5837 West. Vernor Hwy., Detroit 9
Ryerson, F. S. 28 W. Adams, Suite 802, Detroit
Rydzewski, Jos. B. 12170 Jos. Campau, Detroit 12
Ryerson, Frank L. (A) 307 Fine Arts Bldg., Detroit 26

Sacchetti, James V. Wayne Co. General Hosp., Eloise
Sack, Anthony G. 2567 W. Grand Blvd., Detroit 8
Sadler, Henry H., Jr. 1512 St. Antoine, Detroit
Sadzikowski, Joseph T. 6319 Michigan, Detroit
Sage, Bernard A. 1013 Haigh, Dearborn
Sage, Edward O. (E) 415 Burns Drive, Detroit
Sage, Thomas 7815 E. Jefferson, Detroit 14
Sager, Edward L. 13902 Gratiot Ave., Detroit 5
St. Amour, Hector J. 9545 Grand River, Detroit
St. Louis, R. J. 10909 W. Jefferson, River Rouge 18
Sakorraphos, Stelios N. 1346 Broadway, Detroit 26
Salchow, Paul T. Herman Kiefer Hospital, Detroit
Salisbury, Carolyn S.....527 Professional Bldg., Detroit
Salomon, James L. 2900 S. Fort St., Detroit 25
Salowich, John N. 15235 Harrison, Allen Park
Saltzstein, Harry C. 966 Fisher Bldg., Detroit 2
Sand, Harry H. 2474 S. Telegraph, Dearborn
Sanders, Alex W. 920 Maccabees Bldg., Detroit 2
Sander, Irvin W. 5050 Cass Avenue, Detroit 2
Sanderson, Alvord R.....
978 Pemberton Road, Grosse Pointe Park
Sanderson, Suzanne M. 15 E. Kirby Ave., Detroit 2
Sandler, Nathaniel.....1004 Kales Building, Detroit 26
Sands, G. E.....12746 Broadstreet, Detroit
Sandweiss, D. J.....9739 Dexter Blvd., Detroit 6
Sapala, M. Andrew.....6356 Michigan, Detroit
Saraf, L. B.....14540 E. Warren, Detroit
Sargent, William R.....15036 Oakfield, Detroit 27
Sarracino, J. B. (A).....532 Marquette Dr., Detroit 14
Saunders, W. H. (A).....1801 E. Stadium, Ann Arbor
Sauk, John J.....640 Maccabees Bldg., Detroit
Sauter, Simon H.....1082 E. Grand Blvd., Detroit 7
Savignac, Eugene M.....4777 E. Outer Drive, Detroit 12
Scarney, Herman D.....573 Fisher Building, Detroit 2
Schaefer, R. L. 1206 Kales Building, Detroit 26
Schaefer, Robert L., Jr. (M)....1206 Kales Bldg., Detroit
Schaeffer, Martin..1404 Dav. Broderick Tow., Detroit 26
Schane, David A. (M).....
Scheinberg, Schayel.....966 Fisher Bldg., Detroit
Schembeck, I. S.....1655 David Whitney Bldg., Detroit 26
Schiff, Donald W. (M).....U.S.P.H. Service, Turtle Mt.
Consolidated, Indian Agency, Belcourt, N. D.
Schiller, A. E.....2008 David Broderick Tower, Detroit
Schillinger, Harold K.....4838 Neckel, Dearborn
Schinagel, Geza.....4400 Livernois, Detroit 10
Schirack, Ray D.....15850 E. Warren Avenue, Detroit 24
Schkloven, Norman 532 Maccabees Bldg., Detroit
Schlafer, Nathan H.....
1806 David Broderick Tower, Detroit 26
Schlemer, John H.....13826 Dexter Blvd., Detroit 6
Schlesinger, Henry.....13534 Woodward, Detroit 3
Schwaltz, John D...1701 David Broderick Tower, Detroit
Schmidt, Harry E. 667 Fisher Bldg., Detroit
Schmidt, Milton R.....2615 W. Jefferson, Trenton
Schmidt, Werner F.....1807 Stroh Building, Detroit
Schmier, Burton L.....5440 Cass, Detroit 2
Schmitt, Norman L.....10127 W. McNichols, Detroit 21
Schneck, R. J.....641 David Whitney Bldg., Detroit 26
Schneider, Curt P.....655 Fisher Bldg., Detroit 2
Schoenfield, Gilbert D.....8830 W. McNichols, Detroit 21
Scholes, Daniel R.....113 Martin Place, Detroit 1
Schooten, Sarah S.....954 Maccabees Bldg., Detroit 2
Schorr, Robert L. (E).....1325 E. Jefferson, Detroit 7
Schraer, Paul H.....7220 Gratiot Avenue, Detroit 13
Schreiber, Frederic.....10 Peterboro, Detroit 1
Schroeder, Carlisle F.....7815 E. Jefferson, Detroit
Schulte, Carl H.....3919 John R, Detroit
Schultz, Ernest C. 840 David Whitney Bldg., Detroit
Schuneman, H. A.....
23760 Woodward Avenue, Pleasant Ridge
Schwartz, Ben.....275 W. Grand Blvd., Detroit 16
Schwartzberg, Jos. A.....5001 14th St., Detroit 8
Schwartz, Louis A.....861 Fisher Bldg., Detroit 2
Schwartz, Oscar D...7441 West Seven Mile Road, Detroit
Schweigert, C. F.....10627 Cadieux, Detroit 24
Sciarrino, Stanley V.....15388 Livernois, Detroit 21
Scott, R. J.....7333 W. 7 Mile Road, Detroit 21
Scott, William J.....79 Kercheval, Grosse Pointe Farms
Scoville, Victor T. Box 550, Wayne
Scruton, Foster D.....5419 Livernois, Detroit 10
Seabrooks, B. F., Jr. 9136 Oakland Avenue, Detroit
Sears, Charles H. 1628 N. Bush, Santa Ana, Calif.
Secord, Eugene W.....761 Fisher Bldg., Detroit 2
Seeley, James B.....13530 Michigan Ave., Dearborn
Seeley, Ward F.....1807 David Whitney Bldg., Detroit 26
Seibert, Alvin H.....
1180 Bedford Road, Grosse Pointe Park, Detroit 30
Seiferlein, A. L. 508 Dav. Whitney Bldg., Detroit 26
Segar, Laurence F...1410 Dav. Broderick Tow., Detroit 26
Self, William G.....19365 Mack Avenue, Detroit
Sellers, Charles W. 2314 W. Grand Blvd., Detroit 6
Sellers, Graham A.....2405 W. McNichols Rd., Detroit 21
Selman, J. H.....8942 Dexter Blvd., Detroit 6
Serrester, Bernard F.....18650 W. Warren, Detroit 10
Sewell, George 1116 David Whitney Bldg., Detroit 26
Shafarman, Eugene M.....5320 John R, Detroit 2
Shaffer, Jos. H.....Henry Ford Hospital, Detroit 2
Shaffer,, Loren W.....3852 Bishop Road, Detroit
Shafter, Royce R.....655 Fisher Bldg., Detroit 2
Shanoski, Stanley J.....11301 E. McNichols, Detroit 5
Shapiro, I. Allen.....4400 Livernois, Detroit 21
Shapiro, Jacob.....9110 Kercheval, Detroit 14
Shapiro, Reuben I.....636 Maccabees Bldg., Detroit
Sharrer, Charles H.....873 Lakewood, Detroit 15
Shaw, N. D. 22128 Cleveland, Dearborn
Shelden, Warren E.....17300 Schaeffer, Detroit
Sheldon, J. A. (L).....
1435 Three Mile Drive, Grosse Pointe Park 30
Shelton, C. F.....910 David Broderick Tower, Detroit 26
Sheppard, Emma L. W.....27631 Gilbert, Centerline
Sherman, William LaRue.....10 Peterboro, Detroit 1
Sherrin, E. R...17555 James Couzens Highway, Detroit 35
Sherwood, DeWitt L. (L).....
6170 Michigan Ave., Detroit 10
Shewchuk, Alexander P.....7300 Allen Road, Allen Park
Shields, William L.....18600 Woodward, Detroit 3
Shifrin, Peter G.....767 Fisher Bldg., Detroit 2
Shipton, W. Harvey.....2679 Montclair Ave., Detroit 14
Shiovitz, Louis.....5419 Michigan Ave., Detroit 10
Shlain, Benjamin.....10244 W. 7 Mile Road, Detroit
Shortz, Gerald..504 Doctors Bldg., 3919 John R, Detroit
Shotwell, Carlos W. (L).....10 Peterboro, Detroit 1
Shreve, Alfred J. 10149 Michigan Ave., Dearborn
Shulak, Irving B...1714 David Broderick Tow., Detroit 26
Shulman, Herschel A.....622 Maccabees Building, Detroit
Shumaker, E. J.....22691 Michigan, Dearborn
Siddall, Roger S.....955 Fisher Bldg., Detroit 2
Sieber, Edward H.....15146 Michigan Ave., Dearborn
Siefert, John L.....12720 E. Outer Drive, Detroit
Siefert, William A.....16849 Grand River, Detroit
Siegel, Henry.....7441 W. 7 Mile Road, Detroit
Sigler, John W. Henry Ford Hospital, Detroit
Sill, Jack A.....19635 Mack Avenue, Detroit 30
Silvarman, I. Z. 9103 Van Dyke, Detroit 13
Silver, I. W.....20000 W. Chicago, Detroit 28
Silverman, Maurice M.....3925 Joy Road, Detroit 6
Silverman, Max.....11340 Dexter Blvd., Detroit 6
Simon, Emil R. 1020 Maccabees Bldg., Detroit 2
Simon, Heinz G.....5097 Balfour Road, Detroit 24
Simmons, Donald R.....815 Kales Building, Detroit
Simpson, Clarence E. (L).....629 Blaine, Detroit 26
Sinclair, James W. 11801 Moran Drive, Detroit 24
Singer, Floyd W.....13530 Michigan, Dearborn
Sippola, George W.....13603 LaSalle, Detroit 6
Sisson, John M.....17201 W. McNichols, Detroit
Skinner, W. Clare.....9815 Grand River, Detroit 4
Sklover, J. I. 1326 E. 7 Mile Road, Detroit 3
Skrzycki, Stephen S.....10040 Joseph Campau, Detroit 12
Skully, Edward J.....14000 Linnhurst, Detroit
Sladen, F. J.....Henry Ford Hospital, Detroit
Slahetka, Vincent E. 7435 Michigan Ave., Detroit

Slaughter, F. M. 455 E. Adams, Detroit 26
Slaugenhaupt, J. G...418 Transportation Bldg., Detroit 26
Slazinski, Leo W.....7618 Michigan, Detroit 10
Slevin, John G...1514 David Broderick Tower, Detroit 26
Sliwin, E. P.....641 David Whitney, Detroit
Slusky, Joseph.....1826 Oakman Blvd., Detroit
Small, Henry.....11507 Hamilton, Detroit 3
Smathers, Homer M.....1405 Kales Building, Detroit 27
Smeck, Arthur R.....1036 Waterman, Detroit 9
Smith, Clarence V.....1716 E. Grand Blvd., Detroit, 11
Smith, Claude A.....15 Linden St., River Rouge 18
Smith, Douglas H.....25447 Plymouth, Detroit 28
Smith, F. J.....Henry Ford Hospital, Detroit
Smith, Henry L.....16401 Grand River Ave., Detroit 27
Smith, J. Allen.....14140 Puritan, Detroit 27
Smith, Richmond Address Unknown
Snead, James G.....4190 Bedford Road, Detroit 24
Snedeker, Bernard C.....18800 Woodward Ave., Detroit 3
Snow, L. W.....508 W. Main Street, Northville
Snyder, Arthur M.....503 Medical Arts Bldg., Detroit
Sobel, Robert A.....612 Kales Bldg., Detroit
Socall, Charles J.....8500 Mt. Elliott, Detroit 11
Sokol, William M. 10 Peterboro, Detroit 1
Sokolov, Raymond A.....755 Fisher Bldg., Detroit 2
Solomon, Abraham B. 16636 W. Chicago, Detroit 28
Somers, Donald C.....3919 John R, Detroit 1
Sonda, Lewis P.....552 David Whitney Bldg., Detroit 26
Sorock, Milton L...3027 David Stott Building, Detroit 26
Spademan, Loren C.....1013 Dav. Whit. Bldg., Detroit 26
Spalding, Edward D.....10 Peterboro, Detroit 1
Sparling, Harold I.....251 Main Street, Northville
Spector, Maurice J.....12504 E. Jefferson, Detroit 15
Speck, Carlos C.....6525 Park Avenue, Allen Park
Spero, Gerald D. 7330 W. 7 Mile Rd., Detroit 26
Sperry Frederick L.....463 Fisher Bldg., Detroit 2
Springborn, B. R.....15818 E. Warren, Detroit 24
Spiro, Adolph S. 11255 Mack Ave., Detroit 15
Sprunk, Carl J.....869 Fisher Bldg., Detroit 2
Squires, W. H. Wayne Co. General Hosp., Eloise
Stafford, Frank W. J.....1111 Griswold, Detroit
Stalker, Hugh.....15315 E. Jefferson, Grosse Pointe 30
Stamell, B. B.....658 Maccabees Bldg., Detroit
Stamell, Meyer.....14634 Greenfield, Detroit
Stanton, James M.....1001 Stroh Building, Detroit
Stanton, Myron R. 3400 W. Warren, Detroit
Stapleton, William J., Jr. (E).....
641 David Whitney Bldg., Detroit 26
Starrs, Thomas C. (L)..509 Fox Theater Bldg., Detroit 1
Staub, Howard P.....Box 32 R. Park, Detroit 32
Stearns, A. B.....504 Doctors Bldg., Detroit 1
Stebbins, Charles E.....856 Fisher Building, Detroit
Steele, Hugh H.....Henry Ford Hospital, Detroit 2
Stefani, Ernest L.....4126 W. McNichols, Detroit 21
Stefani, Raymond T.....13516 Stoepel, Detroit 4
Steffensen, Ellis H. Henry Ford Hospital, Detroit
Stein, Albert H.....19334 San Juan Drive, Detroit 21
Stein, Edward.....909 Kales Bldg., Detroit 26
Stein, James R. 125 W. Nine Mile Road, Ferndale
Stein, Saul C.....23105 Van Dyke, Van Dyke
Steinbach, Albert L.....1229 David Whitney Bldg., Detroit
Steinbach, Henry B...1229 Dav. Whitney Bldg., Detroit 26
Steinberger, Eugene J. 6409 W. Fort St., Detroit 9
Steiner, Frederick B.....29627 Ford Road, Garden City
Steiner, Gabriel.....10 Peterboro, Detroit 1
Steiner, L. J.....Henry Ford Hospital, Detroit
Steinhardt, Milton J. 670 Maccabees Bldg., Detroit
Stellhorn, Chester E.....12900 W. 7 Mile Road, Detroit 21
Stellhorn, Mary Christine.....16616 Mack Ave., Detroit
Stenborg, W. P.....1069 Fisher Building, Detroit 2
Stephens, Homer C.....4302 McGraw, Detroit
Sterba, Richard F.....1130 Parker, Detroit 14
Sterling, Robert R...1541 Dav. Whitney Bldg., Detroit 26
Stern, Edward A.....12710 Dexter, Detroit 6
Stern, H. L.....14137 Warwick, Detroit 23
Stern, Louis D.....1049 David Whitney Bldg., Detroit
Stevens, Charles H. 14934 Ward, Detroit 27
Stevenson, Charles S. 1405 Kales Building, Detroit
Stewart, Harry L., Jr.....
3635 LaEntrada, Santa Barbara, Calif.
Stewart, M. M.....1069 Fisher Building, Detroit
Stewart, Thomas O.....17187 Schaefer Hwy., Detroit 35
Stiefel, Daniel M.....1563 Dav. Whitney Bldg., Detroit 26
Stillwater, Karl.....1636 Burlingame, Detroit
Stirling, A. M. 10 Peterboro, Detroit 1
Stith, Dwight E.....9101 Oakland, Detroit 11
Stobbe, Godfrey D.....Grace Hospital, Detroit
Stocker, Harry.....5718 Devonshire, Detroit 5
Stocker, Lawrence L.....7330 W. 7 Mile Rd., Detroit 26
Stockwell, B. W...703 Doctors Bldg., 3919 John R, Detroit
Stokfisz, Thaddeus 7012 Michigan Ave., Detroit 10
Straith, Claire L...1713 David Whitney Bldg., Detroit 26
Straith, R. E.....1713 David Whitney Bldg., Detroit 26
Strand, Martin E.....22400 Cherry Hill, West Dearborn
Stricker, Henry D.....5624 W. Fort St., Detroit 9
Strickroot, Fred L.....707 Kales Bldg., Detroit
Strohschein, D. F. 1063 Fisher Bldg., Detroit 2
Stryker, Joan C.....21604 E. River Road, Grosse Isle
Stryker, Walter A.....Wyandotte Gen. Hosp., Wyandotte
Stubbs, C. T.....13930 Woodward, Detroit 3
Stubbs, Harold W.....13930 Woodward, Detroit 3
Stuecheli, Milton B.....1230 Bishop Road, Grosse Pointe
Stump, George D...1314 David Whitney Bldg., Detroit 26
Sugar, David I.....13120 Broadstreet, Detroit
Sugar, H. Saul.....311 Kales Building, Detroit
Sugarman, Marcus H.....9739 Dexter, Detroit 6
Sullivan, Hugh A...1053 David Whitney Bldg., Detroit 26
Sullivan, J. J., Jr. (M).....
c/o Dispensary, U. S. Navy Ord. Depot, Bangor, Wash.
Summers, William A.....
1613 David Whitney Bldg., Detroit 26
Summers, William S.....1613 David Whitney Bldg., Detroit
Surbis, John P.....493 W. Grand Blvd., Detroit 16
Sutherland, Jacob M.....662 Fisher Bldg., Detroit 2
Swanson, Carl W.....936 Alter Road, Detroit 15
Swanson, Cleary N.....
16921 James Couzens Highway, Detroit 27
Swanson, Robert G.....936 Alter Road, Detroit
Swartz, Fred G., Jr.....1229 David Whitney Bldg., Detroit
Sweeny, Donald N., Jr.....8445 E. Jefferson, Detroit 14
Sweeney, Francis X.....1420 St. Antoine, Detroit 26
Swift, Karl L.....869 Fisher Bldg., Detroit 2
Switzer, Bertrand C.....17354 James Couzen, Detroit
Szappanyos, B. J.....2567 W. Grand Blvd., Detroit
Szejda, J. C.....3003 Harper, Detroit
Szilagyi, D. Emerick Henry Ford Hospital, Detroit
Szladek, F. J.....4045 W. Jefferson, Ecorse
Szmigiel, A. J.....7527 E. 7 Mile Road, Detroit 34
Szokolai, Joseph P. 2694 Carter Street, Detroit

Talbot, Frank G.....
Murray Corporation, Foot of Great Lakes, Ecorse
Tallant, Edward J.....14001 Greenfield, Detroit
Tamblyn, E. J.....15315 E. Jefferson, Detroit 30
Tapert, Julius C.....888 Chalmers, Detroit 15
Tasker, Helen E. 76 W. Adams, Detroit
Tassie, Ralph N.....14060 Saratoga, Detroit
Tatelis, Gabriel A. 1011 E. Grand Blvd., Detroit
Tatelman, Maurice.....410 Kales Building, Detroit 26
Taurence, William H.....1860 Ford, Wyandotte
Taylor, Ivan B.....504 Doctor Bldg., 3919 John R, Detroit
Taylor, J. L.....1566 W. Grand Blvd., Detroit
Taylor, Nelson M.....654 St. Clair, Grosse Pointe 30
Taylor, Reu Spencer (L).....1942 Clarkdale, Detroit 9
Tazzioli, Henry A.....1260 Marlborough, Detroit 15
Tear, Malcolm J. J. 5008 Trumbull Ave., Detroit 8
Teitelbaum, Myer.....405 Kales Bldg., Detroit 26
Tenaglia,, Thomas A.....9 Salliotte, Ecorse 18
Tenerowicz, Rudolph G.....2925 Lehman, Detroit 12
Texter, Elmer C.....7457 Gratiot Ave., Detroit 13
Thompson, Arthur Lee.....6125 Scotten, Detroit 10
Thompson, H. O.....6014 W. Fort, Detroit 9
Thompson, W. A.....6125 Scotten, Detroit 10
Thomson, Daniel C.....2966 Biddle Avenue, Wyandotte
Thornnell, Harold E.....4839 Beaubien, Detroit 1
Thosteson, George C.....
1139 David Whitney Bldg., Detroit 26

Thumann, R. C., Jr.....1757 David Whitney Bldg., Detroit
Thumin, Sadie.....15306 Joy Road, Detroit
Toaz, Robert B.....13700 Woodward, Detroit 3
Toepel, Otto T. (E).....195 E. Grand Blvd., Detroit
Tomsu, Charles L.....6170 Michigan Ave., Detroit 10
Torres, Estelle.....3985 Caniff, Detroit
Townsend, Frank M.....1551 Trumbull, Detroit 16
Torres, Raul.....1076 Maccabees Building, Detroit
Tregenza, W. K.....18530 Grand River, Detroit
Tremain, Harold L.....106 W. Davison, Detroit
Troester, George A.....1140 Maccabees Bldg., Detroit
Trombino, James F. V.....2567 W. Grand Blvd., Detroit 8
Trombley, Bryan.....755 David Whitney Bldg., Detroit 26
Truba, Paul K. 1409 Kales Bldg., Detroit
Truszkowski, Edward G. ...11838 Jos. Campau, Detroit 12
Trythall, S. W.....13300 Livernois, Detroit 4
Tulloch, John.....923 David Whitney Bldg., Detroit
Tupper, Roy D.....15101 W. 7 Mile Road, Detroit 19
Turbett, Claude W. (L).....
4230 Commonwealth Ave., Detroit 8
Turcotte, Vincent J.....14015 Gratiot, Detroit 5
Turkel, Henry.....1302 Industrial Bank Bldg., Detroit 26
Turnbull, Jack V.....22340 Michigan, Dearborn
Tuynman, Peter E.....15865 Wyoming, Detroit 21
Tyson, William E. E. (L).....2949 Gratiot, Detroit 7

Ujda, Chester J.....35080 Chestnut, Wayne
Ulbrich, H. L.....5029 Seneca, Detroit
Ulrich, Willis H.....22365 Grand River, Detroit
Umphrey, Clarence E.....13331 Livernois Ave., Detroit 4
Usher, William Kay.....15605 Kercheval, Detroit 30

Vale, C. Fremont..1306 David Whitney Bldg., Detroit 26
Van Becelaere, L. H. 10 Bourassa, Ecorse
VandenBerg, Henry J., Jr.....966 Fisher Bldg., Detroit 2
Van Eck, James E.....9165 Whittier, Detroit 24
Van Hoek, Donald E.
20825 Mack Avenuue, Grosse Pointe Woods
Van Nest, A. E. (A).....14702 E. Jefferson, Detroit 15
Van Raaphorst, L. F.....1306 Kales Building, Detroit 26
Van Rhee, George.....10 Peterboro, Detroit 1
Van Riper, Steven L.....1490 Iroquois, Detroit 14
Vardon, Edward M.....12897 Woodward Ave., Detroit 3
Vasu, V. O.....4829 Woodward, Detroit 1
Vogel, Hyman A.....6319 Michigan, Detroit 10
Vokes, Milton D.....10182 Gratiot Ave., Detroit
Vonder Heide, E. C.....17190 Strathmore, Detroit 21
Vossler, A. E.....825 David Whitney Bldg., Detroit 26

Waddington, Jos E. G. (E)..3818 Northwestern, Detroit 6
Waggoner, C. Stanley.....
541 David Whitney Bldg., Detroit 26
Waggoner, Lyle G...404 David Whitney Bldg., Detroit 26
Wainger, Max J...1012 Dav. Broderick Tower, Detroit 26
Wainstock, Michael A.
1508 David Broderick Tower, Detroit 26
Wakeman, Everal M.....22276 Garrison, Dearborn
Waldbott, George L.....10 Peterboro, Detroit 1
Walker, George L.....Veterans Admin. Hosp., Dearborn
Watts, John C. 7360 12th Street, Detroit 6
Walker, John Paul 1211 Bishop Road, Grosse Pointe
Walker, Roger V...1255 David Whitney Bldg., Detroit 26
Wallace, S. Willard.....7815 E. Jefferson, Detroit 14
Walls, Arch.....17201 W. McNichols Road, Detroit
Walser, Howard Carleton.....566 Fisher Bldg., Detroit 2
Walsh, C. R.....4168 Yorkshire Road, Detroit 24
Walsh, Francis P.....474 Fisher Bldg., Detroit 2
Walter, Floyd J.....19600 Grand River, Detroit 23
Walters, Albert G.....11078 Gratiot Ave., Detroit 5
Walter, Arthur W. 14201 Rutland, Detroit 27
Waltz, Paul J.....16127 Woodward Ave., Detroit 3
Wangner, William F. 7220 Gratiot, Detroit 7
Warden, Horace F. W...8011 W. Vernor Hwy., Detroit 9
Warner, J. F.....1508 David Broderick Tower, Detroit 26
Warner, P. L.....10314 Puritan, Detroit 21
Warren, Irving A...1406 Dav. Broderick Tow., Detroit 26
Warren, Wadsworth.....
1144 David Whitney Bldg., Detroit 26
Wasserman, Lewis C.....562 Maccabees Bldg., Detroit 26
Waszak, Charles J.....2501 West Grand Blvd., Detroit 8
Watson, Douglas J. 14001 Greenfield, Detroit
Watson, Harwood G.....935 S. Military, Dearborn
Watson, J. Edwin.....2536 W. Grand Blvd., Detroit 8
Watson, Robert W.....18916 Woodward, Detroit 3
Watts, Frederick B.....16321 Mack, Detroit
Watts, John C.....7360 12th Street, Detroit 6
Watts, Joseph.....742 Maccabees Bldg., Detroit 2
Wayne, Morris A.....15930 Livernois, Detroit 21
Weaver, Clarence E.....113 Martin Place, Detroit 1
Weber, Karl.....16400 E. Warren, Detroit 27
Weaver, Delmar F.....571 Fisher Bldg., Detroit
Webster, John E.....840 David Whitney Bldg., Detroit 26
Weed, Milton R.....1997 E. Grand Blvd., Detroit 11
Wehenkel, Albert M. (L).....7356 12th Street, Detroit 6
Weidner, J. H.....c/o Dearborn Engineering Lab.
21500 Oakwood, Dearborn
Weiner, Maurice B.....1114 Maccabees Bldg., Detroit 2
Weingarden, David 13240 Vassar Drive, Detroit
Weinstein, Jacob.....4237 Grand River Ave., Detroit 8
Weisberg, A. Allen.....20 W. 7 Mile Road, Detroit 3
Weisberg, Harry.....618 Maccabees Bldg., Detroit 2
Weisberg, Jacob.....618 Maccabees Bldg., Detroit 2
Weisenthal, Irvin.....5764 Woodward, Detroit 2
Weiser, Frank A.....4162 John R., Detroit
Weiss, Casimer P.....10040 Joseph Campau, Detroit 12
Weiss, J. G.....2237 W. Grand Blvd., Detroit 8
Weiss, Woodrow W. 60 W. Hancock, Detroit
Weller, Charles N...1136 Dav. Whitney Bldg., Detroit 26
Wells, Martha L. 760 Fisher Bldg., Detroit
Weltman, Carl G...1701 David Whitney Bldg., Detroit 26
Wendel, Jacob S.....744 David Whitney Bldg., Detroit 26
Wenzel, Jacob F.....1006 Kales Bldg., Detroit 26
West, Howard Gaige.....7310 Grand River, Detroit 4
Weston, Horace L.....703 Mutual Building, Detroit 26
Welch, W. K.....Letterman Army Hospital
San Francisco, Calif.
Welch, W. K.....
Letterman Army Hosp., San Francisco, Calif.
Welch, John H.....18550 W. Outer Drive, Dearborn 7
Werle, Peter Paul.....142 St. Antoine, Detroit 26
Weston, Bernard.....3200 Tyler, Detroit 6
Weston, Earl E.....18101 James Couzens Hwy., Detroit 21
Weston, Jean K.....4500 Burns, Detroit
Weyher, Russell F.....2437 S. LaSalle Gardens, Detroit
Whalen, Neil J.....1515 David Whitney Bldg., Detroit 26
Wharton, Thomas V.....2853 Biddle, Wyandotte
Wheeler, Stewart C. 19207 Schaefer, Detroit
Whelan, Joseph L.....28 West Adams Avenue, Detroit 26
Whinnery, Randall A.....752 Fisher Bldg., Detroit 2
White, Donald H. 1580 W. Fort St., Lincoln Park
White, Milo R.....Henry Ford Hospital, Detroit 2
White, Milton W.....2329 E. Grand Blvd., Detroit 11
White Prosper D.....66 Tuxedo, Highland Park
White, Theodore M.....7159 Michigan Ave., Detroit 10
Whitehead, Leston S.....Henry Ford Hospital, Detroit 2
Whitehead, Walter K.....
1129 David Whitney Bldg., Detroit 26
Whiteley, Robert K.....
541-3 David Whitney Bldg., Detroit 26
Whitney, Elmer L.....Henry Ford Hospital, Detroit 21
Whitney, Rex E.....5525 W. Chicago Blvd., Detroit 4
Whittaker, Alfred H.....1427 E. Jefferson, Detroit 7
Wiant, John L.....513 Professional Bldg., Detroit 1
Wiechowski, Henry E.....10345 Joseph Campau, Detroit
Wiener, Israel.....8431 Lawton, Detroit 6
Wikiera, Edward S.....13181 Littlefield, Detroit 27
Williams, Clarence J.....
15324 E. Jefferson, Grosse Pte. Park, Detroit 30
Wiener, Morton.....612 Kales Bldg., Detroit 26
Wietresen, Fred K...260 Manor Rd., Rte. 2, Birmingham
Williamson, J. G. (A).....3660 McKinley, Dearborn
Wight, Fred B.....1048 David Whitney Bldg., Detroit 26
Wilcox, L. F.....110 Professional Bldg., Detroit 1
Wiley, William M.....Receiving Hospital, Detroit 26
Wilhelm, Seymour K. 3925 Joy Road, Detroit 6
Wilkinson, A. P.....974 Fisher Bldg., Detroit 2
Wilner, I. A.....17239 W. McNichols Road, Detroit 19

Wilson, Andrew G. 4741 Spokane, Detroit
Wilson, Gerald A.....4741 Spokane, Detroit 4
Wilson, Merton C. 15439 Harper, Detroit
Wollank, Helen Wilson.....15324 E. Jefferson, Detroit 30
Wilson, Stuart C.....10 Peterboro, Detroit 1
Wilson, W. J. (E).....749 David Whitney Bldg., Detroit
Winton, George J.....1007 David Stott Bldg., Detroit 26
Winnick, Lawrence C. 19120 Snowden, Detroit
Wise, Robert K.....15801 W. McNichols, Detroit 35
Wishropp, E. A.....227 Kenwood Court, Grosse Pointe
Wissman, H. C.....6356 W. Fort, Detroit 9
Wittenberg, Arthur A.....7101 W. Chicago, Detroit
Wittenberg, Samson S.....934 Maccabees Bldg., Detroit 2
Wittenberg, Sydnev S.....4400 Livernois, Detroit 10
Witter, Joseph A.....344 Glendale, Detroit 3
Witter, Frank C. (L).....344 Glendale Ave., Detroit 3
Witus, Carl.....8045 E. Jefferson, Detroit 14
Witus, Morris.....9036 Dexter Blvd., Detroit 6
Wolfe, Max O.....7-260 General Motors Bldg., Detroit 2
Wollank, Helen W. 15324 E. Jefferson, Detroit
Wollenberg, R. A. C. (L)
939 David Whitney Bldg., Detroit 26
Wood, A. L. 2018 N. Telegraph, Dearborn
Wood, Kenneth A. 3919 John R, Detroit 1
Wood, Wilford C. 463 Fisher Bldg., Detroit
Woodworth, W. P.....17387 Quincy Avenue, Detroit 21
Worzniak, Joseph J.....2312 Biddle St., Wyandotte
Wreggit, Winston R.....79 Highland Ave., Detroit 3
Wright, C. H. (A)..Harlem Hospital, New York 30, N. Y.
Wright, Lance (M)
USPHS, Medical Center, Hot Springs, Ark.
Wruble, Joseph.....411 Seldon, Detroit
Wunsch, Richard E.....7815 E. Jefferson, Detroit 14
Yamasaki, Ken 3465 Chatsworth, Detroit 7

Yates, Arthur J. W. 8045 E. Jefferson, Detroit
Yesayian, H. G.....609 Kales Bldg., Detroit 26
Yetzer, William J. 760 Fisher Bldg., Detroit
Yott, William J.....5243 Bishop, Detroit 24
Young, Donald A.....14807 W. McNichols, Detroit
Young, Donald C.....1197 Edison, Detroit
Young, Lloyd B.....857 Fisher Bldg., Detroit 2
Young, Viola M.....10 Peterboro, Detroit 1

Zabinski, Edward J.....19036 Van Dyke, Detroit 12
Zackheim, Herschel S. 22265 Garrison, Dearborn
Zawadzki, E. S.....14961 Piedmont Ave., Detroit
Zbikowski, Joseph E. Wayne Co. Gen. Hosp., Eloise
Zbudowski, Myron R.....2758 Belmont, Hamtramck
Zemens, Joseph L.....1580 E. Grand Blvd., Detroit 32
Ziegler, Robert F.....Henry Ford Hospital, Detroit
Zielinski, Charles J.....7341 W. Warren, Detroit 10
Zinn, George H.....641 David Whitney Bldg., Detroit 26
Zinterhofer, John.....
27621 Santa Barbara Dr., Route 6, Birmingham
Zolliker, Margaret Z. 20390 Harper Avenue, Detroit
Zonnis, M. E.....1064 Fisher Building, Detroit 2
Zukowski, Henry J.....
1916 Manchester Blvd., Grosse Pte Woods 30
Zukowski, Sigmund A.....6626 Van Dyke, Detroit 13

WEXFORD-MISSAUKEE COUNTIES

Daugharty, Robert V. 115 S. Mitchell St., Cadillac
Holm, Augustus (L).....2525 Ninth Avenue, Moline, Ill.
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Lommen, Ralph G.....Manton
Merritt, C. E.....Manton
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Moore, Gregory P.....115 S. Mitchell St., Cadillac
Murphy, Michael R. Granite Bldg., Cadillac
Paye, Philip H.....311 Evart, Cadillac
Posthuma, Millard 124 E. Cass St., Cadillac
Smith, Fred R.....James Bogg Bldg., Lake City
Smith, Wallace J.....East Harris Street, Cadillac
Stokes, William H.....Lake City
Tornberg, Gordon C.....124 E. Case Street, Cadillac

Michigan State Medical Society

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Livesay, Mrs. Jackson.....Flint
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MacGregor, Mrs. Delbert.....Flint
Macksood, Mrs. Joseph.....Flint
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McLeod, Mrs. Kenneth.....Flint
McTaggart, Mrs. David.....Flint
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Van Harn, Mrs. Ray.....Flin

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Breakey, Mrs. Robert S. Lansing
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Laughead, Mrs. C. A. East Lansing
LeDuc, Mrs. D. M. East Lansing
Loree, Mrs. M. C. Lansing
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Martin, Mrs. W. Lansing
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Warford, Mrs. J. T. Lansing
Webb, Mrs. R. O. Okemos
Weinburg, Mrs. H. B. East Lansing
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Smith, Mrs. R. Earle Grand Rapids
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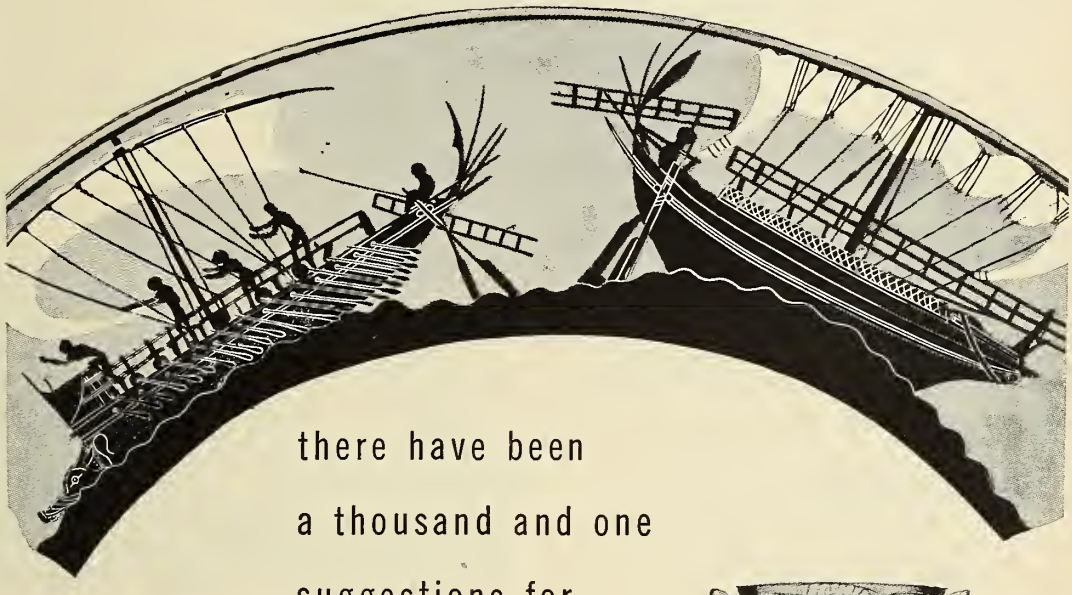
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Michigan's Department of Health

Albert E. Heustis, M.D., Commissioner

Accidents, fourth leading cause of death in Michigan, rank first in toll of working years, according to a study made in the Section of Statistical Methods of the Department. Working years are estimated as those from ages 18 to 65. In 1950, accidents were responsible for 3,783 deaths in Michigan and the loss of nearly 58,000 working years.

In addition, for every person killed by accident, 100 others are disabled. This means that an estimated 378,000 persons suffered disabling accidental injuries in Michigan in 1950.

While almost five and one-half times as many persons died from heart disease as from accidents, the average age at death was 67.9 years. Statistically speaking, this caused no loss in productive years. Over twice as many died from cancer, but with 62.2 the average age at death from cancer, there was a loss of only 2.8 productive years per death. Over one and one-half times as many persons died from apoplexy but the average age at death was 70.4 years, so there was no loss of working years.

From the standpoint of statistical averages the person dying from heart disease or apoplexy actually had a dividend of three to five years over what is normally considered a working life, while the accident victim fell short by 15.3 years and the motor vehicle accident victim by 23.6 years.

Most Michigan accidents occur on the highway, with almost as many at home and a much smaller number on the job. Falls are the leading cause of home accidents, with burns and scalds, mechanical suffocation, poisoning, gas and firearms following. Persons 65 years of age and over suffer the greatest number of home accidents, with children under five a close second. At these two ends of the life span, home accidents outnumber motor vehicle accidents, accounting for over half the accidental deaths.

Births in Michigan will reach a new high in 1952 judging from the first four months of the year. The number of live births recorded during those four months exceeds that of the corresponding period last year by over 2,200. In 1951, the number of live births in the state broke all records, reaching 171,568. The previous high year had been 1947, with 160,275 births recorded.

A case of smallpox occurred in a southwest Michigan county in early July. A migrant worker in one of the training camps developed the disease. Fortunately he had only been in Michigan 3 days and had not been out of the camp since his arrival so there were few exposures. Other members of the group were vaccinated promptly and no spread of the disease is expected.

With July 15 the scheduled closing date, the special case finding program in venereal disease and tuberculosis carried on in Detroit since May first has recorded 24,252 chest x-rays and 35,966 blood tests.

Department x-ray units will be in operation at five fairs this fall, and at three more if arrangements can be made. They are the State Fair, the Ionia Fair and the Alpena, Isabella and Midland County fairs. This is a smaller number of fairs visited than last year because the Department has only three units in the field and two of them have been assigned to the special case finding program in Detroit. Last fall, 53,982 persons were x-rayed at fairs. Of 1,124 found to have chest abnormalities, 560 had suspected tuberculosis.

A recent death in the engraving industry resulting from the use of a pure benzol solvent has caused the Department's Division of Industrial Health to start a pilot study on the use of solvents by engravers in Grand Rapids—a major engraving center.

If the study shows that engravers are using toxic solvents, the Department will step up its activities in the industry in an attempt to substitute solvents that are non-toxic.

While this is the first such death reported in that industry for a number of years, in other industries they are more common and are of constant concern to industrial health engineers. Several deaths from toxic solvents have occurred in the state in the past few months, chiefly in the dry cleaning and chemical industries.

For several years, vision conservation consultants of the Department have felt the need for a simplified yet relatively accurate means of measuring visual acuity at 20 feet. To meet this need, a Modified Symbol Chart has been developed in the Vision Unit. It is in no way meant to replace the Symbol Chart which has been in use for years. Both charts will be stocked by the Department for use by staff members and by local health departments.

The new chart eliminates all of the symbols except two groups of six each of the 20/30 size. Included are the same number of symbols of the 20/20 size letters so that anyone wishing to screen for farsightedness and having plus sphere glasses available may do so.

To help prevent memorizing, the new chart may be hung in any of four positions, giving a total of sixteen combinations of six symbols.

ONLY SIXTY IN ENGLAND PAY TAXES ON LARGE INCOMES

The thin ranks of Britain's much-soaked earners of big paychecks have been weeded again. The inland revenue commissioners reported only sixty persons had incomes of 6,000 pounds ($16,800) or more after they paid income taxes for the year that ended in March, 1950.

The year before there had been eighty-six members of this dwindling elite corps.

And the little guys paid most of the taxes. Revenue officials said most of the money collected came from 9,290,000 people earning between 5 and 10 pounds ($14 to $28) a week.



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In Memoriam

FILLMORE S. CURRY, M.D., of Detroit, died June 9, 1952, at the age of forty-six.

He was graduated from the University of Michigan Medical School in 1929 and served an internship at Harper Hospital, Detroit, until 1931.

Dr. Curry served a surgical fellowship at the Mayo Clinic in Rochester, Minnesota, and was associate surgeon at the Clinic in 1935. Then he came to Detroit and practiced surgery for sixteen years.

Dr. Curry was on the staff of Harper Hospital and Highland Park General Hospital. He was a member of the American College of Surgeons, the Detroit Academy of Surgeons, and diplomate of the American Board of Surgery.

Besides his wife, Geraldine, he is survived by two sons, Richard and Daniel. He also leaves his parents, Mr. and Mrs. Walter Curry of Cadillac, and a brother, Jerrold, of Connecticut.

DAVID H. FAUMAN, M.D., of Detroit, died December 31, 1951, at the age of sixty.

For the past twenty-five years Dr. Fauman had practiced in Detroit. In 1951 he was elected an Associate Member by the Michigan State Medical Society House of Delegates.

Dr. Fauman was raised in Rochester, N. Y. He received his medical degree from the University of Toronto Faculty of Medicine. Following his graduation he practiced in Toronto and then took postgraduate work in Vienna; Rotunda Hospital, Dublin, Ireland; and at the Chicago Lying-In Hospital.

He is survived by his wife, Rose; a daughter, Mrs. G. S. Allen, of Toronto; and a son, Joseph of Detroit. He also leaves four grandchildren. His mother, sister, and brother also are survivors, living in Rochester, N. Y.

CLARENCE C. GMEINER, M.D., of Detroit, died May 24, 1952, at the age of sixty-two. An obstetrician and gynecologist, Dr. Gmeiner had practiced in Detroit for the past thirty-nine years. He was graduated from the Detroit College of Medicine in 1913 at the age of twenty-three and is reportedly the youngest graduate from that school.

He served his internship at Providence Hospital, Detroit, before entering private practice. He was a charter member of the staff of the Highland Park General Hospital and also was a member of the staff of Woman's Hospital and Children's Hospital.

He is survived by his wife, Emily, three sons and one daughter. They are Clarence Gmeiner, Jr., William L. Gmeiner, Richard L. Gmeiner and Mrs. E. Z. Boies of Battle Creek.

ARCHIBALD E. NAYLOR, M.D., of Detroit, died June 28, 1952, at the age of sixty-five.

For the past forty years Dr. Naylor, who limited his practice to Internal Medicine, was on the staff of Har-

per Hospital, Detroit. He was graduated from the University of Toronto Faculty of Medicine in 1909 and received his medical degree at the Detroit College of Medicine in 1912.

Dr. Naylor was long active in the Wayne County Medical Society and was one of the organizers of its annual golf tournament which was inaugurated in 1930.

He is survived by his wife, Addie; a son, Arthur A. Naylor; and a daughter, Mrs. Barbara J. Stafford. He also leaves a sister, Mrs. Gertrude Benson, and three grandchildren.

FRED R. REED, M.D., of Three Rivers, died June 2, 1952, at the age of sixty-two.

For the past thirteen years he had served the community of Three Rivers as a surgeon. Previous to that, Dr. Reed had practiced in Detroit for twenty-five years following his graduation from the University of Michigan Medical School in 1914.

While in Detroit Dr. Reed was a surgeon for the Detroit Terminal Railway from 1915 to 1924. He was a charter member of the staff of Highland Park General Hospital and also served on the auxiliary staff of Grace Hospital, Detroit.

Dr. Reed was a member of the St. Joseph Medical Society and the American College of Surgeons. He was also active in the Michigan State Medical Society where he served as a member of the Public Relations Committee from 1940 to 1945 and was chairman for two years.

Dr. Reed was the Chief of Staff of the Three Rivers Hospital in 1951 as well as a member of the auxiliary staff of the Sturgis Hospital.

Besides his activity in medical circles, Dr. Reed was a member of the Board of Directors of the Three Rivers Chamber of Commerce in 1950-51, co-chairman of the Three Rivers Community Council in 1951, and medical director of Civil Defense of St. Joseph County in 1950-51.

During World War I he served in the U. S. Navy for two years as a lieutenant in the medical corps.

He is survived by his wife, Virginia, three daughters, and one son. They are Mrs. Elizabeth McBride, of Rock Island, Ill.; Mrs. Nancy Nelson of Manhattan Beach, California; Mary Edna Reed and Fred R. Reed, Jr., of Three Rivers.

OSCAR U. SHAPIRO, M.D., of Detroit, died May 19, 1952, at the age of forty-one.

Dr. Shapiro was graduated from the University of Michigan Medical School in 1937. He served his internship at Providence Hospital, Detroit.

He was active in the work of the Wayne County Medical Society and served as secretary of the Maimonides Medical Society.

He is survived by his wife, Sybil, three children, and his parents.

RAYMOND G. TUCK, M.D., of Royal Oak, died June 22, 1952, at the age of sixty.

Dr. Tuck, who had been forced into inactivity for the past several years because of ill health, had been med-

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A MEDICAL
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In addition to private conferences as needed, group re-education is indispensable in leading the patient back toward total abstinence.

The concept of alcoholism as a medical problem, now generally accepted, is basic in the successful control of the "problem drinker."

At The Keeley Institute the therapeutic regimen is formulated on this premise. Specialized care of the individual patient rests in the hands of a highly experienced staff of physicians who supervise every step of the patient's progress.

Aversion treatment is not used, nor is restraint employed. Rather, the patient is aided toward rehabilitation through highly coordinated diet therapy, re-education, exercise and pleasant activities in an environment conducive to wholesome normal living—all under careful medical supervision.

The referring physician is kept informed of the patient's progress and receives a summary of the case upon the patient's dismissal.

[*This is the fifth of a series describing the successive steps in the treatment of the "Problem Drinker."*]

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ical director and deputy health director in charge of the Southern Oakland branch of the Oakland County Health Department since 1941.

Dr. Tuck was a friend of the late Franklin D. Roosevelt. They were both stricken with polio the same day in 1921 and met while traveling to Warm Springs, Georgia. Dr. Tuck later worked with Mr. Roosevelt in helping to develop Warm Springs as a national foundation.

Dr. Tuck was appointed administrator of the State Emergency Relief Administration in Oakland County in 1933. During the depression of the early thirties, Dr. Tuck developed a workable plan for the medical care of indigents. This "Tuck Plan" brought him nationwide attention and was emulated by many states and counties. Dr. Tuck was invited across the land to outline his unique medical care system to welfare and medical groups.

Dr. Tuck received his medical degree in 1917 from the Detroit College of Medicine. In 1919 he established his practice in Pontiac. Later he practiced in Brown City before returning to Pontiac in 1929 to be on the staff at the Oakland County Tuberculosis Sanatorium. He was a veteran of World War I.

FREDERICK A. WATTS, M.D., of Owosso. died June 7, 1952, at the age of eighty-two.

He served the community of Owosso for forty-one years until illness limited his practice two years ago. Previous to that, Dr. Watts had practiced in Port Hope from 1904 to 1909.

He was graduated from the Detroit College of Medicine in 1899.

Dr. Watts was an emeritus member of the Michigan State Medical Society. In 1949 he was honored by Wayne University in recognition of his long service in the medical profession. For many years Dr. Watts was a city physician of Owosso.

He is survived by two sons, Frederick B. Watts, M.D., of Detroit, and John B. Watts, of California. He also leaves a sister, Mrs. William R. Cutting, of Simcoe, and five grandchildren.

SENATOR MURRAY AT GENEVA ILO CONFERENCE

(Continued from Page 981)

benefits; old-age assistance; workmen's compensation; unemployment compensation; employment services; medical care and sickness benefits; maternity benefits; and family allowances, some of which Congress has specifically provided for, some of which Congress has recognized as appropriate only for determination by individual States, and some of which Congress and State legislatures have determined as appropriate for private rather than public action; and . . ." (Emphasis ours.)—MARGARIE SHEARON, Challenge to Socialism, June 19, 1952.

Correspondence

Wilfrid Haughey, M.D., Editor,
Battle Creek, Michigan

Dear Wilfrid:

During the last two weeks, I have had several inquiries concerning a health and accident policy for members of the MSMS. It seems that the A. George Washington Health and Accident Insurance Company has circularized many members of the MSMS and they try to leave the impression that they were the insurance company who were to offer insurance to the MSMS at our request.

As you know, the plan that the Council has worked out will be presented to the full Council in July before offering it to the House of Delegates in September.

I thought possibly it would be a good idea to run a notice in the JOURNAL stating that the MSMS is developing a plan to be presented to the members of the MSMS directly after the annual meeting in September and that no policy will be offered before that time.

With kindest, personal regards, I am

Sincerely,
W. S. JONES, M.D.
Councilor

July 7, 1952

Mr. William J. Burns,
Mich. State Medical Society,
606 Townsend St.
Lansing, Michigan

Dear Bill:

The six JOURNALS arrived yesterday. My thanks for such prompt service.

Some day, soon, I would like to have a session with you on the possibilities of action through the legislature, or through whatever official channels might be necessary, to tighten up regulations on the general set-up and conduct of many of the "Homes For The Aged" in this State which are far, far below any reasonable concept of a "home"—for humans. I am sure the problem is not new to the medical profession. If there is anything I can do to help, I want to do it.

Best wishes, always,

Sincerely,
A. M. SMITH

June 10, 1952
8100 E. Jefferson Ave.
Detroit 14, Michigan

Dear Doctor:

Physicians from various sections of the country have reported that blood dyscrasias (thrombocytopenia, leukopenia, granulocytopenia, agranulocytosis, and aplastic anemia) have occurred in patients who have received Chloromycetin® (chloramphenicol, Parke-Davis). Among these there has been no uniformity of circumstances, including age, sex, dosage, type of concomitant therapy, or diagnosis. Frequently, though again not uniformly, the individual patient's history includes reference to earlier therapy with Chloromycetin and other drugs and in several instances to intermittent therapy, planned or unplanned, over prolonged periods.

The exact number of cases of aplastic anemia associated with the use of Chloromycetin is not known, but it is recognized that many have terminated fatally. Further, clinical evidence from published and unpublished reports, indicates that intermittent therapy with the antibiotic, and

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particularly indiscriminate therapy for minor affections, frequently obtain. These facts indicate that there is a calculated risk involved in the use of this potent antibiotic so that alert clinical observations and adequate blood studies should be made to detect any depression of bone marrow function as early as possible and before an irreversible state occurs.

Parke, Davis & Company assures the medical profession that as information accumulates from continuing studies on the relation of blood disorders to Chloromycetin it will be disseminated promptly through appropriate channels.

Doctor, please read our pronouncement in the *Journal of the American Medical Association* issue of July 12, 1952.

Sincerely yours,

E. A. Sharp, M.D., *Director,*
Dept. of Clinical Investigation
Parke, Davis & Company

July 7, 1952

A. L. Ziliak, M.D., President
L. Fernald Foster, M.D., Secretary
Bay County Medical Society

Dear Doctors:

In connection with the Bay City General Hospital problem with which the members of the Bay County Medical Society recently were confronted, the Michigan State Medical Society, through action of its Executive Committee of The Council on June 18, commends the Bay County Medical Society and its members for its dignity and integrity in defense of the practice of scientific medicine.

Through its courageous action, the Bay County Medical Society has demonstrated its zeal for the ideals of hospital standardization, created many years ago for the benefit of the people and of public health.

The Executive Committee of The Council of the Michigan State Medical Society congratulates the Bay County Medical Society and each and everyone of its members for its righteous stand in the face of unjust criticism and bitter attacks from those who place selfish interests above the best public service.

Sincerely,

Otto O. Beck, M.D.,
President

July 3, 1952

WOMEN DOCTORS

Lowther and Downes studied the careers of 1,240 women who, in the twenty years prior to 1940, had graduated from the medical schools of Columbia, Cornell, Johns Hopkins, New York University, Yale, the University of Pennsylvania and Woman's Medical College of Pennsylvania.

They found that 82 per cent of the married women remain in full-time medical practice and 90 per cent of them engage in some form of medical activity.

Twenty-four per cent of this group were found to have taken enough advanced training to qualify as medical specialists and an additional 8 per cent combined partial specialization with general practice.

The specialties most frequently chosen by women were pediatrics, psychiatry, internal medicine, and obstetrics and gynecology.—*Bulletin M.H.C.,* June, 1952.

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Laboratory Fees in Hospital	5.00	10.00	15.00	20.00
Operating Room in Hospital	10.00	20.00	30.00	40.00
Anesthetic in Hospital	10.00	20.00	30.00	40.00
X-Ray in Hospital	10.00	20.00	30.00	40.00
Medicines in Hospital	10.00	20.00	30.00	40.00
Ambulance to or from Hospital	10.00	20.00	30.00	40.00

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. NEWS MEDICAL

MICHIGAN AUTHORS

N. M. Brittrich, M.D. and **Joseph S. Rangatore, M.D.**, of Detroit, published an article, "Spinal Anesthesia in Obstetrics," in the *American Journal of Obstetrics and Gynecology,* and an abstract appeared in the *American Practitioner and Digest of Treatment,* June, 1952.

Manuosus A. Peirchelis, M.D., of Ann Arbor, published an article, "Beta Irritation in Ophthalmology" in the *American Journal of Ophthalmology,* May, 1952.

Frank A. Vesy, M.D., of Detroit, published an article, "Sclerotomy in Retinal Detachment," in the *American Journal of Ophthalmology,* May 1952.

V. Everett Kinsey, Ph.D., Kresge Eye Institute, of Detroit, published an article, "An Explanation of The Corneal Haze and Halo Produced by Contact Lenses in the *American Journal of Ophthalmology,* May 1952.

John J. Prendergast, M.D.; Richard L. Fenichel, M.S., and **Byrne M. Daly, M.D.**, of Detroit, are the authors of an article, "Albumin and Globulin Changes in Burns as Demonstrated by Electrophoresis," published in the *Archives of Surgery,* June 1952.

John M. Hammer, M.D.; Frank E. Visscher, Ph.D., and **Adrian Tazelaar, Jr.**, of Kalamazoo, published an article, "Methods of Altering the Incidence of Experimental Ulcers in Dragstedt Animals," in the *Archives of Surgery,* June, 1952.

Russell L. Mustard, M.D., F.A.C.S., and **Harry R. Custer, M.D.**, of Battle Creek, are the authors of an article, "The Management of Acute Cholecystitis," published in *Surgery, Gynecology and Obstetrics,* July, 1952.

H. C. Saltzstein, M.D., of Detroit, et al authored an original article on "Blood Loss During Operations" which appeared in the June 21, 1952, edition of *JAMA.*

* * *

Dr. Warren B. Cooksey, Detroit physician and president of the United Health and Welfare Fund for the past two years, was re-elected president at the annual meeting held Thursday, May 8, at the Hotel Olds, Lansing.

The resignations of Warren D. Pierce, secretary and executive director of the Fund since its beginning in 1947, and M. C. (Shorty) Meador, assistant director and campaign secretary, were announced at the meeting.

* * *

Dr. Karl A. Meyer, president of the Cook County Graduate School of Medicine, has announced the receipt by the school of a donation of $100,000 from the Joseph and Helen Regenstein Foundation. Presentation of the donation was made on the occasion of the official opening of the school's new building located at 707 South Wood Street, Chicago, Illinois.

Mr. Joseph Regenstein, who established the Foundation which made the gift, is a prominent Chicago industrialist. The proceeds of the donation will be used to expand the school's activities in the field of graduate medical education.

* * *

Postgraduate Training.—The following members of the Michigan State Medical Society are now attending postgraduate courses at the Cook County Graduate School of Medicine: Stewart C. McArthur, M.D., Clare; William A. Sautter, M.D., Horton; Leo L. Marston, M.D., Lakeview; C. J. Carpenter, M.D., Wayne.

* * *

Jerome W. Conn, M.D., Ann Arbor, took part in a conference arranged by the Ciba Foundation of London, England, June 27 to July 4, 1952, where he discussed "The Influence of the Adrenal Cortical Steroids upon Carbohydrate Metabolism in Man." He also attended a conference in Leiden, Holland, under the auspices of the United Nations Educational Scientific and Cultural Organization. His subject: "The Possible Role of the Pituitary Adrenal in the Pathogenesis of Diabetes Mellitus."

* * *

The *American Journal of Psychiatrics* for July, 1952, contains a full page picture of **Dr. Leo H. Bartemeir,** retiring president of the American Psychiatric Association. It contains his presidential address and a biographical sketch of the doctor written by Henry W. Brosin, M.D., of Pittsburgh, Pa.

This number of the JOURNAL also has reports of the annual meeting, book reviews, papers, notes and other items.

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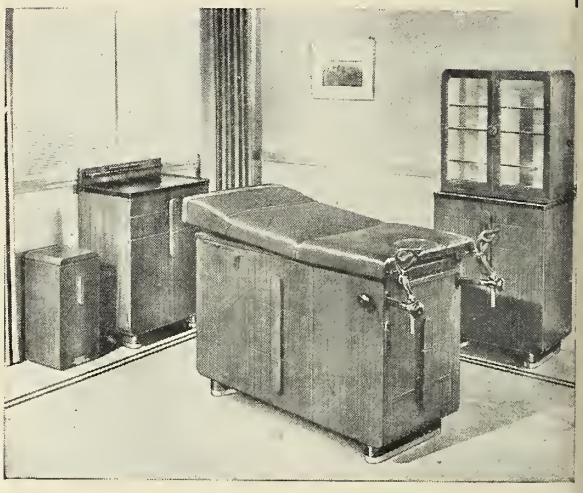
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R. J. Hubbell, M.D., Kalamazoo, President-Elect of the Michigan State Medical Society, was married to Agnes Maday Jenkins of Seattle, Washington, on August 9.

Congratulations, Doctor and Mrs. Hubbell.

* * *

The National Gastroenterological Association will hold its seventeenth annual scientific session at Hotel Statler, New York City, October 20-22, 1952. For program and information, write the Secretary at 1819 Broadway, New York 23, N. Y.

* * *

The Council on National Emergency Medical Service of the American Medical Association has, during the past several months, sponsored a series of articles on the medical aspects of civil defense which has appeared in the *Journal of the American Medical Association.*

These articles have now been reproduced in booklet form. It appears from the large number of requests A.M.A. has received for the booklet that the articles are of genuine interest to the medical profession and the general public. The booklet sells for 25c a single copy, and 20c per copy for orders of 100 or more.

* * *

Action of Maternal Health Committee.— Dr. Corneliuson, representing the State Board of Health, requested an opinion from the Committee as to the feasibility of enforcement of the rule requiring serological tests on pregnant women within thirty days of delivery, as now required by the regulations and rules for maternity hospitals. After considerable discussion the Committee felt that the regulations as now stated, and as recommended by the State Venereal Disease Committee, were beneficial and should be enforced.

Motion: The regulations concerning taking of serological tests for syphilis within thirty days prior to delivery remain as written with the recommendation that compliance with the rule be ordered by the State Department of Health.

It was felt that perhaps the regulations have not been sufficiently publicized and that a copy should be sent to all hospitals and to private physicians so they might be aware of their existence. The motion was seconded and unanimously approved.

It was approved by the Executive Committee of The Council, on June 18, 1952.

* * *

Incidence of poliomyelitis has been "significantly higher" this season over the comparable period last year in eight states and Hawaii, according to PHS. It lists the following cases reported since March, with last year's cases in parentheses: Ohio, 24 (6); Iowa, 20 (9); Missouri, 15 (6); Florida, 67 (52); Mississippi, 64 (18); Louisiana, 89 (49); Texas, 467 (278); California, 202 (159) and Hawaii, 39 (1). The national totals are 296 cases this year compared with 162 for the same period in 1951, or an increase of nearly 18 per cent.

* * *

Continuation of the steel strike is expected to force a drastic cutback shortly in the amount of steel allocated for construction of *hospitals and clinics.*

While no restrictive orders have yet been issued, officials of the Division of Civilian Health Requirements (PHS) anticipate them unless steel production can be resumed.

The Division is planning to distribute whatever steel it is allowed among building projects already under way, to avoid unnecessary unemployment. It is expected that work will be forbidden on jobs not already started when and if a curtailment order is issued. Paradoxically, a 300% increase in copper will be allowed, starting July 1, on most hospital construction work. Until the steel strike, copper presented the most critical problem among the scarce metals. Producers of certain equipment important to hospitals, including refrigerators, also will be allowed increased supplies of copper.

* * *

Detroit Institute of Cancer Research

The Fifth Annual Scientific Meeting of the Institute will be held Monday, Tuesday and Wednesday, October 20, 21 and 22, 1952.

The scientific sessions will be held in the small auditorium of the Engineering Society of Detroit, 100 Farnsworth Avenue. The fundamental sciences will occupy the first two days of the meeting with morning and afternoon sessions on both days. Speakers and their titles for the first two days are as follows:

C. B. Anfinsen, Jr., Ph.D., National Heart Institute—The nature of biosynthetic mechanisms of protein synthesis.

Konrad Bloch, Ph.D., University of Chicago—The biological synthesis of cholesterol.

Jacob Furth, M.D., Oak Ridge National Laboratary—The problem of autonomy and dependence of tumor cells.

G. Gomori, M.D., Ph.D., The University of Chicago—Esterases of animal tissues.

Alexander Hollaender, Ph.D., Oak Ridge National Laboratory—Studies on the basic mechanism of the effects of radiation on individual cells.

Laurence H. Snyder, Sc.D., The University of Oklahoma—Genetics and its implication for human disease.

Paul Weiss, Ph..D., The University of Chicago—Growth and differentiation on the cellular and molecular levels.

Carroll M. Williams, Ph.D., M.D., Harvard University—Biochemical mechanisms in insect growth and metamorphosis.

D. W. Woolley, Ph.D., The Rockefeller Institute for Medical Research—The considered use of Antimetabolites.

The clinical program will be held on the afternoon of the third day beginning at 2:00 p.m. The clinical program will include the following talks:

Loyal Davis, M.D., Northwestern University Medical School—The localization and treatment of gliomas of the brain.

Sidney Farber, M.D., The Children's Medical Center—A review of our most recent experience in the chemotherapy of cancer.

George T. Pack, M.D.—Pack Medical Group—Problem of pigmented moles and malignant melanoma.

Shields Warren, M.D., New England Deaconess Hospital—An appraisal of radioisotopes in cancer therapy.

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Naval Reserve Officers.—The Commanding Officer of Volunteer Reserve Medical Unit 9-5, Detroit, Michigan, cordially invites all Medical Corps, Dental Corps, Nurse Corps and Medical Service Corps Officers to attend a dinner meeting with the District Medical Reserve Program Officer.

Date: September 30, 1952.

Place: Officers Club, Naval Air Station, Grosse Isle, Michigan.

Time: 6:30 p.m.

Speaker: Capt. Laurence E. C. Joers, MC, USNR.

Subject: "The Medical Department of the Navy, Regular and Reserve."

Reservations are mandatory. Kindly mail checks ($3.00) to Cdr. Meshel Rice (MC) USNR, 2415 W. Grand Boulevard, Detroit (8) Michigan.

Capt. Osborne A. Brines, MC, USNR
Commanding

* * *

Veterans Administration.—According to new Veterans Administration ruling, state and private hospitals treating psychosis patients recently declared service-connected will be reimbursed for care from the time of application for service-connected status by the veteran instead of from the time the veteran is actually declared service-connected disabled.

* * *

Charles Donatelli, M.D., of Toledo, won the 1952 championship of the American Medical Golfing Association with a score of 154 (76-78) for thirty-six holes, at Medina Country Club, Chicago, on June 9.

Aaron A. Farbman, M.D., Detroit, was winner of the 100 volume display of current medical journals, bound by Publishers Authorized Binding Service on the occasion of the June, 1952, AMA Annual Session in Chicago. Dr. Farbman has presented the 100 volumes to the Detroit Memorial Hospital.

* * *

S. E. Gould, M.D., Eloise, attended the Central States' Conference on Brucellosis in Animal and Human, Saint Paul, July 7, 8 and 9, as official representative of the Michigan State Medical Society.

* * *

Dispensing Barbituric Acid Preparations.—The Director of Drugs and Drug Stores, Michigan Board of Pharmacy, invites the attention of all Michigan practitioners of medicine to the dispensing of barbituric acid preparations without proper labeling and marking on the containers dispatched, and without the name of the patient. The Michigan Dangerous Drug Act specifically provides for such labels and for the patient's name. The provisions of this Michigan law are invited to the serious attention of all MSMS members.

* * *

The notebooks distributed to all registrants at the 1952 MSMS Annual Session are received with the compliments of Bruce Publishing Company, Saint Paul, printers of The Journal MSMS.

Thank you, Bruce Publishing Company, for your continued thoughtfulness on the occasion at our Annual Sessions!

* * *

The New York Academy of Medicine will hold its

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25th Annual Graduate Fortnight October 6-17, 1952, at its headquarters, 2 E. 103rd Street, New York 29.

For complete program, write the secretary, Graduate Fortnight, at above address. The registration fee for the entire program is $10 ($5 for the second week).

* * *

Fifteen state medical societies now employ a full time public relations director or consultant. Twenty-five states list separate public relations budgets.

Eight state societies now employ field representatives to implement their programs, including public relations, among the counties. Seven other state medical societies employ half-time field men, and several others are considering the hiring of men to fill similar positions in the very near future.

* * *

Holiday for hospitals and clinics on Election Day.—This suggestion from John V. Sullivan, M.D., of Akron, was recently received by AMA President L. H. Bauer, M.D. Dr. Sullivan writes, "I would like to suggest that presidential election day be a legal holiday for every hospital in the nation. This would involve suspension of clinics and operating schedules. What more important holiday is there during the year?"

* * *

The American Heart Association recently awarded $361,522.00 for seventy-two research grants-in-aid, according to Irving S. Wright, M.D., president. The investigations are being conducted at institutions in twenty states, the District of Columbia, Montreal, and Beirut, Lebanon.

The grants included $5,880 to the University of Michigan Medical School (Mark Nickerson) and $6,184 to Wayne University (Carl Djerassi).

* * *

Beaver Island physician. A doctor of medicine is needed at Beaver Island, Michigan. For full information, write State Health Commissioner A. E. Heustis, M.D., Michigan Department of Health, Lansing, Michigan.

* * *

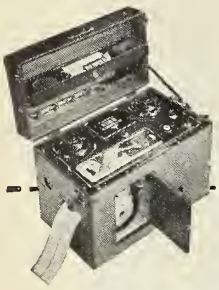
Wm. A. Hudson, M.D., Detroit, was elected first vice president of the American College of Chest Physicians at its Chicago annual meeting in June, 1952.

Willard B. Howes, M.D., Detroit, is a member of the Board of Regents and Constantine P. Mehas, M.D., Pontiac, is a member of the Board of Governors.

Michigan registrants at the Chest Physicians annual meeting included: Robert Berman, M.D., M. M. Braverman, M.D., J. T. Cheng, M.D., Nicholas DeJanney, M.D., B. E. Goodrich, M.D., Willard Howes, M.D., W. A. Hudson, M.D., F. L Jones, M.D., V. A. Kelmenson, M.D., Rupert Markoe, M.D., R. I. Shapiro, M.D., Keh-ming Sun, M.D., and K. A. Wood, M.D., all from Detroit; C. T. Root, M.D., Fort Custer; I. T. Gadzikowski, M.D., and Richard Meade, M.D., from Grand Rapids; F. C. Test, M.D., Mt. Clemens; V. George Chabut, M.D., Northville; W. H. Howard, M.D., Northville, and G. H. Phillips, M.D., Pontiac.

* * *

Norman B. McCullough, M.D., has been appointed Chief of Clinical Research at the Microbiological Insti-



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tute of the National Institute of Health, Bethesda. Dr. McCullough is a native of Michigan, being born in Milford in 1909.

* * *

"Utopia in a Straitjacket," which appeared in *The Freeman* of June 16, describes Britain's four-year experiment in socialized medicine. Melchior Palyi, who conducted a survey of Britain's national health program for the publication, states that the Britain scheme has stifled medical research, degraded the doctor, and virtually bankrupted the nation.

Copies of *The Freeman* may be obtained by writing the editorial offices at 240 Madison Ave. New York 16—25 cents the copy.

* * *

"Homecoming" featured the 54th meeting of the Upper Peninsula Medical Society at Iron Mountain June 27 and 28: All speakers were former UP "boys" who had gone out into the world to gain success in their chosen field of medical practice. The essayists included Louis J. Hirschman, M.D., Traverse City (who originated in Republic, Michigan); Rear Admiral C. A. Swanson, (MC) USN (Marquette); C. J. Curry, M.D., Flint, (Iron County); Grant H. Laing, M.D., Chicago (Iron Mountain); Grover C. Penberthy, M.D., Detroit (Houghton); Norman F. Miller, M.D., Ann Arbor (Iron Mountain); Luther R. Leader, M.D., Detroit (Ironwood); John L. Garvey, M.D., Milwaukee (Iron Mountain); Paul H. Garvey, M.D., Rochester, N. Y. (Iron Mountain); Wm. B. Seaman, M.D., St. Louis, Mo. (Iron Mountain); Timothy R. Murphy, M.D., Milwaukee (Crystal Falls); John A. Newkirk, M.D., Elgin, Ill. (Norway); Carl A. Moyer, M.D., St. Louis, Mo. (Baraga); Angus Goetz, M.D., Detroit (Detour), and Carleton Fox, D.D.S., Detroit (Ironwood).

At the luncheon of June 27, presided over by W. H. Huron, M.D., Iron Mountain, president of the Dickinson-Iron County Medical Society and AMA Delegate from Michigan, the "Formula For Freedom" was presented by the Michigan State Medical Society through Secretary L. Fernald Foster, M.D., Bay City, H. W. Brenneman, Lansing, Public Relations Counsel, and D. Hale Brake, Treasurer of the State of Michigan.

Moderators of the scientific program included Wm. Fiedling, M.D., of Norway, Wm. A. Alexander, M.D., of Iron Mountain, L. E. Irvine, M.D., of Iron River, and C. A. Cooper, M.D., of Stambaugh

The Upper Peninsula Medical Society Annual Session featured meetings of its Woman's Auxiliary, the Office Nurses and Assistants Society, and the American Cancer Society, Upper Peninsula Division.

The largest registration in the history of the Upper Peninsula Medical Society and a most enthusiastic response on the part of all who registered testified to the excellent arrangements and scientific program developed by the Dickinson-Iron County Medical Society committee, ably headed by D. R. Smith, M.D., Iron Mountain and E. T. Palm, M.D., Crystal Falls. Twenty firms exhibited at the 1952 UP Homecoming Meeting.

Louis J. Hirschman, M.D., was toastmaster at the Annual Banquet, Saturday, June 28, which was a highlight ending of a very successful meeting.

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Registrants at the meeting included the following: C. G. Menzies, M.D., Iron Mountain; C. G. Steinke, M.D., Iron Mountain; H. D. McEachran, M.D., Iron Mountain; W. H. Alexander, M.D., Iron Mountain; J. M. Schroeder, M.D., Iron Mountain; W. H. Huron, M.D., Iron Mountain; D. R. Smith, M.D., Iron Mountain; E. A. McCormack, M.D., Niagara, Wisc.; E. R. Addison, M.D., Crystal Falls; N. F. Miller, M.D., Ann Arbor; Edward Sawbridge, M.D., Stephenson; K. C. Kerwell, M.D., Stephenson; W. B. Seaman, M.D., St. Louis, Mo.; G. H. Laing, M.D., Chicago, Ill.; R. J. Rogers, M.D., Oconto, Wisc.; D. F. LeMire, M.D., Escanaba; Gereon Fredrickson, M.D., Iron Mountain; J. R. Heidenreich, M.D., Dagget; N. L. Lindquist, M.D., Escanaba; D. P. Hornbogen, M.D., Marquette; L. P. Rahm, M.D., Grosse Pointe; N. J. Frenn, M.D., Bark River; J. W. Towey, M.D., Powers; G. H. Boyce, M.D., Iron Mountain; W. N. Hayes, M.D., Norway; J. A. Cowan, M.D., Lansing; Alfred LaBine, M.D., Houghton; Simon Levin, M.D., Iron River; A. S. Narotzky, M.D., Ishpeming; J. L. Garvey, M.D., Milwaukee, Wisconsin; H. H. Haight, M.D., Washington, D. C.; R. F. Lamb, M.D., Niagara, Wisc.; A. B. Aldrich, M.D., Houghton; H. J. Winkler, M.D., L'Anse; L. G. Glickman, M.D., Menominee; Moses Cooperstock, M.D., Marquette; L. R. Leader, M.D., Detroit; W. A. Schmutzler, M.D., Kingsford; M. W. Fiedling, M.D., Norway; T. B. Mackie, M.D., Sault Ste. Marie; E. S. Rhind, M.D., Sault Ste. Marie; A. R. Peterson, M.D., Daggett; G. C. Penberthy, M.D., Detroit; J. O. Newkirk, M.D., Elgin, Ill.; E. T. Palm, M.D., Crystal Falls; W. G. Mackersie, M.D., Detroit; W. J. Caster, M.D., Marquette; P. H. Garvey, M.D., Rochester, N. Y.; F. C. Anderson, M.D., Escanaba; D. C. Eisele, M.D., Ironwood; G. J. Curry, M.D., Flint; S. N. Lyttle, M.D., Flint; N. L. Mathews, M.D., Marquette; S. K. Sweaney, M.D., Powers; J. R. Acocks, M.D., Marquette; T. A. McInary, M.D., L. P. Groos, M.D., Escanaba; Rear Admiral Swanson (MC) USN, Great Lakes, Ill.; W. C. Lambert, M.D., Marquette; F. J. DeWane, M.D., Menominee; J. R. Dehlin, M.D., Gladstone; A. W. Erickson, M.D., Ishpeming; J. H. Fyvie, M.D., Manistique; J. T. Kaye, M.D., Menominee; B. T. Montgomery, M.D., Sault Ste. Marie; H. M. Harrington, M.D., Sault Ste. Marie; L. J. Hirschman, M.D., Traverse City; C. R. Smith, M.D., Hancock; C. A. Moyer, M.D., St. Louis, Mo.; W. M. LeFevre, M.D., Muskegon; H. R. Brukardt, M.D., Menominee; A. L. Amolsch, M.D., Marquette; T. P. Wickliffe, M.D., Calumet; L. E. Irvine, M.D., Iron River; C. J. Mock, M.D., Chicago, Ill.; W. F. Strong, M.D., Ontonagon; Isaiah Sicotte, M.D., Michigamme; R. A. Tearman, M.D., Munising; L. W. Howe, M.D., Marquette; A. H. Miller, M.D., Gladstone; W. S. Jones, M.D., Menominee; P. J. Murphy, M.D., Calumet; J. J. Walch, M.D., Escanaba; D. T. Anderson, M.D., Iron Mountain; L. Fernald Foster, M.D., Bay City; R. J. Maginn, M.D., Goodman, Wisc.; D. Hale Brake, Lansing; J. W. Castellucci, Detroit; L. H. Freye, Detroit; R. T. Bolich, Detroit; L. G. Goodrich, Detroit; R. D. Cecconi, Detroit; J. P. Rahm, Ann Arbor; M. J. Boucher, Detroit; J. J. Herbert, Manistique; Stuart A. Campbell, Lansing; Hugh W. Brenneman, Lansing; Wm. J. Burns, Lansing; Carleton Fox, D.D.S., Detroit; J. C. O'Donnell, D.D.S., Iron Mountain; L. J. Straub, D.D.S., Iron Mountain; C. O. Veranth, D.D.S., Iron Mountain.

* * *

The University of Michigan School of Public Health was granted $25,000 for "instruction in public health practices for cancer control" by the Federal Security Agency, Public Health Service, National Cancer Institute, according to a release dated July 8.

Grants "to help support medical and scientific research activities" were made by the Public Health Service of the Federal Security Agency during the first half of

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the current fiscal year, including the following to Michigan institutions: $20,470 to Michigan State College (three grants); $8,154 to the University of Michigan, and $5,646 to Wayne County General Hospital at Eloise.

* * *

Joseph S. Lawrence, M.D., long time director of the AMA's Washington office, was tendered a testimonial luncheon by 300 friends during the AMA Annual Session in Chicago. Dr. Lawrence will retire September 1 but will remain as advisor to the AMA in Washington.

Best wishes, Dr. Lawrence—you have done a grand job!

* * *

Harry J. Loynd, President of Parke, Davis & Co., was recipient of an honorary Doctor of Science degree conferred by the Philadelphia College of Pharmacy and Science a 131-year-old institution.

Mr. Loynd, who has been with Parke, Davis for twenty-two years, was elevated to the presidency of this old Detroit company in April, 1951. The degree was conferred "in recognition of the leadership which he evidenced in the field of public health and human welfare."

* * *

Hill-Burton Hospital Construction approved on June 1 a grant of $401,500 for the Lapeer County Hospital at Lapeer, Michigan. This institution will supply fifty-two additional beds and will cost a total of $953,500.

Oceana Hospital at Hart also was granted $200,750 toward a total $400,000 cost; this institution will supply thirty-two additional beds.

* * *

Popular JMSMS.—Returns from the survey of our State Journal, made in the February 29, 1952, Secretary's Letter, re the department of JMSMS most popular with our members, indicates that the great plurality favored the scientific articles as their first choice.

* * *

"Physicians have helped add years to life. At age sixty-five let them now relax and add life to their years."
—Kenneth B. Babcock, M.D., Detroit.

* * *

Olin West, M.D., long-time Secretary and General Manager of the American Medical Association, who retired April 1, 1946, died in Nashville, Tennessee, on June 19, 1952. He was seventy-eight years of age.

First as Field Secretary and later as Secretary-General Manager of the AMA, Dr. West served Medicine and its national organization for more than a quarter of a century.

At the 1946 San Francisco meeting, the AMA House of Delegates adopted a resolution commending Dr. West's long service in behalf of the medical profession.

* * *

The 1952 Clinical (Interim) Session of the AMA will be held in Denver; the 1953 Interim Session will be in St. Louis; 1954 in Miami; 1955 in Boston.

* * *

During the recent AMA Annual Session in Chicago, the Chicago Medical Society contributed $25,000 to the American Medical Education Foundation. In addition, the Woman's Auxiliary to the American Medical Asso-

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iation contributed $10,000 and the American College f Radiology, $2,000.

The physicians of Illinois are assessing themselves $20 ach in the year 1952, as their contribution to the AMEF.

There are 400,000 active cases of tuberculosis in the United States, according to estimates reported by the statistical service of the National Tuberculosis Association. Of these, 150,000 have not been diagnosed or officially reported, another 40,000 are sputum-positive patients living at home and 75,000 are patients diagnosed active who have had no medical examinations within the past year—an estimated total of approximately 250,000 Americans who are in a position to spread tuberculosis to their fellow citizens.

Routine screening by x-ray of all patients who seek medical care would uncover a large proportion of the unknown cases of tuberculosis.

MICHIGAN TUBERCULOSIS ASSOCIATION

The 1953 Michigan Clinical Institute will feature a ancer symposium the morning of Thursday, March 12. peakers to be invited are:

1. Lloyd Craver, M.D., New York, N. Y., on "Diagnostic Problems of Cancer."
2. M. H. Griswold, M.D., Hartford, Conn., on "Prognosis of Cancer."
3. H. W. K. Dargeon, M.D., New York, N. Y., on "Childhood Cancer" (Sykes lecture).
4. H. W. Cole, M.D., Cleveland, Ohio, on "Cancer of the Skin."

Luncheon in honor of the guest speakers will follow these four presentations. The symposium and the luncheon are under the sponsorship of the MSMS Cancer Control Committee, the American Cancer Society (both Divisions in Michigan), and the Michigan Department of Health.

* * *

F. E. Luger, M.D., Saginaw, President of the Saginaw County Medical Society, writes in his President's Page (*Bulletin, Saginaw County Medical Society* for May, 1952):

"The best way we can avoid the evils of socialization as applied to medicine is to take an active interest in politics. Many of you may still believe that the Doctor should not voice an opinion regarding any problem in the political world. That this belief is antiquated has been proven by the results our medical organizations have obtained in combating and sponsoring various issues which have been of interest to our group.

"The machinery is set up to pave the way for our participation in the affairs of our government. Our



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interest in these affairs may mean the difference between the practice of our profession as it is at present or the possibility of a government controlled medical organization which will be unsatisfactory, not only to us but to the public."

* * *

"The time to take a vacation is while you can still enjoy it and do the things that you have always wanted and intended to do. . . . You have a permanent asset in the memory of a good vacation." P. S. Bradshaw, M.D., President, Muskegon County Medical Society in the *MCMS Bulletin,* June, 1952.

* * *

MSMS President Otto O. Beck will be the honored guest at a testimonial banquet tendered by the Oakland County Medical Society on September 3.

The annual award of the Oakland County Medical Society to one of its members for outstanding service to the medical profession was voted to Dr. Beck, who has served as President of the Oakland County Medical Society, Member and Chairman of the MSMS Council and is now President of the Michigan State Medical Society.

The award night is scheduled for the Knollwood Country Club, Oakland County, on Wednesday, September 3.

* * *

The Michigan Health Council's television show called "The Court of Health" has been channelled on WJBK-TV, Detroit, since June 1. The hour runs from 10:30 to 11 a.m.

The program through July 13 was as follows:

June 1 Title: "AREAS OF CO-OPERATION IN HEALTH"
Type: Introduction
Content: Discussion of co-operation and liaison between Doctors of Medicine, Hospitals and Michigan Department of Health.
Guests: Otto O. Beck, M.D., President, MSMS
J. K. Altland, M.D., Michigan Department of Health
Mr. Glen Fausey, President, Michigan Hospital Association

June 8 Title: "OPPORTUNITIES IN THE NURSING PROFESSION IN MICHIGAN"
Type: Organizational — Michigan Nursing Center Assn.
Content: Nursing as a Career
Film—"Girls in White"
Introduction of two Student Nurse Award Winners
Guests: Miss Lucy Germain, President, Michigan Nursing Center Association
Mrs. Grace Wulff, Detroit Council on Community Nursing
Jean Gibbs and Joan Engquist, Nurses

June 15 Title: "SUMMER HEALTH HAZARDS"
Type: Seasonal
Content: Discussion of Summer Health and Accident Hazards. Accident plates from Michigan State Police files with brief commentary.

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	Guests:	Arthur E. Schiller, M.D., Dermatologist, Detroit Lt. C. F. Van Blankensteyn, Commanding Officer, Safety and Traffic Bureau, Michigan State Police, East Lansing.
June 22		No show due to coast-to-coast telethon with Crosby and Hope running through our regular time.
June 29	Title:	"ACTIVITIES OF THE DEARBORN HEALTH COUNCIL"
	Type:	Local
	Content:	Preview of T.B. Survey, Dental Clinic, and past projects, also future program. Explanation of Health Council idea and how it is formed and operated.
	Guests:	Mrs. Mary Finnson, Dearborn Health Department Dr. Harold Lynch, Dentist, Dearborn Mr. Roscoe Simmons, Dearborn Public Schools Mrs. Muriel Binder, Dearborn Health Council Miss Atishun, T.B. case
July 6	Title:	"NEW HOPE FOR HEARTS"
	Type:	Organizational
	Content:	Discussion of research being done with possibility of preventing heart attacks. With experiment by M.D. showing artificial clotting. Also film on the heart as a wonderful machine.
	Guests:	Frederic Johnson, M.D., Wayne University College of Medicine Mrs. Hugh Wilson, Vice President, Michigan Heart Association.
July 13	Title:	"SUMMER SANITATION"
	Type:	Organizational
	Content:	Discussion of broad aspects of sanitation with emphasis on summertime and vacational hazards. Ten-minute film (Walt Disney production).
	Guests:	John Hepler, Dir. of Engineering, Michigan Department of Health Morton S. Hilbert, Public Health Engineer, Wayne County Health Department, Eloise

Programs for the balance of July and for August and September are:

July 20	Title:	"FARM SAFETY WEEK"
	Type:	Seasonal
	Member:	The Michigan Farmer—M.S.C. and Farm organizations
July 27	Title:	"FAITH IN YOUR PHARMACIST"
	Type:	Organizational
	Member:	Michigan State Pharmaceutical Association
Aug. 3	Title:	"POLIO"
	Type:	Organizational and seasonal
	Member:	National Foundation for Infantile Paralysis

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Aug. 10	Title:	"HOW THE AUTOMOBILE INDUSTRY SAFEGUARDS THE HEALTH OF ITS WORKERS."
	Type:	Seasonal
	Content:	Discussion of Industrial Health facilities and programs in industry.
Aug. 17	Title:	"THE ACTIVITIES OF THE GARDEN CITY HEALTH COUNCIL"
	Type:	Local and organizational
	Member:	Garden City Health Council
Aug. 24	Title:	"THE MENTALLY RETARDED CHILD"
	Type:	Organizational
	Member:	Michigan Association of Parents and Friends of Mentally Retarded Children
Aug. 31	Title:	"GUARD YOUR HEART"
	Type:	Organizational
	Member:	Michigan Heart Association
Sept. 7	Title:	"HEALTH IN SCHOOL"
	Type:	Organizational and seasonal
	Member:	Michigan Education Association
Sept. 14	Title:	"PUBLIC HEALTH"
	Type:	Organizational
	Member:	Michigan Public Health Association
Sept. 21	Title:	"COMMUNITY HEALTH"
	Type:	Local
	Member:	Centerline School Health Council

* * *

IMPORTANT DATES

1. *The MSMS Cancer Control Committee announces that the fourth Michigan Cancer Conference* will be held October 9 at the Kellogg Center for Continuing Education, East Lansing (on the Michigan State College campus). The conference theme is "Health Investment Day." For complete program write F. L. Rector, M.D., Secretary, Cancer Control Committee, 606 Townsend Street, Lansing 15, Michigan.
2. *The sixth annual Michigan Rural Health Conference* will be held January 16-17, 1953, at the Kellogg Center, East Lansing, Michigan (on Michigan State College campus). Milon Grinnel of East Lansing, Editor of the *Michigan Farmer,* is Chairman of the sixth Michigan Rural Health Conference. Eugene Wiard of the Michigan Health Council, 706 N. Washington Avenue, Lansing 6, Michigan, was reelected Secretary.
3. *The fourth annual Michigan Industrial Health Day* will be held on Tuesday, March 10, 1953 (the day preceding the Michigan Clinical Institute), in the Sheraton-Cadillac Hotel, Detroit. For program, write P. J. Ochsner, M.D., 515 West St., Lansing, Michigan.
4. *The seventh Michigan Clinical Institute* is scheduled for the Sheraton-Cadillac Hotel, Detroit, March 11-12-13, 1953.

 The "block system," which proved so popular in March, 1952, will be repeated at the 1953 Michigan Clinical Institute. Wednesday, March 11 will feature "surgery" in the morning and "obstetrics and pediatrics" in the afternoon. On Thursday, March 12, the morning subjects will be devoted to "cancer control" and the afternoon to "surgery of trauma." On Friday, March 13, "heart and rheumatic fever" talks will be heard on the morning with "intestinal medicine" subjects in the afternoon.

DETROIT PHYSIOLOGICAL SOCIETY

(Continued from Page 1024)

eration. In the cat, a spinothalamic tract could not be demonstrated. The spinoreticular fibers probably represent a pathway for sensory modalities which bypass the medial lemniscus. An oscillographic study of evoked electrical potentials in cerebral cortex, midbrain tegmentum, cerebellum is in progress in this laboratory. The results indicate that, in the cat at least, bilateral spinal pathways are available for impulses originated from nerves of "superficial" and "deep" sensibility. These impulses presumably relay in the medullar reticular formation. Chronic preparation with cord and midbrain lesions indicate a bilateral representation of the same systems and again point to the reticular formation of the medulla as a site of sensory inflow. The present evidence, still too incomplete to allow any definite statement on the problem of the specificity of the central pathway for pain, casts many doubts on the validity of our concepts on the subject and reveals important gaps in our knowledge of the sensory pathway in general.

THE DOCTOR'S LIBRARY

Acknowledgment of all books received will be made in this column, and this will be deemed by us as full compensation to those sending them. A selection will be made for review, as expedient.

A HANDBOOK OF OPERATIVE SURGERY. SURGICAL GYNECOLOGY INCLUDING IMPORTANT OBSTETRICAL OPERATIONS. By J. P. Greenhill, M.D., Professor of Gynecology, Cook County Graduate School of Medicine; Attending Gynecologist, Cook County Hospital; Attending Obstetrician and Gynecologist, Michael Reese Hospital. Illustrated by Angela Bartenbach. Chicago: The Year Book Publishers, Inc., 1952. Price $8.50.

This is a very compact book by a very popular author. It is of a size that would fit conveniently in one's pocket and for that reason is an excellent edition for the medical student.

Dr. Greenhill has very wisely concentrated on illustrative drawings and minimized the text. By consulting excellent drawings made from his own material one can refresh his memory of an operative procedure at a glance.

The text covers most gynecological and obstetrical procedures. It further includes those abdominal operations that the gynecologist might be confronted with in everyday practice.

We are very pleased with our copy of this book.

CARDIOGRAPHY IN GENERAL PRACTICE, Electrocardiography, Vectocardiography, and Ballistocardiography. By Abraham I. Schaffer, M.D., Assistant Visiting Physician, Metropolitan City Hospital; Assistant Adjunct Bronx Hospital; Assistant Physician, Flower-Fifth Ave. Hospital. Baltimore: The Williams & Wilkins Co., 1952. Price $3.00.

This is a small, easily handled book giving the fundamentals of electrocardiography, outlining the forms and meanings of tracings. There is a chapter on how the heart behaves electrically, with illustrations and diagrams to explain the philosophy of the waves. Various forms of heart disease are discussed with the explanation of the tracings. The illustrations are many but very simple, each one explaining a single fact. The book is intended to help the average physician acquire a working knowledge of this very recent aid to diagnosis.

SIGNS AND SYMPTOMS. Applied Pathologic Physiology and Clinical Interpretation Edited By Cyril Mitchell MacBryde, A.B., M.D., F.A.C.P. Associate Professor of Clinical Medicine, Washington University School of Medicine; Assistant Physician, the Barnes Hospital; Director, Metabolism and Endocrine Clinics, Washington University Clinics, St. Louis, Missouri Second Edition. 98 Illustrations, 50 charts and 8 color plates. Philadelphia: J. B. Lippincott Co., 1952. Price $10.00.

This text, emphasizing physical diagnosis in the practice of medicine, is in keeping with the present-day swing back away from the over-emphasis on the laboratory, which has until recently prevailed so much in our diagnostic approach to disease. This text attempts to present the "why" behind many of the symptoms and signs commonly seen in the everyday practice of the busy physician, be he general practitioner or specialist.

The book, edited by Dr. MacBryde, is divided into chapters each bearing the title of a particular sign or symptom, which is discussed by an outstanding authority in the particular field represented.

The format is in double column, good size print which makes for ease of reading and is well illustrated. It is a book which may be picked up and read with interest in any physician's spare moments.

Although some of the material presented is somewhat controversial, the book on the whole is very well done, and is one which any physician interested in the scientific side of his practice should possess.

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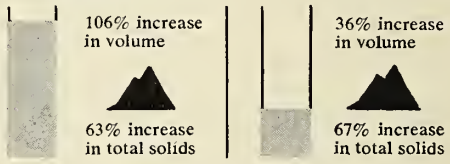
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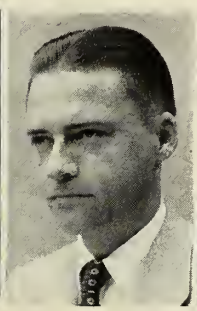
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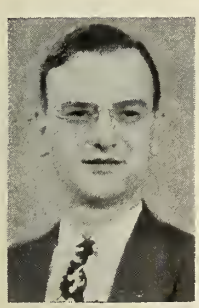
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HIGHLIGHTS OF MID-SUMMER SESSION OF THE COUNCIL
July 13-14-15, 1952

One hundred five items were considered by The Council at its Mid-Summer Session. Chief in importance were:

- Monthly financial reports, as well as the semi-annual balance sheet covering all MSMS funds, were presented, studied and approved. The quarterly and semi-annual reports of the Cancer Control Committee were studied and approved. Bills payable were inspected and payment was authorized.
- Cancer Manual. Michigan Health Commissioner A. E. Heustis, M.D., stated that the State Health Department would finance the publication of 5,000 copies of the new Cancer Manual "A Story of Cancer for High Schools" in the sum of $1,635.00; The Council ordered that full credit be given in the brochure to the Michigan Department of Health and to Commissioner A. E. Heustis, M.D., and to the American Cancer Society, Michigan Division.
- Request of Michigan State Board of Registration in Medicine for more finances from fees increased by 1952 Legislative Act: The Council voted to offer its co-operation to the Michigan State Board of Registration in Medicine through a Liaison Committee when the appointment of same is requested by the Board.
- Beaumont Memorial Restoration. President Otto O. Beck, M.D., reported that contributions to transform the old American Fur Company store on Mackinac Island into a memorial to Dr. Beaumont now totaled $20,154.00, representing more than half the goal of $40,000.

 The Finance Committee through Chairman W. S. Jones, M.D., recommended that a loan, not to exceed $20,000, be made from MSMS funds to begin work on the Beaumont Memorial Restoration; this recommendation was approved by The Council.

 A proposed agreement between the Michigan State Medical Society and the Mackinac Island State Park Commission was presented; this document authorizes MSMS to restore the Beaumont Memorial, having complete control until it turns over the building to the State Park Commission which agrees to maintain it in perpetuity; this contract as drafted by Legal Counsel J. Joseph Herbert and approved by the Beaumont Memorial Restoration Committee, was approved by The Council. A Working Committee was appointed: W. S. Jones, M.D., Menominee, Chairman; Otto O. Beck, M.D., Birmingham; State Treasurer D. Hale Brake, Lansing; William Bromme, M.D., Detroit; State Park Commission Chairman W. F. Doyle, Mackinac Island; Legal Counsel J. Joseph Herbert, Manistique; State Architect A. N. Languis, Lansing; G. B. Saltonstall, M.D., Charlevoix; and L. Fernald Foster, M.D., Bay City, as Secretary.

 The Council Chairman was authorized to appoint a Beaumont Memorial Consultative Committee, representative of the medical profession and of the public.
- The Treasurer's Report concerning bonds of the Michigan State Medical Society was presented and approved. The Council designated the Michgan National Bank, Grand Rapids Office, as the depository for the MSMS bonds and funds in the account of the Treasurer.
- Annual Session of The Council. The dates of January 29-30-31, 1953, at the Sheraton-Cadillac Hotel, Detroit, were selected for this Session; the MSMS Public Relations Conference is to be held Sunday, February 1, 1953, at the Sheraton-Cadillac Hotel.
- Testimonial Dinner in honor of Otto O. Beck M.D., Birmingham, sponsored by the Oaklanc County Medical Society on September 3: officia MSMS representatives were selected to attenc this meeting in honor of Dr. Beck, President o the Michigan State Medical Society.
- AMA Clinical Session in Detroit, 1956. T commemorate the centennial of an AMA meet ing in Detroit in 1856, The Council voted t invite the AMA to hold its Clinical Sessio (December) in Detroit in 1956.
- Medical Advisory Committee to Michigan Ho pital Service. A request from M.H.S. (Blu Cross) that MSMS appoint a Medical Advisor Committee to set up the duties and be advisc to Harry F. Becker, M.D., of Battle Creek, D rector of the newly-created Physician Relatio ship Division, resulted in the appointment of study committee to report to The Council c September 21, 1952: W. S. Reveno, M.D Chairman; Otto O. Beck, M.D., E. C. Baun garten, M.D., William Bromme, M.D., R. Novy, M.D., D. R. Smith, M.D., W. M. LeFev M.D., J. E. Livesay, M.D., J. D. Miller, M.D R. W. Shook, M.D., and L. Fernald Foste M.D., as Secretary.
- Lilly vs. Internal Revenue Service. The Leg Counsel reported that the U. S. Supreme Cou had reversed the Circuit Court of Appeals in tl case re rebates on eyeglass purchases on t grounds that such a rebate is a deductible ite because it is not something specifically prohibit by law; (in Michigan the penal law specifica prohibits fee-splitting, so rebates may not deductible in this state).

(Continued on Page 1122)



Salt is what makes things taste bad when it isn't in them.*

Most people find foods unappealing and insipid without salt. Therefore, when salt restriction is indicated, the patient must be impressed with the importance of a salt-free diet and must adhere faithfully to a rigid regimen. "With the development of such preparations as Neocurtasal . . . the problem of palatability and a salty taste has been fairly well solved . . ."[1]

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1. Merrymon, M. P.: The Use of the Low Sodium Diet. *South Dokota Jour. Med. & Phorm.*, 2:57, Feb., 1949.
2. Heller, E. M.: The Treotment of Essentiol Hypertension. *Canod. Med. Assn. Jour.*, 61:293, Sept., 1949.

*Author unidentified. From Mencken, H. L.: A New Dictionory of Quototions. New York, Alfred A. Knopf, 1942, p. 1057.

HIGHLIGHTS OF THE COUNCIL

(Continued from Page 1120)

- Public Relations Counsel H. W. Brenneman reported that publicity emphasizing scientific advances in medicine made by *doctors of medicine* would be featured in releases beginning next autumn. A 14-point program of such publicity was presented and approved.
- Supporting Membership in World Medical Association, for the year 1952, was authorized.
- The Annual Report of The Council (consisting of eleven closely typewritten legal-size pages) was presented, amended slightly, and ordered published in the Handbook for Delegates.
- Annual joint meeting with Michigan Crippled Children Commission resulted in discussion of (a) decreased legislative appropriations for medical care and treatment of afflicted children; (b) orthopedic field clinics for cerebral palsy cases; (c) wide variation in county fee schedules for care of afflicted children; (d) Department of Administration's amendment re pro-rata payment.
- Group health and accident insurance program for MSMS members: the findings of the Special Study Committee were ordered held for further discussion by The Council at its September 21 meeting in Detroit, with interim studies to be continued by the Committee.
- Annual Reports of all MSMS Committees were presented and referred to the MSMS House of Delegates.
- The monthly progress reports of the Rheumatic Fever Control Co-ordinator and of the Legal Counsel were presented and approved.
- Matters of mutual interest were presented by Michigan Health Commissioner A. E. Heustis, M.D., Lansing.
- The annual joint meeting with the Michigan Health Council was held and the "Mid-year Review of Activities and Progress of the MHC" was presented by seven of its officers and staff.
- The annual joint meeting with the Michigan Hospital Association was held with six of its officers being present to discuss four matters of mutual interest.
- JOURNAL covers and content for Numbers from September, 1952, to and including December, 1953, were presented by Editor Wilfrid Haughey, M.D., and approved by The Council.
- Committee reports were given consideration as follows: (a) Postgraduate Medical Education Committee, meeting of June 19; (b) Committee on Iodized Salt, meeting of June 24; (c) 1953 Michigan Clinical Institute Committee on Arrangements, meeting of June 25; (e) Rheumatic Fever Control Committee, meeting of July 14; (e) Beaumont Memorial Committee, meeting of July 14; (f) Committee on Arbitration (re Uniform Fee Schedule for Governmental Agencies), meeting of July 14; (g) Medical Advisory Committee to Michigan Hospital Service (Blue Cross), meeting of July 15.

REAPPORTIONMENT

Vote "NO" on No. 2—Vote "YES" on No. 3.

How you vote in the November 4 General Election on the two proposals to reapportion the Michigan Legislature will determine how you will be governed in this State in the years to come.

Appearing as Proposal No. 3 on the ballot is the reapportionment proposition which will give you **fair representation** in the Legislature. This proposal is sponsored by the Michigan Committee for a Balanced Legislature—a committee of farm, business and professional people.

Proposal No. 3 gives assurance that everyone—citizens and occupational interests throughout the state—will have equal voice in our state government.

VOTE "YES" ON PROPOSAL NO. 3.

Proposal No. 2 is sponsored by the Michigan Committee for Representative Government—composed of liberal groups who seek to control the Legislature by concentrating power in four large Michigan counties.

The proposal receiving the largest number of votes will be the one to amend the Constitution. **Be sure to cast your ballot for both propositions.**

VOTE "NO" ON NO. 2—VOTE "YES" ON NO. 3.

Proposal No. 2	**Yes** ☐	**NO** ☐
Proposal No. 3	**YES** ☐	**No** ☐

Vote on BOTH *Propositions*

MORE PR MEN AT WORK IN MEDICAL FIELD

AMA PR Director Leo Brown reports that according to two recent surveys, more state medical association are hiring trained lay personnel to carry out public relations programs than ever before.

A study conducted by the West Virginia State Medical Association revealed that fifteen states now employ a full-time PR director or consultant. Executive secretaries handle public relations activities in twenty-nine other states. With twenty-five listing separate PR budgets, the average public relations expenditure is approximately $20,330 annually.

In another survey carried out by the AMA it was learned that eight state societies now employ field representatives to implement their programs among the counties. This study showed that seven other states employ half-time field men and several others are considering hiring men to fill similar positions. The survey indicated that these field men are considered valuable additions to the state society staffs because they build closer working relationship between the state organizations and the county societies.

(Continued on Page 1124)


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(Continued from Page 1122)

AMA FELLOWSHIP ABOLISHED

The AMA House of Delegates in June, 1952, officially abolished Fellowships in the Association. Provision has been made for service, affiliate, and honorary fellowships to be incorporated in the membership classification.

TRIBUTES TO MEDICAL PROFESSION

"Let your light shine" is good PR advice—*and two electric companies recently added to the gleam of the medical profession by spotlighting the doctor and offering tributes to the medical man.*

In April the Pennsylvania Power & Light Company carried an advertisement in the *Allentown Evening Chronicle and Morning Call* complimenting the *Lehigh County Medical Society on its 100th anniversary.* Beneath an operating room scene was this caption: "Who would you want to guide the scalpel at this critical moment?" In the ad copy the public was urged to "stop and think about whose hand you want to guide the scalpel when your life is at stake," when certain groups argue for socialized medicine.

The Pennsylvania Power & Light Company wrote all Lehigh County physicians telling them about the ad and pointing out that power companies are allies in the continuing fight to ward off socialism. In the Company's annual report the operating room scene was reproduced in color and in the cutline hailing medical progress was this statement: "Our industry is proud to have had a part in these unparallel accomplishments."

Throughout 1952 the X-Ray Department of *General Electric is carrying a series of advertisements in "Newsweek" magazine paying tribute to physicians and proudly identifying the Company with medical progress.* In a letter to all county public relations chairmen describing the GE series, Dr. Allen W. Cowley, Public Relations Chairman of the Pennsylvania State Medical Society, suggested ways in which doctors could express their appreciation for the General Electric tribute.

FELLOWSHIPS FOR BASIC RESEARCH IN ARTHRITIS

The Arthritis and Rheumatism Foundation is offering to qualified individuals research fellowships in the basic sciences related to arthritis.

Fellowships will be granted on both the predoctoral and postdoctoral levels, and will run for one year with prospect of renewal.

The predoctoral fellowships will range from $1,500 to $3,000 per annum depending on the family responsibilities of the fellow, and the postdoctoral fellowships will range from $3,000 to $6,000 on the same basis.

The deadline for applications is November 1, 1952. Applications will be reviewed and awards made by February 15, 1953.

For information and application forms, address the Medical Director, The Arthritis and Rheumatism Foundation, 23 West 45th Street, New York 36, N. Y.

MEDICAL MEETINGS AND CLINIC DAYS

A list of known medical meetings and clinic days, sponsored by county medical societies and other physicians' groups in Michigan, follows:

1952	
Oct. 8	Clara Elizabeth Fund—Genesee County Medical Society—Lectures of 1952...Flint
Oct. 9	Fourth Michigan Cancer Conference Kellogg Center, East Lansing
Nov. 17-18	Wayne County and Michigan Academies of General Practice Kellogg Center, East Lansing
Autumn	MSMS Postgraduate Extramural Courses State-wide
1953	
Jan. 16-17	Sixth Annual Michigan Rural Health Conference Kellogg Center, East Lansing
Mar. 10	MICHIGAN INDUSTRIAL HEALTH DAY..Sheraton-Cadillac Hotel, Detroit
Mar. 11-13	MICHIGAN CLINICAL INSTITUTE Sheraton-Cadillac Hotel, Detroit Complete program will be published in the December JMSMS. Plan now to attend and secure your room reservations by writing Robert M. Buckley, Secretary Committee on Hotels, Michigan Clinical Institute, c/o Sheraton-Cadillac Hotel Detroit.
April 9	Genesee County Medical Society 8th Annual Cancer Day.....Flint
May 13	Annual Clinic Day and Reunion of Wayne University College of Medicine Hotel Fort Shelby, Detroit

Additions to this list of meetings are invited by the Editor of JMSMS, in order to make this monthly announcement complete and accurate.

ADEQUACY OF RESERVES FOR JOB INSURANCE

A measure of adequacy of reserves at the end of 19[illegible] reveals that at one extreme Iowa, Colorado, and New Mexico could meet average annual postwar costs for more than twenty years without collecting another cent in contributions or earning any additional interest. At the other extreme, funds available for benefits in Rhode Island were equal to only 1.2 years of postwar costs, and in Massachusetts to only 1.7 years.

(Continued on Page 1126)

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(Continued from Page 1124)

GREEK MEDICINAL HERB GROWERS

Among the rites was the address of a prayer to Jupiter that the drug might be effective, and that was indicated by the sign ℞. Today every physician begins every prescription he writes with that sign to Jupiter, ℞, praying the remedy may cure the disease.—*Florida Grower,* August, 1952.

URGES HOLIDAY FOR HOSPITALS ON ELECTION DAY

In a recent letter to AMA President Louis H. Bauer, Dr. John V. Sullivan, Akron, proposed an idea which merits some serious thought. He suggested that clinics and operating schedules be placed on a holiday status on election day in November.

Dr. Sullivan said that many doctors don't go to the polls because of heavy schedules at the hospitals.

"I would like to suggest," he said, "that presidential election day this year be a legal holiday for every hospital in the nation. This would involve suspension of clinics and operating schedules. What more important holiday is there during the year?"

GOVERNMENT PATERNALISM HELD MENACE

"Big government is a serious threat to the liberties of this country," The First National Bank of Boston declared in the current issue of its New England Letter. "Historical evidence clearly shows," the bank declared, "that government paternalism is the greatest internal menace, since it undermines the wealth-creating powers of the people and destroys personal initiative, which has been responsible for our unparalleled economic and social progress. The American people should awaken from their lethargy and not be jockeyed by siren voices into trading freedom for so-called security.

"Since 1930, government employment of all kinds has increased at four times, and federal civilian employment at eleven times the rate of increase in the total population. All told, there are about 6.8 million civilian workers on state and Federal pay rolls. This is equivalent to nearly one government worker for every 6.6 families in the country, as against a ratio of about one to 10 in 1929.

THE HIDDEN TAXES ARE EVEN WORSE

The Tax Foundation reports that a hypothetical family of 3.2 persons having an income of $70 a week, and who's income tax is about $300 averages $798 in hidden taxes. At the $15,000 level, the same family pays about $2,600 in income taxes and $4,000 in hidden taxes.

WILL WE LEARN FROM EXPERIENCE?

Back in 1913 when the income tax started, there were some hot arguments over the principle of the thing. But the new idea was accepted, in spite of principle, presumably because those in the lower income groups, who are always in the majority, figured their pocketbooks were safe and would escape the tax.

But look how Frankenstein has grown and turned on its creators! Let it be a lesson to all those misguided souls who dream of getting something for nothing at their fellow citizen's expense!

	1913	Today
Number of people paying Federal Income Taxes	under 400,000	55,000,000
Personal tax exemption	$3,000	$600
Minimum tax rate	1% over $3,000	22.2% over $600
Maximum tax rate	7% over $500,000	92% over $200,000
Tax rate on corporations	1%	70% (combined)

INCOME TAXES

"The Government last year collected about $362 in taxes for each man, woman and child in the country —or $1,402 FROM THE AVERAGE FAMILY.

"The internal revenue bureau announced that total collections in the last calendar year amounted to $56,093,339,429.69—by far the biggest total in history."—*Detroit News.*

* * *

Life insurance ownership in this country was at a record $253.1 billion on January 1, under an aggregate of over 210 million policies, the Institute of Life Insurance reported. This an average of more than four policies for each family in the country.

Cook County Graduate School of Medicine

ANNOUNCES CONTINUOUS COURSES

SURGERY—Intensive Course in Surgical Technic, two weeks, starting September 22, October 6, October 20.
Surgical Technic, Surgical Anatomy and Clinical Surgery, four weeks, starting October 20.
Surgical Anatomy and Clinical Surgery, two weeks, starting September 22, November 3.
Surgery of Colon and Rectum, one week, starting September 15, October 20.
Gallbladder Surgery, ten hours, starting October 20.
Bronchoscopy, one week, by appointment.
General Surgery, one week, starting October 6.
General Surgery, two weeks, starting October 6.
Breast and Thyroid Surgery, one week, starting October 6.
Esophageal Surgery, one week, starting October 13.
Thoracic Surgery, one week, starting October 20.
Fractures and Traumatic Surgery, two weeks, starting October 6.
GYNECOLOGY—Intensive Course, two weeks, starting October 20.
Vaginal Approach to Pelvic Surgery, one week, starting September 22, November 3.
OBSTETRICS—Intensive Course, two weeks, starting September 29, November 3.
MEDICINE—Electrocardiography and Heart Disease, two weeks, starting September 22.
Intensive General Course, two weeks, starting October 13.
Gastroenterology, two weeks, starting October 27.
Gastroscopy and Gastroenterology, two weeks, starting September 15, November 3.
CYSTOSCOPY—Ten-day Practical Course starting every two weeks.
DERMATOLOGY—Intensive Course, two weeks, starting October 13.

TEACHING FACULTY—ATTENDING STAFF OF COOK COUNTY HOSPITAL

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Battle Creek, Michigan

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*G. K. SWARTZ, A.B., M.D.—Chief of Staff—Neuropsychiatry.

*H. E. ANDERSON, B.S., M.D., M.S., D.N.B.—Consultant in Dermatology.

H. R. BODINE, M.D.—Consultant in Gynecology.

*C. W. BRAINARD, B.S., M.D., F.A.C.S.—Consultant in Orthopedics.

M. J. CAPRON, M.D., F.A.C.P.—Consultant in Internal Medicine.

*A. R. DICKSON, M.D., F.A.C.S.—Chief Surgeon.

MARGERY J. GILFILLAN, M.D., Internal Medicine.

*WILFRID HAUGHEY, A.M., M.D., F.A.C.S.—Diseases of the Eye, Ear, Nose and Throat.

*D. K. HIBBS, B.S., M.S., M.D., F.A.C.S.—Urology.

*A. A. HUMPHREY, B.S., M.D., F.A.C.P.—Pathologist.

R. M. KELLOGG, D.D.S.—Dentistry and Oral Surgery.

NETTIE E. KNAPP, M.D.—Internal Medicine.

*G. T. PATRICK, M.D.—Radiologist.

*D. J. PEARSON, M.D.—Proctology.

GEO. W. SLAGLE, M.D., F.A.C.P.—Consultant in Internal Medicine.

W. VANDER VOORT, M.D.—Metabolic Diseases.

S. A. YANNITELLI, B.A., M.D., D.N.B.—Consultant in Diseases of the Chest.

G. H. LONG, D.S.C.—Chiropodist (by appointment).

MATHILDE MESSNER—Physical Therapist.

HARRY MAC CREERY—Recreational Therapy.

*Diplomate of American Board.

PR Accents Good Will

Public relations is a continuing job. While every action of a Michigan M.D. has its public relations effect, it is physically impossible for the doctor of medicine to conduct a complete, personal public relations program of his own.

He must therefore depend upon his county and state medical organizations to reach those outside of his own area of direct social contact. Through the public relations activities of his county and state medical societies, he is able to supply information desired by the people on matters—both scientific and socio-economic — concerning their health.

Doctors of medicine set the overall pattern of the Michigan State Medical Society public relations program; the details and implementation of the program are carried on by trained personnel in the department.

The working tools of the PR department are the various media which reach into the lives of the people of Michigan—television, radio, newspapers, other publications, motion pictures, exhibits, and speakers.

MSMS Public Relations Projects

Before the finished product can be approved by the doctors of medicine and relayed to the public, a certain amount of work behind-the-scenes is necessary on the part of public relations personnel. The following brief outline of the implementation of various public relations projects of MSMS gives a quick glance of the work involved in these activities:

Cinema—The Michigan State Medical Society has three motion pictures available for distribution. They are "To Save Your Life," "To Your Health," and "Lucky Junior." Both "To Your Health" and "Lucky Junior" were produced by a commercial motion picture organization. "To Save Your Life" was produced by the public relations staff at a great saving to MSMS. In the production of this motion picture, it was therefore necessary not only to supervise closely the content of the film but to master all details required in film production. At the onset of the filming this meant working with the photographer to determine exactly what was required to bring forth the proper message in the film. Once this was done it was necessary to arrange for the shots to be taken in hospitals and universities in various parts of the state and to contact persons who would appear in the film as actors. Once the film footage was shot the sequences were organized into proper and logical order, keeping in mind the requirements for dramatic effect and for clarity of the picture's message. When the process of editing was completed, the final script was written. Previously several preliminary scripts had been written in outline form to guide the photographer in the production. After the film was recorded and ready for release, there was still work to be done that would continue as long as the film is used by MSMS. The film was publicized to the doctors of medicine in Michigan and to medical societies outside of Michigan. A campaign was also conducted to interest lay groups in showing the film. When requests began to come in for the film, a distribution schedule was set up for the prints available of "To Save Your Life." This schedule eliminated many conflicts in the distribution of the film to the groups requesting it.

Television—A television show is produced by the Michigan State Medical Society in Detroit each week on WXYZ-TV called "Medical Mailbox." Last May MSMS discontinued its second TV production in Detroit and passed the time spot on to the Michigan Health Council. MSMS personnel continued to act in an advisory capacity for the MHC-TV show which is produced each Sunday on WJBK-TV, Detroit, and is called "Court of Health." In the coming year, the use of television will be augmented to a great extent so that MSMS programs will reach into every corner of the state available to television. The WXYZ television show requires much preliminary planning before it is produced weekly. Contacts are made with television station personnel to insure the production of a type of program in keeping with the policy of the medical profession. The subject matter is carefully selected before the participating doctors or lay persons are contacted to appear on the program. Once the subject matter has been set and the guest doctor has agreed to appear, several consultations regarding the material and the approach to be made of the subject matter

(Continued on Page 1130)

Corticotropin (ACTH)

Upjohn

The Upjohn Company in early June announced production of Cortisone Acetate, 25 mg. Tablets.

Now we are announcing the availability of Corticotropin (ACTH).

Sterile Corticotropin (Upjohn) is available in two potencies: in vials containing 25 U.S.P. units and in vials containing 40 U.S.P. units.

Upjohn's extensive experience in the research and manufacture of adrenal cortical products has made it possible to provide the medical profession with *both* Cortisone and Corticotropin.



THE UPJOHN COMPANY KALAMAZOO MICHIGAN

A contribution of **Upjohn Research** *to this era of metabolic medicine*

(Continued from Page 1128)

are held. In addition to the personal contacts, a certain amount of correspondence before, during, and after each show is required.

Radio—Despite the great popularity of television, MSMS still utilizes the powerful medium of radio. When it is necessary to bring a vital message of the medical society to the people of Michigan, individual broadcasts from Michigan's radio stations are arranged. Because many radio stations require a definite script before a program is broadcast, this must be provided by the public relations department whether it is a straight speech or a panel-type program. During the MSMS Annual Session and the Michigan Clinical Institute, radio time for participating doctors of medicine is arranged.

The five minute health news program, "Tell Me, Doctor" is produced under the direction of the MSMS public relations department. This means supplying material to the writers of the show and approving and processing the finished scripts. From time to time a meeting with the advertising agency handling the show is feasible to work out any problems connected with the production. In addition, publicity has to be developed for the show and the distribution of transcriptions to other state medical societies is handled.

Newspapers—The newspaper is another powerful medium which reaches into every home. All newsworthy activities of the Michigan State Medical Society are supplied to the Michigan dailies and weeklies through periodic news releases. Contact must be constantly maintained with these newspapers. This is done by visits of the public relations Field Secretaries in their assigned areas as well as through local meetings of the press by MSMS representatives. The public relations department also serves as the source of information on all queries from newspapers and maintains individual contact with science writers of the major newspapers. At the time of the Annual Session and the Michigan Clinical Institute, publicity for these meetings is arranged and developed; this includes advance news releases to all Michigan dailies, weeklies, county medical society bulletins, and selected out-of-state newspapers. Before the conventions are held, a press dinner is planned approximately a week prior to the meeting to acquaint the newsmen with the coming events.

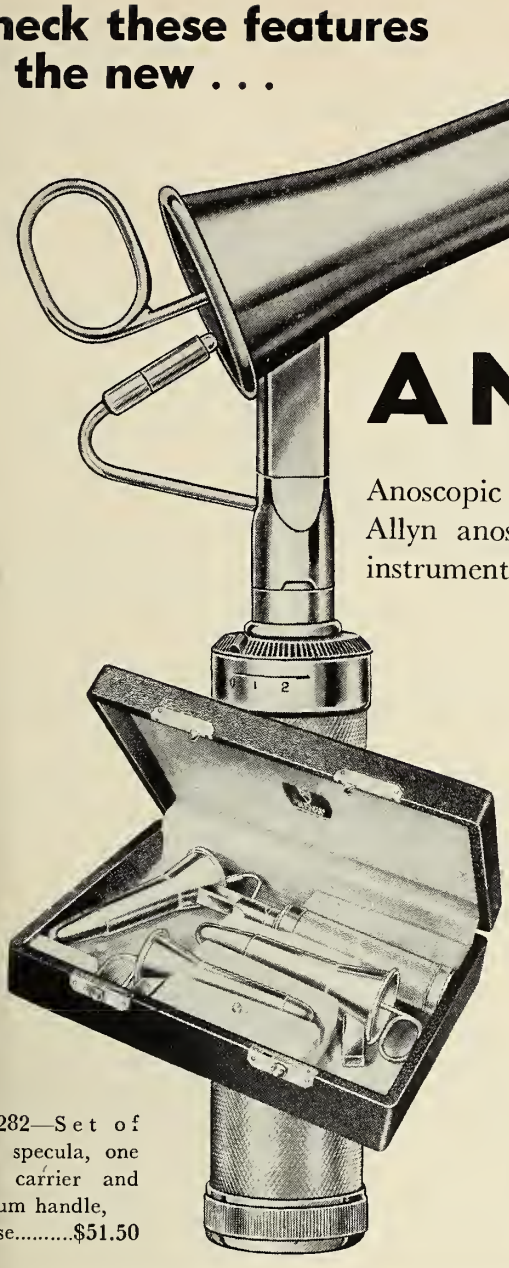
Publications—Messages of the Michigan State Medical Society are brought to the people through the printed word in brochures and pamphlets. Perhaps the most outstanding MSMS brochure is the Medical Association publication, "In Planning Your Career." Requests are constantly received for this brochure which has been distributed to all parts of the United States. Recently the illustrated booklet was revised and brought up to date. This necessitated meetings with the advisory doctors of medicine to make these changes and then with the printers. Just before the Michigan Clinical Institute and the Annual Session, a preliminary program announcing each event is developed. PR personnel also assist in the publication of the AUXILIARY NEWS, the organ of the MSMS Woman's Auxiliary. Throughout the year, various special events also require the development of pamphlets. An example of this is the brochure which was prepared for the Beaumont Restoration.

Articles—At intervals, Michigan's doctors of medicine are asked for articles which will appear in state and national magazines. These are supplied to the magazines on the topic requested or in the case of a staff written article the necessary material are provided the writer. This means, of course, that meetings and correspondence must be undertaken with the writers. Also in this classification aid in the preparation of official speeches to be given by MSMS officers. Also, monthly articles are written for the JOURNAL of the Michigan State Medical Society.

Exhibits—The public relations department supplies exhibits which tell the story of specific activities of Michigan's medical profession. These exhibits are maintained at the Michigan State Fair, the Michigan Clinical Institute, the Annual Session of MSMS, and the Michigan Rural Health Conference. In designing the exhibit, it is necessary to meet with the artist and display personnel to incorporate the ideas requested by the doctors of medicine. When an exhibit is used at any of these meetings it must be manned by PR personnel who distribute pamphlets and answer questions.

(Continued on Page 1132)

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Anoscopic diagnosis is easier and quicker with the Welch Allyn anoscope. Among the features of these superb instruments are:

- Shadow-free, brilliant illumination, requiring no external light source.
- Offset obturator handle ring for ease of insertion and manipulation.
- Specula instantly detachable for sterilization.
- New, scientifically correct shape for painless examination.
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- Choice of lengths, standard 89 mm. (illustrated) or 127 mm.
- Fit any standard Welch Allyn battery handle.

No. 280—Any size speculum complete with obturator and light carrier.....$15.00

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(Continued from Page 1130)

Speakers Bureau—The spoken word plays an important role in MSMS PR activities. Speakers are obtained through the MSMS Speakers Bureau to appear before service clubs, schools and vocational groups. In addition, speakers are provided to out-of-state Woman's Auxiliary affairs and to the various women's clubs in the state.

Legislative—The MSMS Field Secretaries are constantly available to state legislators to supply technical information that these public officials may need in the conduct of their offices.

Organizational Activities

Michigan's Foremost Family Physician—One of the most newsworthy activities of the Michigan State Medical Society is the annual selection of Michigan's Foremost Family Physician. Before and after this selection is made, many preparations in this project fall to the PR Department. These include the supplying of biographical data sheets to county medical societies which have a candidate and later the securing of information and pictures from the candidates themselves. This detailed information on the candidates is submitted to The Council and to the House of Delegates of the Michigan State Medical Society. After the "Foremost" is selected, appropriate publicity throughout the year is developed. Finally, Michigan's Foremost Family Physician is presented to the American Medical Association for the award of the Outstanding General Practitioner of the Year, through the preparation of a dignified, informative brochure.

Fifty Year Club—New members are brought into the Fifty Year Club each year during the Annual Session. Public relations personnel assist in developing publicity to the local newspapers on these "elder statesmen," nominated by their county medical societies.

Meetings—Public Relations personnel are used to cover MSMS meetings not only of the Public Relations Committee and its subcommittees but of other committee meetings. Attendance of public relations personnel is required at the annual County Secretaries-Public Relations Conference, the Michigan Rural Health Conference, Michigan Industrial Health Day, and at PR meetings of the AMA, etc.

All the many and varied activities of the MSMS public relations department are beamed to one major objective: to demonstrate to the people that the *BEST* medical care in the world is available in this State and country. Public relations tells of an important job well done. It helps to maintain goodwill.

INDIVIDUAL INCOMES REACH PEAK

Income received by individual Americans rose from 218 billion dollars in 1950 to 243 billion in 1951—an increase of 12 per cent—the Commerce Department reported recently.

Per capita income was $1,584 in 1951—10 per cent above the 1950 average of $1,439.

The survey dealt with income, before deduction of taxes, received by individuals from all sources. Such income includes wages, salaries, dividends, interest, net rents, social insurance benefits, relief and net income of unincorporated businesses, including farms. It does not include corporation income.

Income payments received by individuals in 1951 were higher than in 1950 in every state of the nation. This was because production and prices were increasing under the impetus of expanding demand.

The largest increases in total payments to individuals occurred in Arizona (23 per cent), South Carolina (21 per cent) and New Mexico and South Dakota (18 per cent each). The principal factor in each of these states was a sharp rise in farm income.

There were increases of 16 per cent in Colorado Georgia and Nevada and 15 per cent in Indiana, Kentucky, Ohio, Utah, Virginia and Wyoming.

Relative differences between states have narrowed over the past two decades but are still wide in many cases.

Per capita income last year ranged from $771 in Mississippi to nearly $2,100 in Delaware and the District of Columbia. Others in the top rank were Nevada $2,029; Connecticut, $1,999; New York, $1,996; California, $1,933; Illinois, $1,928, and New Jersey, $1,885 —*Detroit Free Press,* Aug. 17, 1952.

* * *

TENNIS, WITH INSULIN

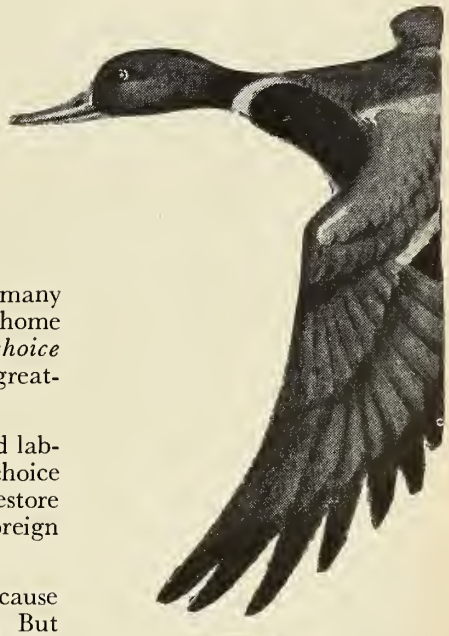
The lone tennis court at their camp in the Catski foothills held all the magic of the center court durin the finals of a championship tournament for the eight diabetic children who looked on the other day. The watched two of America's top tennis stars demonstra that diabetes, with proper medical care and supervisio need be no deterrent to leading a full life. The playe were William Talbert, playing captain of this yea United States Davis Cup team, and Hamilton Richar son, former national junior champion. They too a diabetics. They showed the youngsters that strenuo exercise is both physically and psychologically good f the diabetic and by their example urged the childr to be active and not think of themselves as invalids. T match and the reaction to it on the part of the youn sters were a tribute to the courage of both the playe and the children. It provided new proof that many pe ple suffering from illness can lead successful and we rounded lives.—From the *New York Times*





"THERE'S ALWAYS A

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Due Partly to a Tea Party

179 Years Ago

The revolution that followed the Boston Tea Party many years ago was fought against dictation by anyone at home or abroad. Here at Mallard we feel that *freedom of choice* is one of the important American Freedoms our great-great-grandfathers won.

Freedom of choice lets us choose finest ingredients and laboratory controls in our manufacture. Freedom of choice lets you seek the pharmaceuticals you feel will best restore your patients' health. There is no ruling edict by a foreign commissar.

We're convinced the American people benefit because you are absolutely free to prescribe their medicinals. But maybe we are predjudiced. It's your freedom that allowed you to choose Mallard for over 40 years. Thank you.

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Karl O. Mallard
President, Mallard, Inc.

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DETROIT 16, MICHIGAN

Michigan's Rheumatic Fever Control Program Surges Ahead

Another "Michigan First"

The Rheumatic Fever Control Program of the Michigan State Medical Society, in co-operation with its component county medical societies, continues to progress and develop. This pioneering project remains the only rheumatic fever control program sponsored and organized by a State Medical Society on a state-wide basis, among all the 48 states. It is a Michigan "First."

A measure of recognition of the importance of this undertaking has come from without Michigan in that the Co-ordinator of the MSMS Rheumatic Fever Control Program, Leon DeVel, M.D., of Grand Rapids, has been appointed to membership on the American Council on Rheumatic Fever, and to the chairmanship of the Committee on Rheumatic Fever and Cardiac Disease of the American Academy of Pediatrics.

Program Watched by Critics

The program of the Michigan State Medical Society—a program by and for the doctors of medicine of Michigan—must not fail: it is being closely and critically watched by those who say that a medical society is incapable of assuming leadership in this field. The program of the Michigan State Medical Society is clearly not failing: it is proceeding forward toward its original goals. Nevertheless there still remain large areas for improvement and extension which can be conquered by continued understanding and co-operation of every member of the Michigan State Medical Society and its officers.

Rheumatic Fever Diagnostic and Consultation Centers

The Rheumatic Fever Diagnostic and Consultation Centers, organized in the several medical centers of the State under the auspices of the local county medical society are the feature undertaking of the Michigan Plan. They are designed as an aid to the private practice of medicine to help the M.D.s of Michigan with their difficult diagnostic and management problems in rheumatic fever, suspected rheumatic fever and rheumatic heart disease. It cannot be emphasized often enough or strongly enough that the several Rheumatie Fever Diagnostic and Consultation Centers accept patients *only and exclusively on referral by their family physician* and that the subsequent management of the case remains the responsibility and the privilege of the referring physician.

Rheumatic Fever Centers Organized Prior to January 1, 1952

Alpena Center, serving Alpena, Oscoda, Montmorency and Presque Isle counties, with a population of 49,527. Chairman: Harold Kessler, M.D., Consultant: Aaron Stern, M.D., University Hospital, Ann Arbor. **Continues active.**

Ann Arbor, serving Washtenaw, Monroe, Lenawee and Livingston counties, with a population of 272,655. Chairman: H. H. Riecker, M.D. **Continues active.**

Bay City, serving Bay, Midland, Huron, Gladwin, Clare, Arenac, Roscommon, Ogemaw and Iosco counties, with a population of 211,760. Chairman: Robert E. Fisher, M.D. **Continues active.**

Detroit and Wayne County, serving Wayne County with a population of 2,395,301. Roy D. Tupper, M.D., chairman, Louis J. Bailey, M.D., co-chairman. There are thirteen Diagnostic and Consultation Centers as follows:

	Chairmen—
Providence Hospital	Russell Weyher, M.D.
Harper Hospital	John M. Murphy, M.D.
Memorial Hospital	W. J. Wilson, M.D.
Woman's Hospital	B. I. Johnstone, M.D.
Highland Park Hospital	Louis Jaffe, M.D.
Delray Hospital	David I. Sugar, M.D.
St. Joseph Mercy Hospital	E. D. Maire, M.D.
Receiving Hospital	Gordon B. Myers, M.D.
Henry Ford Hospital	J. A. Johnston, M.D.
Cottage Hospital	Kenneth M. McColl, M.D.
Deaconess Hospital	Carl Witus, M.D.
Grace Hospital	L. T. Colvin, M.D.
Wyandotte General Hospital	D. H. White, M.D.

Grand Rapids: serving Kent, Mecosta, Montcalm, Ionia, Barry, Allegan and Ottawa counties with a population of 520,439. Jerome Webber M.D., chairman. **Continues active.**

Jackson: serving Jackson and Hillsdale counties with a population of 139,159. Frank VanSchoick M.D., chairman. **Continues active.**

Kalamazoo: serving Kalamazoo, St. Joseph, and

(Continued on Page 1136)

DOUBLE DUTY



Military *Bovie*

Be it battle-front or civilian surgical duty—a BOVIE electrosurgical unit serves with equal distinction. Bovie precision and dependability, unequalled by any other electrosurgical apparatus, is the result of more than 34 years continuous research and technological improvement by L-F engineers—augmented by military experience in three wars.

Today's Military BOVIE is built for fast-moving global war and the most extensive and demanding surgical needs. Portable and rugged enough for rough transport and parachute drop, it will resist tropical fungus and drenching rains, or arctic ice and snaws. The development of this unit makes the same safe cutting and coagulating currents available to the military as are so successfully used by the civilian surgeon.

Whether yau're in uniform or out. Bovies are available for your use. The Army, Navy, and Air Force are taking only a portion of taday's accelerated output.

L-F

SYMBOL OF DEPENDABILITY AND PERFORMANCE IN

ELECTROSURGICAL APPARATUS • ELECTROMEDICAL APPARATUS

X-RAY SPECIALTIES

RECOGNIZED THE WORLD OVER

THE LIEBEL-FLARSHEIM COMPANY

CINCINNATI 2, OHIO

(Continued from Page 1134)

parts of Van Buren and Cass counties with a population of 199,843. H. S. Heersma, M.D., chairman. **Continues active.**

Lansing: serving Ingham, Eaton, Clinton and Shiawassee counties with a population of 289,191. Robert McGillicuddy, M.D. **Continues active.**

Marquette: This center inactive, due to the Federal-sponsored program in the Western Upper-Peninsula.

Muskegon: serving Muskegon, Newaygo and Oceana counties with a population of 158,297. Devere R. Boyd, M.D., chairman.

Pontiac: serving Oakland and Macomb counties with a population of 577,718. D. S. Smith, M.D., chairman. **Continues active.**

Saginaw: serving Saginaw, Gratiot, Isabella and Tuscola counties with a population of 253,334. D. P. Gage, M.D., chairman. **Continues active.**

Traverse City: serving Grand Traverse, Antrim, Kalkaska, Missaukee, Wexford, Osceolas, Lake, Mason, Manistee, Benzie and Leelanau counties with a population of 143,172. Mark F. Osterlin, M.D., chairman. **Continues active.**

Among the twenty-five above-listed Rheumatic Fever Diagnostic and Consultation Centers special mention for successful operation of the Center and co-operation by the medical profession should go to the following Centers: Grand Rapids, Kalamazoo, Muskegon, Traverse City, Ann Arbor and Pontiac.

Rheumatic Fever Centers Organized Since January 1, 1952

Benton Harbor-St. Joseph: Sponsored by the Berrien County Medical Society to serve Berrien and parts of Van Buren and Cass counties with a population of 142,699. Marshall J. Feeley, M.D., chairman.

Petoskey: Sponsored by the Northern Michigan Medical Society, to serve Emmet, Charlevoix, Cheboygan and Otsego counties with a population of 49,527. Thomas R. Kirk, M.D., chairman.

Royal Oak: Sponsored by the Oakland County Medical Society to serve southern Oakland county and adjacent parts of Macomb and Wayne counties. James F. Pearce, M.D., chairman.

Sault Ste. Marie: Sponsored by the Chippewa-Mackinac County Medical Society to serve Chippewa, Mackinac, Luce and parts of Schoolcraft counties. Donald D. Finlayson, M.D., chairman.

Unorganized Rheumatic Fever Centers

Battle Creek: To serve Calhoun and Branch counties. President Robert K. Curry, M.D., reports that he expects the Calhoun County Medical Society to approve the projected Battle Creek Rheumatic Fever Center, early this fall.

Port Huron: To serve St. Clair, Sanilac and parts of Lapeer and Macomb counties. President F. E. Ludwig, M.D., of the St. Clair County Medical Society reports that he expects his society to approve a Port Huron Rheumatic Fever Center at an early meeting next fall.

Flint: To serve Genesee and Lapeer counties. Contacts have been made; progress will be reported later.

Desk Reference Cards for Rheumatic Fever

A series of Desk Reference Cards for Rheumatic Fever, featuring various aspects of the Rheumatic Fever problem, have been prepared and are in the process of preparation. Four such cards have been mailed to every member of the Michigan State Medical Society. As follows:

Card No. 1	Diagnostic Criteria of Rheumatic Fever.
Card No. 2	Prevention of Recurrences.
Card No. 3	Mitral Valve Surgery for Mitral Stenosis.
Card No. 4	Heart Murmurs.
Card No. 5	Drugs in Rheumatic Fever: in the process of mailing.
Card No. 6	Classification of Heart Disease. In preparation.
Card No. 7	Growing pains. In preparation.
Card No. 8	The Sedimentation Rate. In preparation.

Postgraduate Fellowships for the Study of Rheumatic Fever

Four fellowships for the postgraduate study o rheumatic fever to attend the Comprehensiv Course in Rheumatic Fever and Rheumatic Hear Disease offered at St. Francis Sanatorium, Lon Island, and carrying each a stipend of up to $50 from May 19 to May 31, 1952, were awarded t and attended by the following physicians, active i MSMS Rheumatic Fever Centers:

Anthony Cefai, M.D., Pontiac.
John D. Littig, M.D., Kalamazoo.
S. T. Harris, M.D., Ypsilanti.
David P. Gage, M.D., Saginaw.

Statistical Report for the First Six Months of 195

There were a total of 275 new admissions to th Rheumatic Fever Centers for the period from Jan uary 1, 1952, to June 30, 1952, plus 142 re-exam

(Continued on Page 1140)

PROOF WITH ONE PUFF?



So distinct is the difference between PHILIP MORRIS and *any* other leading brand, that we believe you will notice it with a single puff. Won't you try this simple test, Doctor, and see?

Take a PHILIP MORRIS and any other cigarette

1. Light up either one first. Take a puff—get a good mouthful of smoke—and s-l-o-w-l-y let the smoke come directly through your nose.
2. Now, do exactly the same thing with the other cigarette.

You will notice a distinct difference between PHILIP MORRIS and any other leading brand.

PHILIP MORRIS

Philip Morris & Co., Ltd., Inc., 100 Park Avenue, New York 17, N. Y.

The Health Plank in Party Platforms

1952 REPUBLICAN PARTY PLATFORM

We recognize that the health of our people as well as their proper medical care cannot be maintained if subject to federal bureaucratic dictation. There should be a just division of responsibility between government, the physician, the voluntary hospital, and voluntary health insurance. *We are opposed to federal compulsory health insurance with its crushing cost, wasteful inefficiency, bureaucratic dead weight, and debased standards of medical care.* We shall support those health activities by government which stimulate the development of adequate hospital services without federal interference in local administration. We favor support of scientific research. We pledge our continuous encouragement of improved methods of assuring health protection.

1952 DEMOCRATIC PARTY PLATFORM

We will continue to work for better health for every American, especially our children. We pledge continued and wholehearted support for the campaign that modern medicine is waging against mental illness, cancer, heart diseases and other disease.

Research.—We favor continued and vigorous support, from private and public sources, of research into the causes, prevention and cure of disease.

Medical Education.—We advocate federal aid for medical education to help overcome the growing shortages of doctors, nurses, and other trained health personnel.

Hospitals and Health Centers.—We pledge continued support for federal aid to hospital construction. We pledge increased federal aid to promote public health through preventive programs and health services, especially in rural areas.

Cost of Medical Care.—We also advocate a resolute attack on the heavy financial hazard of serious illness. We recognize that the costs of modern medical care have grown to be prohibitive for many millions of people. We commend President Truman for establishing the non-partisan commission on the health needs of the nation to seek an acceptable solution of this urgent problem.

STATEMENTS ON HEALTH INSURANCE

General Dwight D. Eisenhower, *Republican Nominee for President*—At his press conference in Abilene, Kansas, on June 5, 1952, General Eisenhower was asked the question: "Are you for Compulsory Health Insurance?"

Here is General Eisenhower's reply:

"I am not going to answer too specifically, because what could be in a bill labeled compulsory health insurance? I am not so certain. But I can tell you this: I am quite certain over the years that I was at Columbia, no one spoke out more than I did against the centralization of power in Washington, against bureaucratic government and submitting our lives toward a control that would lead inevitably to socialism. . . . I do believe that every American has a right to decent medical care."

In discussing Federal aid to medical education, General Eisenhower said that in private universities we must "support medical education by private means, because if we didn't it would be the first step toward the socialization of medicine, and I am against socialization."

Governor Adlai Stevenson of Illinois, *Democratic Nominee for President.*—

"I am against the socialization of the practice of medicine as much as I would be against the socialization of my own profession, the law. . . . If the insurance principle could be brought to bear on these catastrophic illnesses, it would largely eliminate the specter of terror from the average home. . . . I am sure that . . . the common objective can be largely realized without the destruction of professional independence.

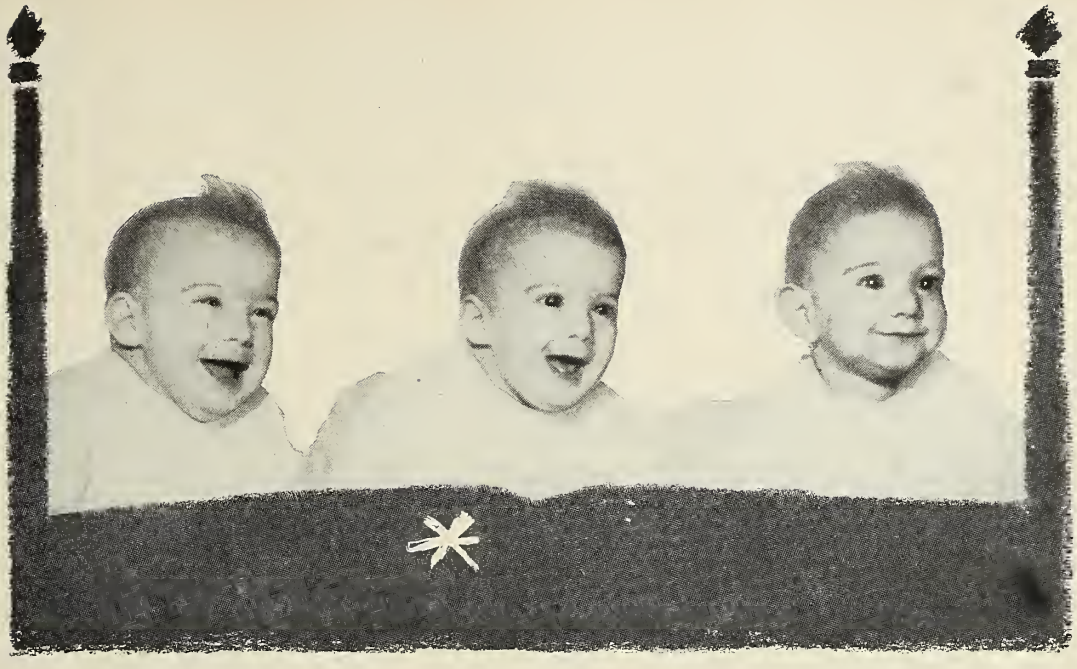
"Basically, the problem is how to lift people over the costs of major illness. I don't know whether voluntary plans can do the job. I think the new commission on medical needs may well add some light and remove some heat, enabling us to find a satisfactory solution to this perplexing problem."

In a press conference on July 30, 1952, Governor Stevenson was asked whether he saw "eye to eye with Federal Security Administrator Oscar Ewing" on the issue of Compulsory Health Insurance.

Governor Stevenson's reply to this question was as follows:

"No, on a number of occasions in the past I have indicated that I thought a new approach was necessary. I emphatically believe that we must find some solution

(Continued on Page 1140)



* This identical triplet allergic to milk

MULL-SOY eliminated symptoms, gave superior weight and growth curves

From the Summary* "A case of gastrointestinal allergy caused by milk in one of a set of identical female triplets is reported. Elimination of milk from the diet of the allergic baby and substitution of soy milk caused a dramatic regression of symptoms, and weight gains which surpassed those of the non-allergic sisters."

From the Conclusions* "Milk allergy need no longer be the difficult infant feeding problem it was formerly. Complete elimination of milk and all milk-containing foods is feasible and desirable in milk allergy and can now be safely and simply carried out. The soy preparation [Mull-Soy] fed to Baby R gave weight and growth curves equal to and better than those of the two sisters fed a cow's milk formula."

*Sobel, S. H.: Milk Allergy in a case of Triplets, *Clin. Med.*, August 1952.

EASY—To prescribe—To take—To digest

a liquid, homogenized, vacuum-packed food for all patients allergic to milk

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STATEMENTS ON HEALTH INSURANCE

(Continued from Page 1138)

to the problem of catastrophic illness and its devastating expense.

"The President's Commission, of which my friend Dr. Paul V. Magnuson is Chairman, might well come up with some recommendations and suggestions which would be more palatable, and I am hopefully awaiting the result of the deliberations."

U. S. Senator Richard M. Nixon, *Republican Nominee for Vice President.*—(Excerpts from address delivered before the seventh annual meeting, Conference of Presidents and Other Officers of State Medical Associations, Atlantic City, June 10, 1951.)

"I would like . . . to express my congratulations to the members of this group, and to the medical profession generally, for the very splendid political action the medical profession took in the last campaign leading up to the November election, and in other previous campaigns. As a result of that action, I think we can safely say that . . . there is no chance whatever at this time for any type of compulsory health insurance program to be enacted. . . . On the other hand, I think you must recognize, *and that all of us who are interested in this fight must recognize,* that those who favor such legislation will continue to work fanatically for their cause, in the hope that somehow, sometime in the future, they will be able to accomplish their purpose."

"I think . . . that a great number of people, probably a majority of the people in the country, are convinced that the compulsory health insurance programs which sound so good in theory have not worked out in action in those nations which have tried them."

"I am convinced that the medical profession has taken a very long step in the right direction with its recently announced program of subsidizing medical schools on a voluntary rather than on a government basis. I would suggest also that additional voluntary action is needed (in dealing with) the problem of encouraging wherever possible voluntary health insurance programs. *It seems to me that the objective toward which we should work in the United States is a system where eventually anybody who wants health insurance can get it—where those who should have health insurance are encouraged to get it—but where no one in the United States is compelled to take out such insurance against his will.* If the profession adopts that objective we will remove by voluntary action the strongest arguments that the proponents of government control of the medical profession have at the present time."

"I believe it is essential that all members of the medical profession recognize that an attempt to socialize any American profession—any American institution—constitutes a threat to all."

"Traditionally, the great accomplishments in this country have not been through government action, but through individual and co-operative action. . . . (Our task) is by precept and by example, to prove to the people of the world that a free people, working as individuals, working co-operatively, can solve the problems of our society and can solve them more effectively than can a government."

U. S. Senator John J. Sparkman, *Democratic Nominee for Vice President.*—

"I am in favor of adequate medical attention for the people of this country. However, I have not favored what is generally known as Socialized Medicine.

"I would be opposed to any plan which I thought would, in effect, socialize medicine, and to any medical program which would destroy the relationship of doctor and patient."

The foregoing statement was made by Senator Sparkman in an interview with Mr. Al Goldsmith, editor of *Washington Insurance Newsletter,* on July 31, 1952.

Washington Insurance Newsletter reported that Senator Sparkman strongly indicated he was opposed to the Truman National Compulsory Health Insurance Program, but declined to take a position on specific bills now before the Congress.

In 1949, when the roll was called in the U. S. Senate on President Truman's Reorganization Plan No. 1, which would have created a Department of Welfare, Senator Sparkman stood with medicine in opposition to this scheme to give Federal Security Administrator Oscar Ewing cabinet status, with increased power over the health and medical affairs of the country.

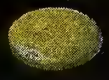
MICHIGAN'S RHEUMATIC FEVER PROGRAM SURGES AHEAD

(Continued from Page 1136)

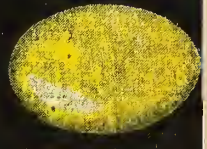
nations, for a grand total of 417 examinations. The diagnosis of rheumatic fever and/or rheumatic heart disease was confirmed in 88 cases. The cumulative register as of June 30, 1952, shows: 3,178 admissions, 850 diagnosed rheumatic fever and/or rheumatic heart disease, 1,948 re-examinations, and a grand total of examinations: 5,126.

Outstanding in their performances are the Alpena, Ann Arbor, Grand Rapids, Kalamazoo, Muskegon, Petoskey and Traverse City Rheumatic Fever Diagnostic and Consultation Centers.

new convenience in broad-spectrum therapy

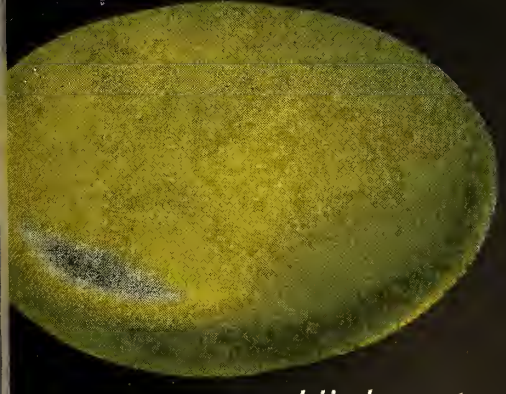


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CRYSTALLINE **Terramycin** AMPHOTERIC SUGAR-COATED **tablets**

Supplied: 250 mg. tablets, bottles of 16 and 100; 100 mg. and 50 mg. tablets, bottles of 25 and 100.



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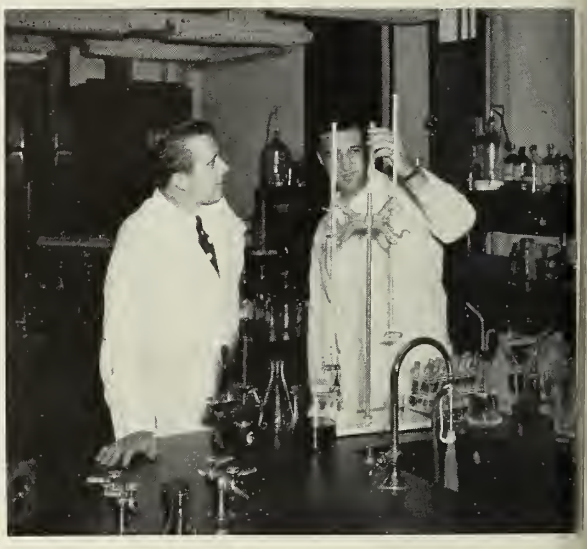
ANTIBIOTIC DIVISION, CHAS. PFIZER & CO., INC., BROOKLYN 6, N. Y.

Heart Beats

LITERATURE AND FILMS AVAILABLE

Realizing the many requests which Doctors of Medicine receive from various non-medical groups to discuss health problems related to the cardiovascular system, the Michigan Heart Association is devoting this page of THE JOURNAL to a complete listing of all lay literature and films available through its office. This valuable service is in keeping with the Association's established policy of being of assistance to the medical profession wherever and whenever possible. It is felt that these pamphlets and motion pictures will be of immeasurable aid to the medical doctor in conducting discussions with lay groups.

All of the material listed below can be secured, *free of charge,* from the Michigan Heart Association, 4421 Woodward, Detroit 1, Michigan, or by calling its office at TEmple 1-8550. Subsequent issues of THE JOURNAL will carry information concerning similar material for use in scientific or medical meetings.



"No one knows when the knowledge gained in laboratories like this . . . may mean to you . . . the difference between life and death."—From Michigan Heart Association film "Heart to Heart."

Pamphlets

CHALLENGE OF HEART DISEASE, by H. M. Marvin, M.D. 16 pp. booklet. Excellent description of the five types of heart disease: congenital, rheumatic, arteriosclerotic, hypertensive, and syphilitic. Summarizes achievements and needs in the field of heart disease.

DISEASES OF THE ARTERIES, by Irving S. Wright, M.D. 14 pp. booklet. Non-technical explanation of three common diseases of the arteries: arteriosclerosis, thrombo-angiitis obliterans, and Raynaud's syndrome.

DISEASES OF THE VEINS, by Nelson W. Barker, M.D. 12 pp. booklet. Describes the functions of the veins and the diseases that affect them, including phlebitis, embolism, and varicose veins.

EMPLOYMENT AND HEART DISEASE, by Leonard J. Goldwater, M.D. 6 pp. booklet. Fifteen questions and answers about employment of cardiac patients that should serve as a guide to employers in employing the handicapped, especially those with diseases of the cardiovascular system.

GOOD NEWS ABOUT YOUR HEART, by Paul D. White, M.D. 3 pp. reprint. An interesting reprint from THIS WEEK magazine telling the hopeful side of picture for those afflicted with heart diseases.

HEART DISEASE CAUSED BY CORONARY ARTERIOSCLEROSIS, by Paul D. White, M.D. 12 pp. booklet. Interesting examples and explanations of this common type of heart disease. Familiar terms are defined.

HEART OF THE HOME—picture edition. 28 pp. booklet. A 10-page introduction outlines in simple terms the principles of work-simplification and suggests how to apply them. Following this there are 18 pages of photographs showing ways to simplify kitchen work without investing much in equipment or carpentry.

HEART QUIZ. 12 pp. folder. Twenty questions about the human heart, correctly answered. Useful as audience participation device and general information piece.

HIGH BLOOD PRESSURE, by E. V. Allen, M.D. 12 pp. booklet. Definition, measurement, cause, seriousness, possible danger and treatment.

KNOW YOUR HEART, by Howard Blakeslee. 31 pp booklet. A brief résumé of the work of the heart and the diseases which attack it. Booklet concludes on hopeful outlook for cardiac sufferers plus research work being carried out by various organizations.

MAN TO MAN. 6 pp. folder. A reassuring message from a heart patient who lived with a "heart condition" and liked it because he followed the advice of his family Doctor of Medicine.

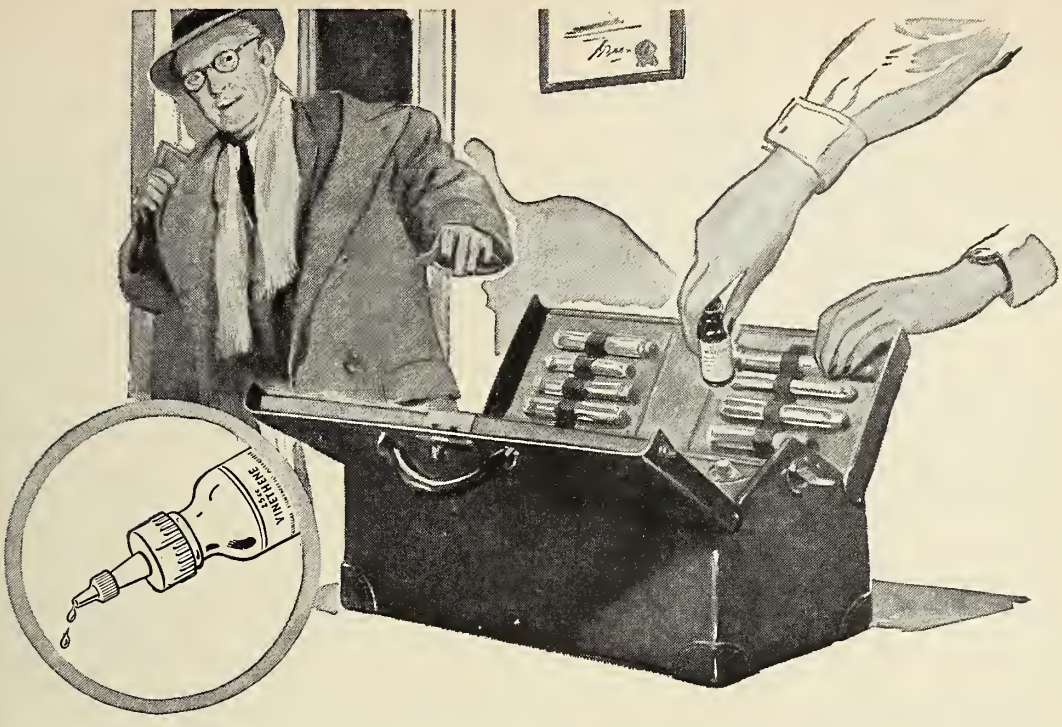
RHEUMATIC FEVER. 6 pp. folder. The facts about rheumatic fever and how to guard against it.

RHEUMATIC FEVER—CHILDHOOD'S GREATEST ENEMY. 31 pp. booklet. A complete word-picture about the causes and care of rheumatic fever patients.

RHEUMATIC FEVER—SHORT LESSONS FOR "RHEUMATIC" FAMILIES. 9 pp. booklet. Danger signals of Rheumatic Fever and "Do's" and "Dont's" for parents of cardiac children.

WHAT THE CLASSROOM TEACHER SHOULD KNOW—AND DO—ABOUT RHEUMATIC FEVER. 10 pp. booklet. An excellent guide to aid the classroom teacher in assisting the medical doctor in detecting rheumatic fever in children. Excellent reading for parents also.

(Continued on Page 1144)



To cope with emergencies... a needed item for the physician's bag

Anesthesia requirements in accidents and other emergencies make VINETHENE a desirable item in every physician's bag. VINETHENE is a practical inhalation anesthetic for short periods of anesthesia. Administered by open-drop technic, it induces anesthesia rapidly and blandly, and is characterized by prompt recovery with a minimum of postoperative nausea.

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Hospitalization at 65

A "Give" But No "Take" Scheme

The Fedcral Security Administration supported plan of Hospitalization-at-65 won't work. It is both financially and physically unsound—the money is not there and the hospital beds are not there.

The Federal Security Administrator has reported that this hospitalization scheme can be financed by a surplus in the Social Security Trust Fund.

This claim was denied by Joseph S. Lawrencc, M.D., advisor to the American Medical Association Washington office. Said Dr. Lawrence:

"There is, of course, an unexpended balance in Social Security collections which for the present is increasing because of the new members who were brought in under H.R. 6000 when it was enacted two years ago; and most of the contributors under Social Security are still young, and not many have reached the retirement age and therefore continue to pay dues. If, however, the Social Security program were ended as of today, all of the surplus and more would be required to liquidate the contracts that the government has entered into with the present contributors."

The shaky financial status of Hospitalization-at-Sixty-Five is further emphasized by a simple fact of human nature. The demand is always great when people think they can get "something for nothing." By providing hospitalization under this FSA plan, the demand would far outstrip the actual need for the service.

It would boil down to this: the thousands of persons now given adequate care outside of hospitals would immediately demand that they be admitted to the hospitals. And under the law it would be their right.

Yet, there is a rub. While these people could demand hospitalization, the number of beds available could not meet the requirements of those cligible under the act. The Division of Hospital Facilities (Hill-Burton) estimates that the eountry has only about half the hospital beds it now needs.

Thus an added burden would be placed on the hospitals. The bill is vague on this score. While it gives the impression that hospitalization (hospital beds) would be guaranteed to Social Security beneficiaries, actually the measure only guarantees payment of hospital costs in a semi-private room for sixty days. The patient, however, must FIRST FIND AN EMPTY BED.

Hospitalization-at-65 is but another wild scheme which is nibbling at the freedom of the American people. The "beneficiary" is forced to pay for the future service whether he wants to or not or whether or not he will even use the service later. And at the same time, there is no assurance that he will ever receive this service even if he needs it.

HEART BEATS

(Continued from Page 1142)

WHAT YOU SHOULD KNOW ABOUT RHEUMATIC FEVER. 8 pp. folder. Facts, definition, cause, treatment, and prevention.

WHY EXECUTIVES DROP DEAD. 5 pp. reprint. A highly informative reprint from FORTUNE magazine explaining the facts about heart disease and the reasons for "heart attacks."

YOUR BLOOD PRESSURE AND YOUR ARTERIES, by A. L. Crosby. 30 pp. booklet. High Blood Pressure and Hardening of the Arteries explained in detail.

YOUR HEART AND THE MICHIGAN HEART ASSOCIATION. 6 pp. folder. What the Michigan Heart Association Is and Does as a voluntary health agency.

Motion Pictures

GUARD YOUR HEART—Running time 27 minutes. 16 mm. black and white, sound story of a middle-aged, hard-driving executive who becomes worried about his heart. Film includes illustrated lecture on the heart and heart disease.

HEART AND CIRCULATION—16 mm. black and white, sound. Running time 10 minutes. Deals with the mechanism of the heart muscle, valve action, normal sounds, rate of beat, constriction, dilation and phenomena of blood pressure. For physiology classes and lay study groups.

HEART TO HEART—16 mm. black and white, sound. Running time 15 minutes. A dramatically illustrated commentary on the heart disease problem and the nature of heart association programs designed to meet that problem.

WONDER ENGINE OF THE BODY—16 mm. black and white, sound. Running time 11 minutes. This film is the animation section of "Guard Your Heart." Particularly useful for High Schools, service clubs, etc.

in hay fever



Pyribenzamine®
unsurpassed

as an antihistaminic agent

And the same is true in the many other allergic manifestations in which antihistamines are prescribed: *allergic rhinitis, serum sickness, angioneurotic edema, drug reactions, and itching skin conditions such as atopic and contact dermatitis and urticaria.* Recognized for its excellent therapeutic effectiveness and wide range of usefulness, Pyribenzamine is prescribed today as it was when it first became known *for maximum relief with minimal side effects.*

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Cancer Comment

POTENTIALLY CANCEROUS LESIONS AND SYMPTOMS

The following list of potentially cancerous lesions and symptoms is reprinted by permission of the *Pennsylvania Medical Journal.* This list was prepared by the Cancer Commission of the Medical Society of the State of Pennsylvania and includes practically all conditions that would cause the physician to suspect cancer when making a physical examination.

SKIN

Keratotic lesions showing any change in character or size.
Warts or moles which may be subjected to irritation or which show any change in size, character, or color, especially those located along the collar, brassiere, girdle or belt line, and in the axillary, inguinal, and perineal regions and feet.
Any lesion of skin of adult showing tendency to grow.

LIP

Keratosis.
Leukoplakia.
Verruca.
Fissures, persisting over four weeks.
Chronic persistent desquamative cheilitis.

TONGUE

Irritated mucous membrane associated with poor mouth hygiene.
Any wart-like growth, sore, or ulcer.
Leukoplakia with or without syphilis.
Node in the neck.

MOUTH OTHER THAN TONGUE

Swelling or thickening of oral mucous membrane.
Wart-like growths of ulcers on cheek, gum, floor of mouth, palate, or tonsils.
Leukoplakia with or without syphilis, especially buccal surface.
Plummer-Vinson's disease.

LARYNX

Persistent hoarseness.

ACCESSORY SINUSES

Any persistent discharge which is unilateral.
Persistent bleeding.
Unexplained pain.

PAROTID GLAND

Any nodule or mass.

THYROID GLAND

Any solitary nodule.
Rapid increase in size.

LUNG

Any mass lesion which is found on x-ray examination with or without symptoms should be considered as possibly malignant.
Persistent cough or asthmatic wheezing.

ESOPHAGUS

Spasms and difficulty in swallowing.
Plummer-Vinson's disease.

STOMACH

Persistent indigestion.
Any mass found on routine survey.
Any ulcerative lesion of stomach found in x-ray examination is under suspicion.

LARGE BOWEL

Unexplained anemia.
Variation in bowel habit.
Palpable abdominal mass.

RECTUM

Polyps.
Unexplained rectal bleeding.
Constipation or diarrhea. Change in bowel habits.

BREAST

Any solitary lump in the breast may be cancerous.
Bloody or serous discharge from the nipple.
Crusting or thickening of nipple.
Unaccounted for dimpling of breast.

VULVA AND EXTERNAL GENITALIA

Any ulcerated lesion of undetermined etiology.
Leukoplakia or kraurosis.
Pigmented moles.

VAGINA

Any ulcerated lesion of undetermined etiology.
Watery, irritating, or blood-stained discharge.

CERVIX

Post-coital or post-douche bleeding.
Any erosion with or without eversion.
Leukoplakia.

UTERUS

Menorrhagia, metrorrhagia.
Any abnormal bleeding, especially after menopause.

OVARY

Any persistent cystic ovarian enlargement over 4 cm in size.
Any solid ovarian neoplasm.
Vague low abdominal pain.

PROSTATE

Any nodule.
Change in urinary stream.

URINARY TRACT

Painless bleeding.

TUMOR OF TESTIS

Any enlargement of testicle.

SOFT TISSUE SARCOMA

Any subcutaneous mass of unknown origin.

BONE MALIGNANCY

Pain or enlargement.

Squamous cell carcinoma in lymph nodes is mo resistant to irradiation as a rule than the primary si

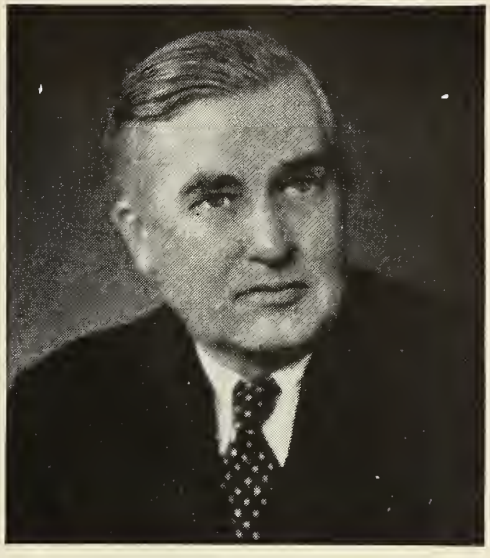
* * *

No visible or palpable neck tumor should be blinc treated without definite diagnosis.



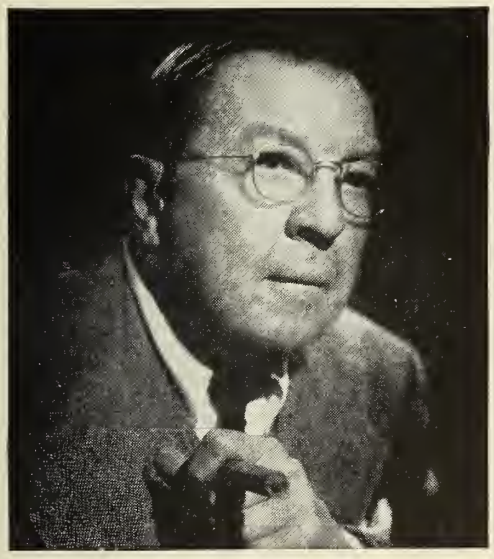
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These three great Americans can afford any type of hearing aid at any price. They wear the seventy-five dollar Zenith hearing aid.

BIOGRAPHICAL DATA BASED ON "WHO'S WHO IN AMERICA."

Editorial Comment

CAME NOT BACK AGAIN

This happy land. a good land just this side of Paradise, is the creation of the marching men who worked and bled and died for the America that is. Of those legions who came not back again everyone has memories more meaningful than just words.

May we in this happy land ask not what can we get but what do we owe to this free country? From Valley Forge to yesterday this great land is kept free by those who marched away singing and on July 4 we think of those who came not back again. Came not back again.—Dave Sugar, Editorial, *Detroit Medical News*, July 7, 1952.

A LOST GOVERNMENT

The people, once the government, have lost their sovereignty and have become slaves to the government they once possessed. They have sold their liberty and independence for subsidies and so-called security. All good citizens who are mature in mind with a normal sense of honor and integrity, are conscious of the insults heaped upon them by the bureaucrats in high places. How long must we endure the stupidity of an irresponsible, extravagant government that insists that the people cannot be trusted with their own local affairs including sacred personal interests such as making their own homes. saving their own money, and choosing their own doctors and doing their own charity.

Without consulting the people or their representatives, Mr. Truman confiscates private property, while Mr. Ewing proposes to use one man's money with which to pay another man's hospitalization costs. In plain English it amounts to this—a man turns over to a stock buyer the estimated price of a pig. The pig is delivered. Nothing is said about the cost. But in time the man is notified of the fact there was a surplus and instead of returning it, he is using it to purchase a pig for someone else, perhaps the original purchaser's neighbor who never works and never saves, or perhaps the pig goes to a perfect stranger.

Is this gross injustice due to both deception and theft or is it the result of plain insanity. Is there any recourse? Yes, when only a pig is at stake, the offender is only a stock buyer, responsible for his acts. Not so when people are the objects of concern. Mr. Ewing is a bureaucrat. He can take our money, which should be refunded and spend it for the so-called security of others saying service will not cost us anything. That he can do this without batting an eye reveals his opinion of our intelligence.

How long, Oh Jupiter, must we endure such injustice! Shall we raise hell now and call a halt or shall we await the evil day of revolution. In the latter event, upon whose hands will the blood be? —Editorial, *The Journal of the Oklahoma State Medical Association,* June, 1952.

DOLLAR DEBACLE

News that merchants across the river in Windsor and other Canadian cities now are demanding three cents more for every American dollar spent should call for sober reflection from every American.

It was not long ago that the proud American visitor in Canada enjoyed a discount on every purchase he made. Today, he must pay a premium.

For many years, the American dollar has been the most sought-after currency in the world. Now it has depreciated in value.

One of the causes for this monetary embarrassment has been the unchecked spiral of inflation in this Country.

One of the reasons that Canadian money is "hard" is because that nation has successfully prevented inflation.

We suggest that our economic "experts" in Washington take a trip to Ottawa to see how it is done.—*Detroit Free Press,* July 14, 1952.

STRANGE OATHS

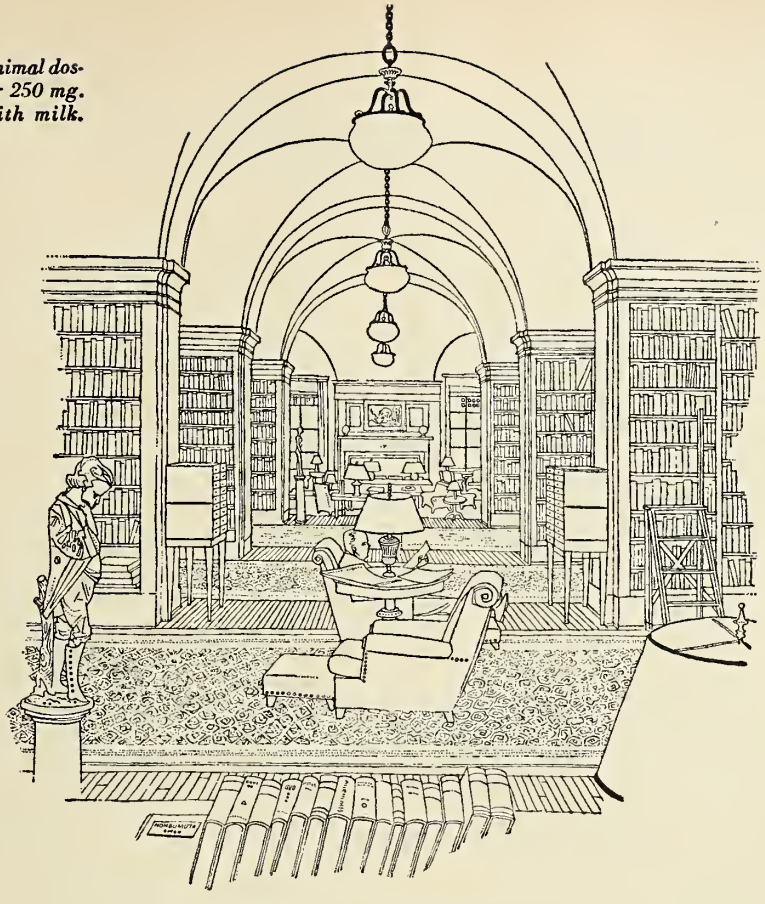
We have just been vouchsafed new light on this time-honored Shakespearean phrase. We received a letter from a young layman, a college student who asked us for a transcript of the Oath of Hypocrites *(sic)* to use in writing a thesis.

This office, however, has no dealings with Hypocrites. We were compelled to write the young man our regrets; we could not help him. But his letter set us to musing. We began to reconstruct the man Hypocrites as archaeologists reconstruct a dinosaur, from an evidential rib or two he has left behind. That he existed, there is little doubt; he left so many direct descendants as to make this almost a certainty. That he had vigor and strength (of a kind), ambition and purpose (of a kind) and an immense talent for turning things to his own advantage seems without doubt, as even a casual study of the family line makes clear.

We conceive him to have been a contemporary of Hippocrates and to a certain extent his imitator. We dare say he had pupils and administered them an oath. We dare say he had patients and administered them—who knows what? We dare s

(Continued on Page 1150)

New aureomycin minimal dosage for adults—four 250 mg. capsules daily, with milk.



Library, Union League Club, Philadelphia, Pa.

From among all antibiotics, Dermatologists often choose

AUREOMYCIN

Hydrochloride Crystalline

because

Aureomycin provides mild bacteriostasis in diseases of the skin.

Aureomycin has been found effective in pinta, yaws and many bacterial infections of the skin (furunculosis, impetigo, pyogenic dermatitides, sycosis vulgaris and tropical ulcer). It is at present considered preferable to administer the drug systemically in these conditions. Aureomycin is also useful in the control of contributing or secondary infections associated with many dermatoses.

Throughout the world, as in the United States, aureomycin is recognized as a broad-spectrum antibiotic of established effectiveness.

Capsules: 50 mg.—Bottles of 25 and 100; 250 mg.—Bottles of 16 and 100.
Ophthalmic: Vials of 25 mg. with dropper; solution prepared by adding 5 cc. distilled water.

LEDERLE LABORATORIES DIVISION AMERICAN CYANAMID COMPANY 30 Rockefeller Plaza, New York 20, N. Y.

STRANGE OATHS

(Continued from Page 1148)

he had colleagues, in whose praise he sometimes spoke at public meetings, thus acquiring a reputation for impartiality and even generosity of mind, and at the same time left himself free to work against the aforementioned colleagues in private.

Unfortunately for us as well as for our young correspondent, Hypocrites' Oath is no longer available. Great distinction undoubtedly awaits any who shall discover this historic document. We conceive of it as modeled (outwardly) after the limpid honesty of the Hippocratian Oath, but honeycombed with secret passages through which Hypocrites might escape at any moment. For Hypocrites, we think, was a smallish man.

There have been whispers that the oath is extant; that it passes from hand to hand under cover of darkness, and that it is even administered now and again to fledgling medicos who can be persuaded that it is merely the Hipprocratian Oath brought down to date, adapted to modern conditions and a great deal less cumbersome to live up to. If this is true, it explains a number of things we have found—and are finding—exceedingly hard to understand.—*Journal, International College of Surgeons,* July, 1952.

PROUD RELIEFERS

It used to be a disgrace to be on welfare. But, in recent years, more and more Americans proudly brag they are on relief. They insist loudly that the world owes them a living.

Despite this self-proclaimed "right" to be supported by the taxpayers, social workers insist welfare rolls must be kept secret because a recipient would have a "traumatic experience" if his landlady or neighbor knew he was on relief.

Now comes word from South Carolina that a poll of recipients shows that several would be disappointed unless their names appeared in the papers as being on the relief rolls.

It used to be a saying that a person is entitled to have his name in the paper three times—when he is born, when he marries and when he dies.

Should we now add—when he goes on relief?—*Detroit Free Press,* July 14, 1952.

FRUITS OF FREE RESEARCH

"The American Medical Association's annual convention, now in session in Chicago, is a clearing house for progress.

"Healing discoveries developed through the researches of individuals and groups are explained and exchanged and become the common possession of all members of the profession as weapons against disease.

"If left wingers who denounce the American Medical Association as a trust had deliberately set out to dream up the silliest charge imaginable they could not have done better.

"Far from restricting and restraining the use of new medical information, the AMA hastens to distribute it as rapidly as possible for the widest possible use.

"The real reason why the AMA is disliked by Fair Deal Socialists and other enemies of free enterprise is that it opposes socialized medicine.

"The medical progress being spread on the record at the convention this week proves how right the association is in resisting governmental regimentation.

"These new discoveries have been made by medical scientists free to develop their own ideas and to pass the benefits of their knowledge along to their patients.

"The medical profession is entirely right in believing that its own trained and dedicated members are better able than any group of politicians to look after the nation's health.

"They are doing it superbly. Every day they learn some new way to do it better.

"The most effective way to check this progress and reduce all medical practice to static mediocrity would be to submit the medical profession to the deadening control of a political bureaucracy.

"For the nation's sake we must help the AMA fight off power-hungry politicians and keep American medicine free."—*Chicago Herald-American.*

HEALTHY AMERICA

A study by the Brookings Institution shows that the average death rate in the United States has been cut nearly in half in the past 50 years.

This has been brought about by advances in medical science, the increased use of medical facilities and the control of communicable diseases.

The advances were made and applied under the free enterprise system by researchers and doctors working for private concerns or for themselves.

The medical record of the past 50 years is the best answer we know of to the demands of those who would seek to socialize medicine. Will Oscar Ewing please take note.—*Detroit Free Press,* August 15, 1952.

WITH NO EXCEPTIONS

"Like Your Doctor? The question was: 'How do you like your doctor?' The typical reply from some 700 reputed community leaders came back 'We like our doctors, but our doctors don't seem to like us.' To meet that criticism the American Psychiatric Association and the Association of American Medical Colleges who conducted the survey have recommended more schooling for medical students in human relations." . . . Editorial, *The Detroit News,* June 16, 1952.

The editorialist, tucking tongue in cheek, the

(Continued on Page 1152)

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WITH NO EXCEPTIONS

(Continued from Page 1150)

pontificates as follows: "If there is a school that teaches the kind of human relations that makes warm and friendly doctors, we haven't heard about it." And neither have we, nor have we heard of any other school — with no exceptions — that could by any device make anyone either warm or friendly, much less both warm and friendly. No brethren! Such things are the stuff that come as gifts from the gods. We have the essence of them when we come into the world, and it is in our homes that such qualities bloom or wither. The school can only nurture and develop what is brought to it. It can't create. What the editorialist said about doctors applies as well to workers in any and all fields—with no exceptions. We say this not in defense of medical schools or our confreres. We say it as an amen to the editorial's proper indictment of the mores of this the 20th century A.D.

And as a point of information, medical school faculties anticipated the change that would take place in the doctor when medicine passed from the empirical stage, when the doctor had little more than warmth and friendship to offer, to the present highly accurate scientific era. For many years now they have accented human relations in the student's approach to the patient. For example: Each year, a group of Detroit's leading physicians augment the faculty in Sociology, at the College of Liberal Arts of Wayne University, to stress the human side of medicine to premedical students.

With those who come to them with warmth and friendliness as part of their makeup, the medical schools do well. With those barren of such qualities the medical schools do no better or no worse than do other schools.—Frank A. Weiser, *Detroit Medical News,* July 28, 1952.

THE CASE AGAINST THE INCOME TAX

The great weight of the burden of the average taxpayer has come to be recognized by the medical profession as a definite mental oppression upon many of our people. In a quiet, homey talk with an eminent physician recently, he stated that many psychopathic cases can be laid at the door of the income tax laws. Frustration, discouragement, and the inability of people, he says, to accommodate their minds to these oppressive and dictatorial laws bring them to the verge of "cracking up." Often members of their families literally have to drag them to competent medical advisers. Then starts a long and protracted fight to restore their health. In truth, he said, it is difficult even for the stolid, sturdy individual, let alone the weak and the sick, to withstand the pressures brought upon them by the government.—From "Man to Man," by Bernard N. Ward, C.P.A., The Caxton Printers, Ltd., Caldwell, Idaho, 1952.

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ARMY MEDICAL SERVICE AND FCC SAVE $148,500 IN DIATHERMY EQUIPMENT

A saving of approximately $148,500 has been effected by the modification of diathermy equipment used at Army and Air Force medical facilities, the Department of Defense announced.

Modification of the equipment, which is used in applying heat treatments to deep-lying muscles and tendons, was made necessary by a 1947 ruling of the Federal Communications Commission changing the frequency bands assigned to diathermy apparatus. In addition, it was necessary to develop a shielding to reduce radiation which caused interferences with communication systems and high frequency equipment in the vicinity of the machines.

Approximately 450 units manufactured prior to July 1, 1947, were ordered taken out of operation after June 30, 1952, by the Federal Communications Commission unless they met requirements established by the regulations of that agency. The cost of replacing such a large number of machines with new equipment meeting the prescribed standards would have amounted to an estimated $184,500. This anticipated expenditure prompted the Army Medical Service to seek ways and means of altering the units at hand to conform with the ruling.

The initial modification, undertaken at the request of the Army Surgeon General, was devised by Federal Communications Commission engineers working with an electronics consultant retained by the Surgeon General. Their combined efforts produced a converted unit which satisfied the requirements of the FCC regulation. Using this rebuilt machine as a model, a second one was produced by military personnel of the Surgeon General's Office and was approved by the Commission in September, 1951.

Skilled medical equipment maintenance personnel at medical depots and Army and Air Force installations throughout the United States and overseas then began a program of converting all existing diathermy units along the lines laid down by the Surgeon General. The cost of modification, including labor and materials, amounted to $80 per unit, totaling $36,000 for all of the 450 machines as compared to the replacement cost of $184,500.

The method of conversion has recently been adopted by the Navy for its older diathermy machines. Instructions on proper procedures for modifying existing units have also been made available by the Federal Communications Commission to civilian institutions and Federal health agencies, thereby making possible further economies for users of diathermy equipment.

ARMY HOSPITAL CONSTRUCTION APPROVED; WORK BEGINS EARLY NEXT YEAR

Following final approval by Chief of Staff, Army Surgeon General's office announced construction will begin early next year on the first of seven permanent, modern hospitals. Plans call for completion of the multi-story structures in three years; together they will have a minimum capacity of 3,200 beds and are *designed for quick expansion during mobilization.* Five-hundred-bed hospitals expandable to 1,000 beds will be built at Fort Benning, Ga.; Fort Bragg, N. C.; Fort Knox, Ky., and Fort Riley, Kansas.; 250-bed hospital expandable to 500, at Fort Belvoir, Va.; 200-bed hospital expandable to 300 at Fort Monmouth, N. J., and 750-bed hospital expandable to 1,000 at Fort Dix, N. J.

General Armstrong said plans prepared by leading civilian and military authorities in the hospital design field have reduced to a minimum luxuries and extras while conserving steel and other scarce materials. Findings of three-year Army research in hospital management will be incorporated in construction, resulting in economy in use of nurses, ward technicians and other scarce personnel.

PHYSICIANS AND DENTISTS INDUCTED IN ARMY AND AIR FORCE

The Department of Defense has requested the Selective Service System to deliver to Armed Forces Induction Stations 355 doctors of medicine and ninety doctors of dentistry during the month of September.

The Armed Forces will assign 180 physicians to the Army and 175 to the Air Force.

All of the dentists will be assigned to the Air Force.

The September call for physicians and dentists brings to a total of 1,522 the number of physicians and to 650 the number of dentists requested since July, 1951.

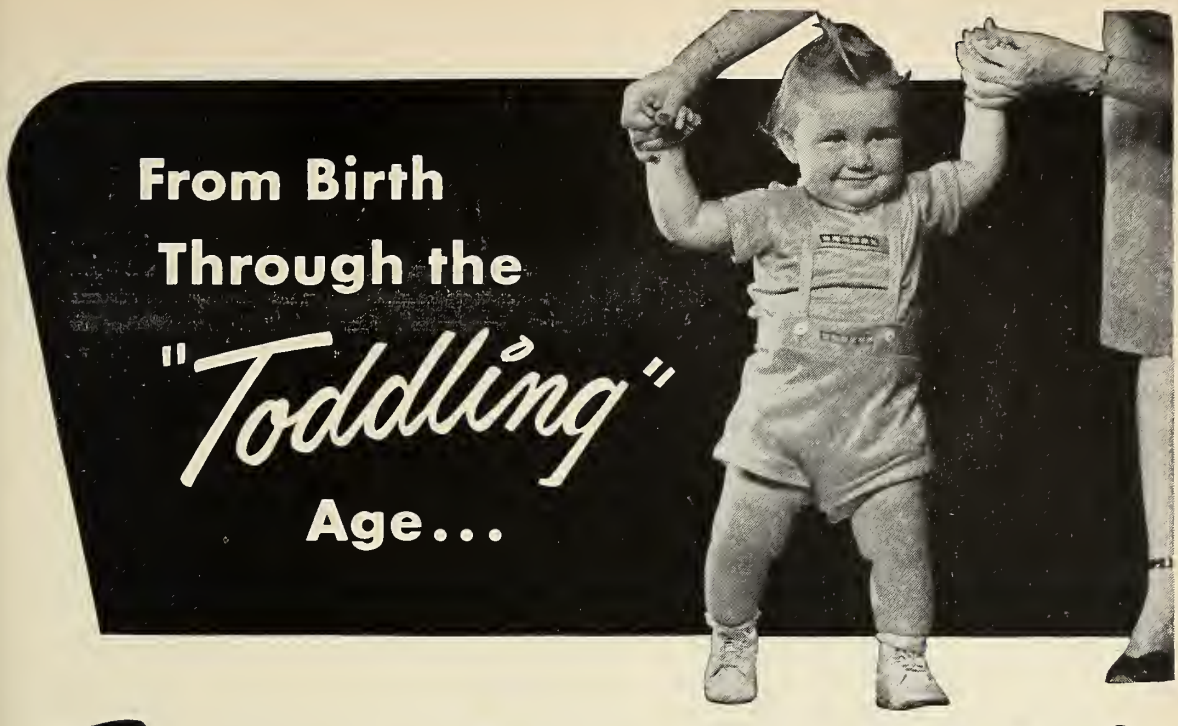
ARMED FORCES MEDICAL LIBRARY

The appointment of Lieutenant Colonel Frank B. Rogers, MC, USA, as Director of the recently established Armed Forces Medical Library was announced by Secretary of the Army Frank Pace, Jr., with the concurrence of the Secretary of Defense.

Colonel Rogers has served since October, 1949, as the Director of the Army Medical Library, the largest such institution in the world, which is the nucleus for the new establishment.

The Armed Forces Medical Library serves as a central medical library for the Army, the Navy, and the Air Force, and as a national library for medicine and related sciences. In addition to the medical activities of the military departments, the facilities of the library are available to other governmental agencies, medical research and development contractors, and civilian physicians and medical scientists.

During the fiscal year 1951, more than 29,700 books were lent to borrowers in the United States. During that same period requests for information numbered 55,900. Through its photoduplication service, the library is able to furnish microfilms or photostatic copies of desired material for a very nominal sum. Also available are microfilm copies of publications which may be obtained on a loan basis. The photoduplication service received 56,000 orders requiring over 1,500,000 pages of film and print reproductions during fiscal year 1951.



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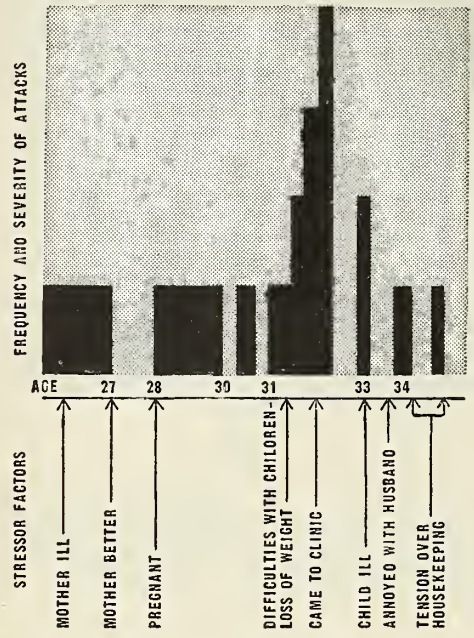
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Stressor factors which evoke autonomic responses occur often in our civilization. They are not always of external origin, frequently, stress springs from the "well of uncertainties, the fears, the angers, and the hostilities that an inadequate childhood nurtures in troubled people in a troubled world." [1]



After: Relationship Between Life Stress And Symptoms — Stevenson, I.: G.P. *4*: 67 (Dec.) 1951

When emotions aroused by these stresses are not dissipated in appropriate biological behavior, heightened autonomic impulses beat against a "moored" physique.[1]

Incessant "emotional buffeting" impinged on labile autonomic pathways is likely to produce deviations from normal body function and *a rash of symptoms.* In such cases, both branches of the autonomic nervous system are involved. For symptomatic relief oral administration of cholinergic and adrenergic blocking agents and central sedation has proven successful. Drugs effective for the several actions respectively are: belladonna alkaloids, ergotamine tartrate and phenobarbital. These drugs may be used individually or in combination,* as required by the individual case, to effect more stable function of the autonomic nervous system, thereby "dampening" overactivity of the involved organ systems.

* Dosage of each ingredient adjusted to the needs of the particular patient.

[1] *Cleghorn, R. A. and Graham, B. F.: Recent Progress in Hormone Research, Vol. IV, New York, Academic Press, Inc., 1949, p. 323.*

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Civil Defense

FLOW OF SUPPLIES STARTS FOR FEDERAL CIVIL DEFENSE MEDICAL STOCKPILES

After months of negotiations, Federal Civil Defense Administration reports that on July 15 it had $1,574,378 in medical supplies and equipment stored in seven federal regional warehouses. *This is 2.67 per cent of the $60 million Congress made available up to July 1,* all now on contract. Almost all material was received after June 1, and shipments soon will be "mushrooming," FCDA said. Regional stockpiles are purchased and maintained entirely by U. S. funds; they are designed to supplement state and local supplies in case of a disaster.

State procurement programs, which FCDA has been pushing for over a year and for which U. S. supplies half the funds, are farther advanced. Half of the $20 million originally earmarked for these matching grants has been used by 13 participating states; on July 15 they had received $3,159,664 in supplies, about a third of the amount on order.

Antibiotics make up a majority of federal supplies and also are the highest dollar-value item going to states. Currently, FCDA officials are working on a budget for fiscal 1953. One problem is to determine how much to spend on the blood program and how much for other medical supplies. Congress allowed FCDA $40 million this year for all agency expenses, in contrast to about $100 million last year.

CIVIL DEFENSE BOOKLET NOW AVAILABLE

The AMA Council on National Emergency Medical Service has just completed publication of a new booklet, entitled "Medical Aspects of Civil Defense," which contains a series of articles sponsored by the council and published in the AMA Journal during the past year.

Many requests for the booklet already have been received. It sells for 25 cents a single copy, and 20 cents per copy for orders of 100 or more. Orders may be placed with the council's office at AMA headquarters.

Contents of the booklet include: Medical Aspects of Civil Defense, Chemical Defense, Atomic Burn Injuries, Radiological Aspects of Civil Defense, Nature of Air Raid Casualties, and Mental Health and Civil Defense.

In more than 40,000 gastrointestinal x-rays for cancer made at Johns Hopkins Hospital, the disease was found in 0.2 per cent of the series or one per 476 examinations.

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As long as any considerable number of people continue their unwillingness to see or hear informative facts about cancer, just so long must the educational program be pursued with intensified vigor.

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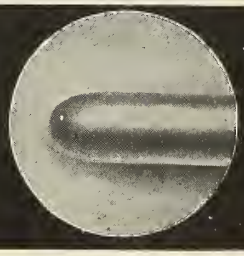
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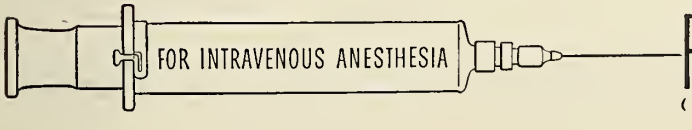


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Adams, R. Charles (1951), Intravenous Administration of Pentothal Sodium in Combination with Other Anesthetic Agents and Methods, J. Missouri Med. Assn., August.

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A recent critical study of the results of dietary treatment in 68 patients with liver cirrhosis indicates that in its early stages the disease may respond to a nutritious high protein diet.* In most instances, advanced cirrhosis can be stabilized, if dietary and living habits are properly adjusted, permitting patients to return to useful endeavors.

Biopsy was employed in establishing diagnosis of liver cirrhosis and in determining the extent of liver change. Individual patients were followed for from one to three or more years. The basic therapeutic regimen consisted of 200 Gm. protein, 500 Gm. carbohydrate, sufficient fat to render the food appetizing, moderate vitamin supplement (one therapeutic capsule daily), and one-half ounce of brewer's yeast three times daily. Variables included use of a low calorie diet (1,500 calories or less) with 150 Gm. protein, 1 Gm. methionine four times daily, and intravenous injections of liver extract.

Meat can play a significant role in the dietary treatment of the patient with liver cirrhosis. It is an outstanding source of protein of excellent biologic quality, the B group of vitamins, iron, and other essential minerals—nutrients especially important in the therapeutic regimen. Other advantages of meat are its palatability, its stimulating effect upon the flow of digestive juices, and its easy digestibility.

*Davis, W. D., Jr.: A Critical Evaluation of Therapy in Cirrhosis of the Liver, South. M. J. *44*:577 (July) 1951.

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The JOURNAL

of the Michigan State Medical Society

Issued Monthly Under the Direction of the Council

VOLUME 51 SEPTEMBER, 1952 NUMBER 9

Activities of the Arthritis and Rheumatism Foundation

By Henry T. Ewald
Chairman, Michigan Chapter
Arthritis and Rheumatism Foundation
Detroit, Michigan

THE LAST FISCAL year of the Michigan Chapter, Arthritis and Rheumatism Foundation, was noteworthy for the development of a new activity to help arthritic sufferers. Dr. James J. Lightbody, our forward-thinking medical director, suggested in September, 1951, that we try to do something for "shut-in" sufferers of arthritis, and in October we started a pilot test in the Detroit area through the Visiting Nurse Association.

The treatments are given by nurses of this association trained in physical therapy. Those able to pay do so, while the bills of those unable to pay are financed by our Michigan Chapter.

So successful was this work in Metropolitan Detroit that we extended the activity, several months ago, to ten other communities in Michigan, through the local Visiting Nurse Associations. As a result we are now also financing deficits on nursing service to arthritics in Grand Rapids, Flint, Pontiac, Bay City, Lansing, Ann Arbor, Muskegon, Kalamazoo, Saginaw and Marquette.

At our annual meeting last July we set aside $36,000 for this work for the twelve-month period which started August 1.

While we took on this new service activity, we have continued our grants-in-aid for arthritis research to Michigan medical schools, hospitals and clinics having facilities and personnel to carry on such work effectively.

Grants-in-aid for arthritis research for the three-year period ending July 31 have totaled $218,000, and we have appropriated $80,000 for arthritis research for the twelve-month period which started August 1. Thus at the end of a four-year period we will have expended just under $300,000 for research in the State of Michigan.

Eight different research projects are now being underwritten by us in seven different institutions in Michigan.

For making possible our activities I wish to extend sincere appreciation to the United Health and Welfare Fund of Michigan, which provides our funds, represented in Metropolitan Detroit by the United Foundation—and to the able leader of this organization, Dr. Warren B. Cooksey, who again has been re-elected president of this organization. This fund-raising state federation is gaining in stature each year through its growing efficiency, and I again wish to call the attention of all medical doctors in all communities in Michigan to the magnificent financial backing United Health is providing them in conquering diseases of all kinds. It seems only reasonable to me, then, that all medical doctors should help this federated fund-raising organization in their respective communities during the local campaign.

What a magnificent job United Health and Welfare of Michigan is doing in providing funds may be deduced from the fact that last year our Michigan Chapter received more money from this organization than was raised by any of the other twenty-three chapters affiliated with the national Arthritis and Rheumatism Foundation, with the exception of the New York State Chapter, which has headquarters in wealthy New York City.

To The Journal of the Michigan State Medical Society, we extend sincere thanks for again devoting practically this entire issue to papers on arthritis—primarily reporting the results of our various research projects. Information itself is

useless unless it is disseminated and put to use. We think this issue of THE JOURNAL makes fruitful the findings of our research projects of the last twelve months. It is a most important part of our general educational activity—along with pamphlets about the home care of arthritic sufferers which we gave out this last year—the showings of our motion picture—exhibits at meetings of the Michigan State Medical Society and other groups—news items of public interest and representation and talks at various gatherings by our medical director, Dr. Lightbody.



Mr. Henry T. Ewald, President of Campbell-Ewald Company, gave a reception at the Detroit Club, March 5, 1952, for General George C. Kenney, President of the National Arthritis Foundation, and for the physicians in charge of the various research projects of the Michigan Chapter. General Kenney had just completed a tour of all of the Chapters of the National Foundation. He gave a very complete and detailed report of the activities of the Foundation throughout the country and stated that the Michigan group was the best organized of any he had seen. He complimented the physicians who were supervising the projects of the research groups in Michigan for their contributions to investigative medicine. Members of the Board of Directors of the Michigan Chapter were present at this reception.

Reading from left to right around the dinner table are the following: Dr. Gordon M. Myers, Professor of Medicine, Wayne University; Dr. Dwight C. Ensign, Chief of Arthritis Department, Henry Ford Hospital; Dr. Alvin Price, Head of Arthritis Department, Harper Hospital; Mr. Lewis S. Robinson, Vice President, National Bank of Detroit; Dr. Hugo A. Freund, President, Child Research Center of Michigan; Dr. J. J. Lightbody, Medical Director, Michigan Chapter; Mr. Walter Laidlaw, Vice President and General Manager, United Foundation; Mr. D. E. Mitchelson, Treasurer, Parke-Davis and Company; Dr. E. C. Vonder Heide, Clinical Research, Parke-Davis and Company; Dr. Frank A. Weiser, Medical Director, Grace Hospital; Mr. Sterling Eaton, Publisher, *Plymouth Mail;* Dr. William D. Robinson, Professor of Medicine, University of Michigan; Mr. John W. Stannard, Business Manager, Michigan Chapter; Mr. Oscar L. Buhr, Vice President, Detroit Trust Company; Dr. Earl A. Peterman, Head of Arthritis Research, Providence Hospital; General George C. Kenney, President, National Arthritis Foundation; Mr. Henry T. Ewald, President, Campbell-Ewald Company; Mr. H. J. McLaurin, General Agent, Aetna Insurance Company, Detroit; Mr. Wm. W. McPeak, Ford Motor Company executive, and representative of Budget Committee, United Foundation; Mr. James A. Kintz, Secretary, Budget Committee, United Foundation; Dr. Samuel D. Jacobson, Medical Director, Wayne County General Hospital; Dr. Ernest Gardner, Professor of Anatomy, Wayne University.

To the Board of Directors of the Michigan Chapter, Arthritis and Rheumatism Foundation, I wish to extend sincere appreciation for their conscientious work as a body, and their willingness, individually, to carry out assignments given them throughout the year.

Arthritis Research in Michigan

III. Arthritis Foundation Expands Home-Care Program

By J. J. Lightbody, M.D.
Detroit, Michigan

THIS IS THE third year that the September number of the Michigan State Medical Society JOURNAL has been devoted to arthritis and rheumatic diseases. The Michigan Chapter of the Arthritis and Rheumatism Foundation and the members of the Michigan Rheumatism Society have accepted this privilege and responsibility of publication, and we hope that in the future there will continue to be a renewed interest in the field of arthritis manifested by the physicians in the State of Michigan.

The Arthritis Foundation has been interested primarily in the field of research into the various causes of arthritis and has been investigating newer methods of treatment of rheumatic diseases, but during the past year there has been increased activity and interest in offering more direct conventional services to the invalid arthritic person at home.

During the past year, through its Medical Advisory Committee and the Board of Directors, the foundation has granted assistance in the operation of arthritis research at Wayne County General Hospital, Child Research Center of Michigan, Henry Ford Hospital, Grace Hospital, Harper Hospital, Receiving Hospital, University of Michigan, Providence Hospital, and Wayne University. Most of the research groups are investigating newer methods of treatment by continuing their observations on a clinical level with the use of various drugs and hormones, particularly the steroid preparations. Only one basic research problem has been under investigation during the past year, and this one was supervised by Dr. Ernest Gardner, professor of anatomy at Wayne University. Several of the investigating groups actually have combined basic and clinical problems.

Much of the original investigation of the clinical effects of cortisone and ACTH was done in Michigan in the research projects whose activities have been subsidized partially or completely by the Arthritis Foundation. We hope, during the coming year, that interest in arthritis research may be stimulated in many other parts of the state, and if there is some particular clinical problem related to arthritis which any individual or group of individuals associated with hospitals or clinics would be interested in developing as a program of research, the Foundation would be very interested in considering a potential project for financial assistance.

Numerous scientific articles have appeared in a large number of medical journals that have been written by men who are actively engaged in research projects supported by the Foundation. One of the objects of the Foundation is to stimulate medical writing on arthritis so as to accentuate the factor of accurate observation of patients and to report more completely the results observed in treatment.

Statistics on the number of arthritics in the State of Michigan and in this entire country are very inaccurate, and there is a great need for a survey of the general problem of arthritis in relation to industrial and occupational disability. One of the members of the Medical Advisory Committee is at present interested in attempting to make a detailed survey of the incidence of arthritis and allied diseases in one of the large industrial plants in the City of Detroit. This survey will demand the full co-operation of the medical department of the corporation, and the information obtained from this type of survey would be invaluable in determining the serious social and economic consequences associated with acute and chronic disability due to musculoskeletal disorders of an arthritic nature.

The Board of Directors of the foundation on recommendation of the Medical Advisory Committee, have approved the continuation of research projects at the following places for next year:

1. Wayne University—Department of Anatomy
2. University of Michigan
3. Providence Hospital
4. Receiving Hospital—Department of Radiology
5. Receiving Hospital—Department of Medicine
6. Child Research Center
7. Henry Ford Hospital
8. Harper Hospital

Dr. Ernest Gardner, professor of anatomy, Wayne University, is planning to continue a study of connective tissue from the point of view of

Dr. Lightbody is medical director of the Arthritis and Rheumatism Foundation, Detroit 2, Michigan.

embryology with special attention to the study of growth rates of chick embryos and fetuses. Dr. O'Rahilly is assisting Dr. Gardner in this basic research project.

Dr. William D. Robinson of the University of Michigan will continue his investigations with long-term hormone therapy and evaluate the new steroid hormones as they become available. Methods of counteracting the undesirable effects of ACTH and cortisone will be explored on a limited number of patients, and the possibility of a combined medical and orthopedic surgical program for rehabilitation of the arthritic is also under consideration. Certain patients with rheumatoid arthritis would be investigated from the standpoint of treatment with the use of antibiotics or nitrogen mustard.

Dr. E. A. Peterman of Providence Hospital will continue his study of long-acting corticotropin in chronic arthritis with the use of a gelatin menstruum and the addition of enzyme inhibitors.

Dr. James Lofstrom, professor of radiology and head of the X-Ray Department of Receiving Hospital, will begin an involved study of osteoarthritis in relation to characteristic bone, cartilage and soft tissue changes with the use of improved roentgen diagnostic techniques. Vascular changes in joints, particularly the hips, have been implicated as a cause of arthritis, and with modern, scientific equipment including micro-radiograph, x-ray diffraction equipment and fractional focus x-ray tubes, it is believed that much more information can be obtained relative to the blood supply of various joints. Portions of this work will be done at Wayne University, Detroit Receiving Hospital, Detroit Memorial Hospital, and Veterans' Hospital. Dr. Lofstrom will be assisted in his work by Dr. P. P. Werle and Dr. H. Linn.

Dr. Gordon B. Myers, professor of medicine at Wayne University and head of the Department of Medicine at Receiving Hospital, will continue a study of Cortone administration on an out-patient basis in the Arthritis Clinic and will have the use of Compound F available for intra-articular use in selected cases.

Dr. Hugo A. Freund, president of the Child Research Center of Michigan, will continue investigations in the etiology of rheumatoid arthritis, particularly the infection theory involving virus-host cell inter-relationships in tissue cultures. This will take into consideration the role of mucoproteins and virus inhibitors, and also a study of possible enzymic effects of viruses on mucoproteins.

Dr. Dwight C. Ensign and Dr. John Siegler, of Henry Ford Hospital, will be investigating the changes in the electrophoretic patterns in rheumatoid arthritics and study the rates of protein synthesis. A glycine product labeled with a stable isotope N^{15} will be utilized to calculate rates of protein synthesis and the size of the nitrogen pool in laboratory animals and human beings.

Dr. Alvin E. Price and the Arthritis Research Committee of Harper Hospial will investigate thyroid function in chronic rheumatoid arthritis, using radioactive tracer studies, protein bound iodine, basal metabolism and blood cholesterol to determine and evaluate changes in thyroid activity. This group will also continue their interest in intra-articular Compound F in a certain number of selected cases. This project will also investigate serum proteins by electrophoresis with a determination of gamma globulin by an immunologic method.

There are several other projects which the Medical Advisory Committee and the Board of Directors have considered for assistance, but up to the present time they have not been approved because of a need for more clarification regarding the methods of investigation.

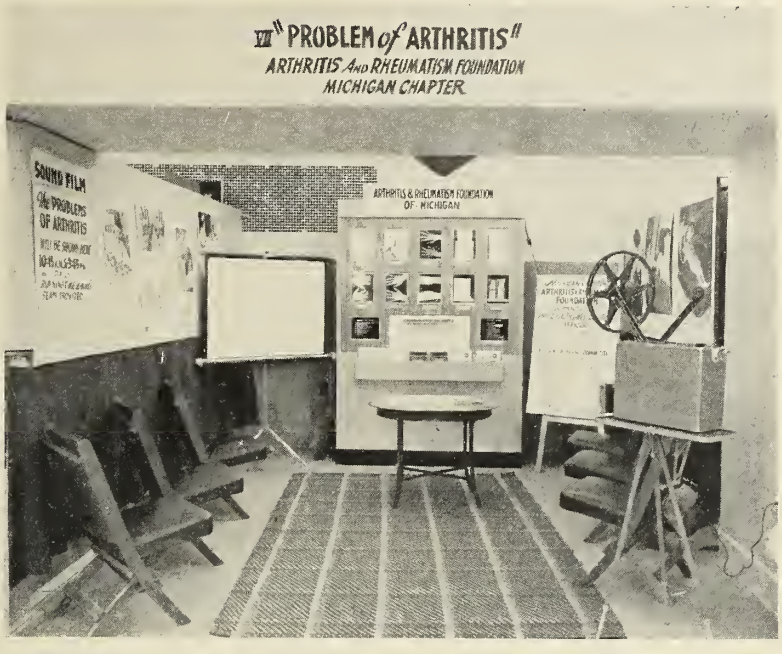
During the past year, the Arthritis Foundation has become interested in the problem of home care for the arthritic, and has developed a program of practical care in which general nursing and physical therapy is brought directly to the arthritic at home. The various Visiting Nurse Associations throughout the state have co-operated completely with this effort to stimulate interest in the invalid and semi-invalid who are incapacitated to such an extent that they are unable to attend clinics, hospitals or doctors' offices for regular treatment.

Many people who have arthritis have in addition some other chronic diseases such as diabetes nephritis, heart disease or cerebral-vascular residual difficulties so that the home care of the arthritic involves a somewhat complicated co-operative program between the physician in charge of the case, and the visiting nurse.

This program was started in Metropolitan Detroit in October of 1951 with the very fine co-operation and interest of Miss Emilie G. Sargent, head of the Visiting Nurse Association, and Miss Helen M. Lehman, chief physical therapist of the VNA in Detroit. After a pilot study of several months activities in the Detroit area, the program of hom

service was expanded to include a large part of the state in those cities which had active Visiting Nurse Associations so that by January 1, 1952, the foundation had completed arrangements with the VNA including injections, which are outlined by the physician in charge of the case.

Eighty-five per cent of the house calls on arthritics are made on patients between the ages of thirty-



Photograph of the scientific exhibit of the Michigan Chapter of the Arthritis and Rheumatism Foundation, which was presented at the convention of the Michigan State Medical Society held in Grand Rapids, Michigan, September 25-29, 1951. The exhibit detailed the typical radiographic patterns of the various types of arthritis along with actual photographs of patients having a variety of types of disabilities due to arthritis and allied diseases.

A thirty-minute sound movie on the diagnosis and treatment of rheumatoid arthritis, including indications and contra-indications of the use of the new hormones—ACTH and Cortisone—was shown at intervals throughout the Convention, and this film is available to any member of the Michigan State Medical Society for hospital or society meetings.

groups in the following cities: Ann Arbor, Bay City, Flint, Grand Rapids, Kalamazoo, Lansing, Marquette, Muskegon, Pontiac, and Saginaw, to assist in the home care of the arthritic and to offer this service to all home arthritics.

Up to August 1, 1952, there have been over 6,500 house calls by visiting nurses in the care of these arthritics at home. Standard forms for the reporting of these cases have been developed, which include the name, address and age of the patient along with the actual diagnosis. Since the inception of this program, there has been a great increase of the number of arthritics being treated at home, and we have found that there is a tremendous need for physical therapists, as it is impossible for the average visiting nurse to give complete physical therapy treatments. The visiting nurse does, however, follow the program of treatment, six to seventy and only 15 per cent below the age of thirty-five. Of the various types of arthritis which is being treated at home, it was found approximately 55 per cent have rheumatoid arthritis, 12 per cent have osteoarthritis, and 18 per cent combined rheumatoid and osteoarthritis. There is a group of unclassified types of arthritis including gout which includes about 15 per cent of the total.

In October, 1951, Mr. Henry T. Ewald, chairman of the board of the foundation, donated an automobile to the Visiting Nurse Association of Detroit to be used in the transportation of portable equipment and the foundation completed the gift by donating a certain number of portable infrared lamps. A portable diathermy unit was presented to the Curative Workshop for treatment of arthritis.

The Medical Advisory Committee of the founda-

tion has suggested that a survey of the home care services is in order to determine which patients have sufficient amount of salvage material present to warrant their transportation to a rehabilitation center such as the Curative Workshop in Detroit. Because of the great interest in rehabilitation programs throughout the country, it was thought that certain cases could be brought back to a status of health by concentrated efforts in occupational therapy, orthopedic surgery, and physical therapy.

The Medical Advisory Committee of the foundation is composed of a group of physicians located throughout the state, and has regular meetings during the year. The foundation wishes to express thanks to these men for their time and effort in supporting and assisting in the program of the foundation.

The physicians of the state are very fortunate indeed to have laymen of the caliber of Mr. Henry T. Ewald, president of Campbell-Ewald Company, and Mr. H. J. McLaurin, general agent of the Aetna Life Insurance Company, as the guiding factors in the administration of this foundation. The Board of Directors of the foundation have devoted much of their valuable time in determining the policies of allocation of funds for research and home care, and are making every effort to stimulate more and greater interest in the subject of arthritis and to bring more direct services to a greater number of people.

The Michigan Chapter of the Arthritis and Rheumatism Foundation is supported entirely by the United Foundation of Michigan, which is the Torch Fund in Detroit.

7338 Woodward Avenue

MICHIGAN CHAPTER
ARTHRITIS AND RHEUMATISM
FOUNDATION

7338 Woodward Ave.

Detroit 2, Michigan

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ACCIDENTS COST U. S. $21 MILLION A DAY

If you spent $1,000,000 a day, it would take you almost 22 years to spend as much as accidents cost the United States in one year.

The National Safety Council says accidents cost the nation $7,900,000,000 last year—or about $21,560,000 a day!

According to "Accident Facts," the council's statistical year book, just off the press, this includes:

$2,900,000,000 in wages lost by disabled persons, lower wages due to permanent partial disability, and the present value of anticipated future earnings of those killed or permanently incapacitated.

$1,400,000,000 property damage in motor-vehicle accidents.

$1,300,000,000 in property destroyed or production lost in occupational accidents.

$1,000,000,000 for administrative and claim settlement costs of insurance. This does not include claims paid.

$731,000,000 in property destroyed by fire.

$550,000,000 for medical fees and hospital expense.—*Journal of Commerce*, July 30, 1952.

The Use of Massive-dose Cortisone in the Treatment of Rheumatoid Arthritis

By John D. Chase, M.D., and
James J. Lightbody, M.D.

Detroit, Michigan

SINCE 1948 the rapid relief of symptoms for the patient with rheumatoid arthritis has been made possible by the use of ACTH and cortisone.[5] However, in the majority of cases this improvement persists only during administration of the hormones or shortly after their discontinuation. Consequently a search has been made for new methods of administration or for a combination of the hormones with other drugs either to potentiate their action or produce a more lasting effect.[3,4,6,12] Bayles[1] outlined a regimen employing doses of cortisone larger than those routinely used, without the appearance of persistent toxic side effects, and obtained remissions which lasted beyond those which might be expected from the usual course of treatment. Because of this promising report a similar program was instituted in an attempt to reproduce the results.

Methods

Seven patients (Table I) were selected for this investigation from the medical service of a large city hospital. The ages of the three women and four men ranged from thirty-seven to fifty-four years. Each patient was well documented as a case of progressive rheumatoid arthritis; the shortest duration of symptoms was five years and the longest fifteen years. No patient was studied who was not largely or totally incapacitated by the illness. In every instance the patient had received other forms of treatment, none of which had resulted in a lasting remission.

Before treatment was started, arthritic evaluation of each case was carefully made by classification of progression of the disease and function according to the criteria of the American Rheumatism Association proposed by Steinbrocker.[11] Each involved joint was closely checked for signs of acuity, and range of motion. Signs of extra-articular disease associated with the rheumatoid arthritis were recorded. Before, during, and after treatment, every patient was followed daily by the same individual and a record was kept of each visit, evaluating the subjective response as well as objective changes. Alteration in the arthritic status was classified according to Steinbrocker's Therapeutic Response index,[11] which was also used to follow the patient after discontinuation of the cortisone.

In addition to functional and subjective arthritic status, cardiopulmonary function was carefully evaluated. The patients were weighed daily. Baseline laboratory examinations included daily urinalysis and eosinophil counts. Twice weekly the blood cell counts, erythrocyte sedimentation rate, fasting blood sugar, plasma sodium, potassium, CO_2 combining power, serum chloride, and electrocardiogram were done. These examinations were carried out through the entire period of hospitalization. X-rays were taken to confirm and substantiate the clinical diagnosis.

Six of the seven patients had a pretreatment biopsy specimen taken from the knee joint by open exploration, and of these, four had similar biopsies taken at the termination of treatment. Testicular biopsy specimens were examined from the four male patients before and after treatment, and when possible a seminal fluid specimen was examined. Urine was collected from all patients before cortisone therapy for determination of gonadotrophins and 17-ketosteroids, and from five post-treatment samples were obtained.

Cortisone was administered in divided doses by parenteral route, reaching a daily dose of 500 mg. or more in every case. This therapy was continued until the appearance of toxic symptoms, at which time the cortisone was stopped abruptly in six cases. In the seventh, such a large amount of the steroid had been given that it was feared adrenal cortical insufficiency would develop, and a weaning process of decreasing doses was followed.

During the period of cortisone administration all patients were placed on a sodium restricted diet, with potassium supplements. This was altered following treatment to either a routine hospital diet, or a special diet designed to combat a specific type of cortisone side-effect.

After discontinuation of cortisone, the patients remained in the hospital until all evidence of cortisone toxicity had subsided; they were then dis-

From Receiving Hospital, and Department of Medicine, Wayne University College of Medicine.

This project supported by Michigan Chapter, Arthritis and Rheumatism Foundation.

TABLE I.

Patient	Age	Sex	Progression	Function Before Treatment	Days Treatment	Total Dose	Treatment Response	Days Remission	Treatment Response Maintained	Function Maintained	Toxicity
F.N.	51	F	III	IV	18	8.75 gm.	II	230	III	II	Hypertension Dyspnea
A.B.	42	M	III	IV	28	14.575 gm.	I	37	IV	IV	Facial fullness Euphoria
M.O.	54	F	IV	IV	22	10.375 gm.	II	13	IV	IV	Psychosis Glycosuria
A.S.	50	M	IV	IV	89	26.625 gm.	II	0	IV	IV	Facial fullness Hyperglycemia
E.B.	40	F	III	III	52	6.125 gm.	II	14	IV	III	Depression Infection
G.H.	48	M	III	IV	48	12.4 gm.	I	78	IV	IV	Facial fullness Tachycardia
J.M.	37	M	III	IV	23	10.8 gm.	I	22	IV	IV	Peptic ulcer Edema

charged and followed by weekly visits to the Outpatient Department of the same hospital.

Case Summaries

Case 1.—G. H., a white man, forty-eight years old, was admitted to the hospital from the Outpatient Department with a history of rheumatoid arthritis for seven years, and classified as progression of arthritis, grade III, function, grade III. The arthritis, which had begun with symptoms in the left ankle, had progressed to involve biliaterally symmetrical joints of all extremities and the cervical spine. Previous treatment included three courses of gold; the first two courses, given soon after the development of the arthritis, had produced some symptomatic relief. Two years before this admission two operative procedures on his knees and ankles had been made to increase their mobility. The patient had received no previous cortisone.

Physical examination revealed a moderately developed but poorly nourished male, who was able to care only for his simplest requirements while at bedrest. All joints were tender, both ankles and knees were edematous with intra-articular effusion, increased temperature, and erythema. Limitation of motion varied from 40 per cent rotatory loss in the left ankle to 15 per cent flexion loss in the right hand. The point of maximum cardiac impulse was 9 cm. from the mid-sternal line in the fourth interspace, and no murmurs were heard. The rate and rhythm were normal. The blood pressure was 120/75, and the fundi showed no evidence of vascular disease. There was no elevation of venous pressure.

After completion of the control study the patient was started on cortisone with a daily dose of 100 mg. This was increased to 300 mg. per day on the seventh day of treatment and continued at this level for the next sixteen days, when the dose was increased to 500 mg. per day and maintained for fourteen days. On the thirty-second day of treatment the patient experienced an attack of tachycardia with a rate of 160 beats per minute. It was auricular in type, as confirmed by electrocardiography, and without therapy fell to 68 beats per minute within three hours. During the next three days a similar episode occurred twice, each time following a cortisone injection. At no time was dyspnea, cough, hemoptysis, chest pain or cardiac failure noted. The cortisone was discontinued after a total dose of 12.4 gm. in thirty-six days and the tachycardia did not reappear. The arthritis had improved, the patient was ambulatory and free of pain, and was now classified as progression of arthritis, grade III, function, grade I, therapeutic response, grade I.

The patient was discharged to the Outpatient Department, and remained in remission until seventy-six days after discontinuation of cortisone, when a relapse occurred with 90 per cent loss of the cortisone-induced improvement. He was readmitted to the hospital and reclassified as progression of arthritis, grade IV, function, grade III, therapeutic response, grade IV.

Case 2.—F. N., a white woman, fifty-six years old, admitted to the hospital with a history of rheumatoid arthritis for fourteen years, was classified as progression of arthritis, grade III, function, grade IV. For five weeks preceding admission increasingly severe pain and joint swelling had confined the patient to her chair. Acute involvement with this exacerbation was most marked in the ankles and right wrist. Previous treatment had been symptomatic with spontaneous remissions until September, 1950, when she received cortisone for the first time with good results. A second course was administered in January, 1951, again with remission, and then relapse within one month after discontinuation of the hormone. Past history disclosed that the patient had been a mild hypertensive but had never been decompensated or received specific cardiac medication.

Physical examination revealed a chronically ill woman with typical deformity of the hands, wrists, elbows, knees, and ankles. There was definite erythema and edema of the ankles and right wrist. Both knees and the left elbow contained minimal effusions without heat or redness. Limitation of motion ranged from no loss in the spine to 90 per cent flexion loss of the right wrist. There was marked disuse atrophy of the interossei. Subcutaneous nodules were palpated over the dorsal surface of the left wrist and both olecranon processes. The fundi showed an A/V ratio of 1:3 with early nicking. No hemorrhages or exudates were seen. The left border of cardiac dullness was ½ cm. outside the mid-clavicular line in the fourth interspace. A soft apical systolic murmur was heard at the apex, and did not radiate. The blood pressure was 134/82. The lungs were normal to auscultation and percussion. The liver was palpated at the right costal

margin as smooth and nontender. The spleen could not be felt. Laboratory investigation showed 10.5 gm. of hemoglobin with 3.88 million red cells, a white blood cell count of 13,700 with 63 per cent neutrophils. The sedimentation rate was 102 mm./hr. The urine was normal.

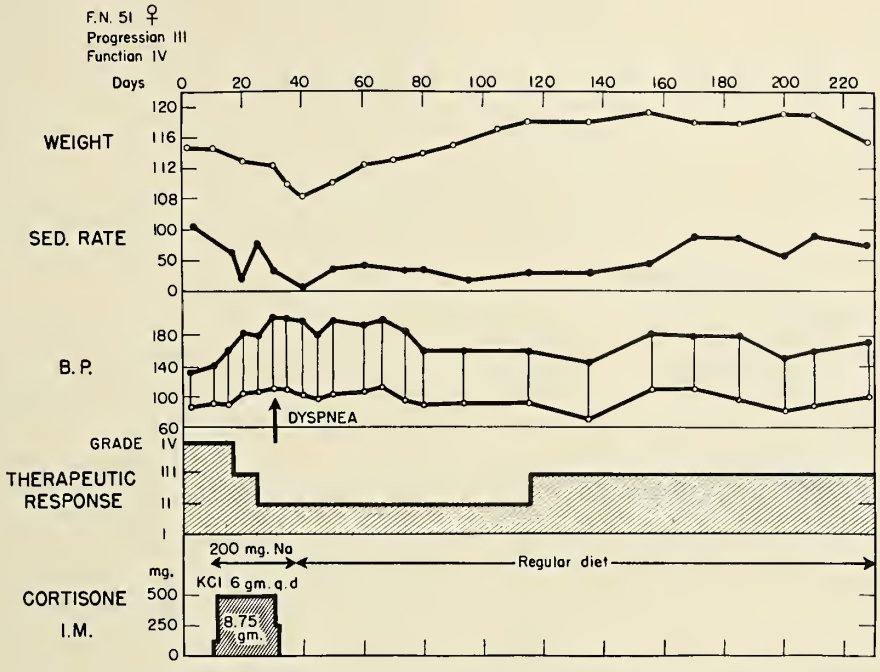


Fig. 1. Patient F. N. Showing particularly the decrease in weight and sedimentation rate with a coincident rise in blood pressure with cortisone therapy.

After suitable control studies, the patient received 125 mg. of cortisone on the fifteenth hospital day. This dose was increased to 500 mg. on the sixteenth day and continued at this level until the thirty-first day. On the thirty-second day the dose was reduced to 250 mg. and then discontinued.

With the institution of hormonal therapy, the patient had been placed on a 200 mg. sodium diet supplemented by 6 gm. of potassium chloride which was continued throughout the treatment period. On this regimen the body weight decreased steadily (Fig. 1) with normal plasma electrolytes. In the same interval the blood pressure had progressively increased, the systolic more than the diastolic, reaching a maximum of 210/106. On the thirty-first hospital day, after seventeen days of cortisone treatment, marked dyspnea with bronchospasm occurred. The heart had not increased in size, and no tachycardia was present. The cervical veins were visible at the clavicular level in the sitting position. There was minimal pitting edema of the ankles. The dyspnea responded favorably to aminophylline and, after discontinuation of the cortisone, did not recur. At this time the patient was ambulatory and the arthritic status classified as progression of arthritis, grade III, function, grade II, and therapeutic response, grade II.

She was discharged to the Outpatient Department, where she maintained the cortisone-induced remission for 148 days, when following an upper respiratory infection, swelling of the right index metacarpal-phalangeal joint appeared. The therapeutic response was accordingly changed to grade III, and has persisted at this level for 230 days.

Case 3.—A. S., a white man, fifty years old, was admitted to the hospital, with a history of rheumatoid arthritis for twelve years, completely bedridden, helpless to feed or care for himself. There were flexion contractures of both knees and both elbows, and swelling, pain and erythema were present in both wrists and hands. The arthritis was classified as progression of arthritis, grade IV, function, grade IV: Previous therapy included blood transfusion, salicylates, and both intramuscular and oral cortisone. The intramuscular cortisone, given ten months before admission to this hospital, had produced temporary relief of symptoms and increased mobility which was not sustained by the oral maintenance route.

Physical examination revealed the patient to be chronically ill with marked pain. Loss of motion ranged from 100 per cent in the knees to 15 per cent in the left hip. The spine was not involved. The spleen was palpable one finger-breadth below the left costal margin.

After pretreatment studies, including hormonal assays and biopsies, intramuscular cortisone was started on the seventh hospital day, with an initial dose of 250 mg. On the next day this was increased to 500 mg. and continued at this level for thirty-four days. By this time the patient was able to perform simple duties, and was semi-ambulatory with crutches. Because of the large total

dose of cortisone received it was felt advisable to discontinue the hormone by gradually decreasing the doses from 250 mg. to 125 mg. to 75 mg. over nineteen days. Since 75 mg. of cortisone failed to maintain a remission, the

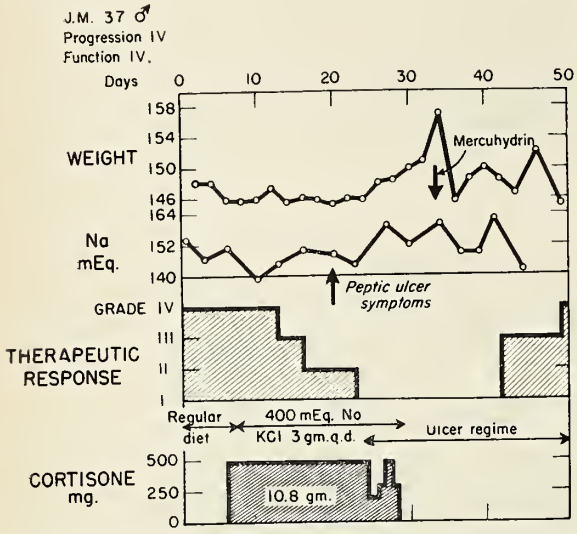


Fig. 2. Patient J. M. Showing clinical course, with the development of ulcer symptoms occurring during second week of cortisone therapy.

schedule was increased again from 75 mg. to 150 mg. to 300 mg. At this higher dose the patient again regained his former mobility, but with a drop in dosage from 300 mg. to 100 mg. effusion of the right knee appeared. It was not considered advisable to maintain this patient over a prolonged period at doses of cortisone above 100 mg. per day; consequently, the dose was reduced to 25 mg. for four days and then discontinued. After 26.625 gm. of cortisone in eighty-nine days, the patient was reclassified as progression of arthritis, grade IV, function, grade IV, and therapeutic response, grade IV.

The side-effects of cortisone observed during the course of treatment were elevation of the blood sugar to 160 mg. from a previously normal level, and moderate facial fullness.

The patient was discharged with symptomatic treatment for relief of pain, and resumed his previous routine of bed and chair nursing care with home physiotherapy. Two months afterwards, while his wife was helping him from bed to chair, he complained of a severe pain in the chest and collapsed. Upon entrance to the hospital, he was found in marked shock with severe dyspnea and profuse perspiration. He expired within an hour, and permission for post-mortem examination was refused.

Case 4.—J. M., a colored man, thirty-seven years old, admitted to the hospital with a history of rheumatoid arthritis for five years, was classified as progression of arthritis, grade III, function, grade IV. He had done heavy labor as a foundry worker until pain and swelling of the hands, wrists, elbows and shoulders forced his retirement. The progressive character of his arthritis was extremely rapid in the upper extremities but did not involve the knees or ankles until two years before this admission. Associated with the joint disease was a striking amount of disuse muscle atrophy. However, motor function of muscle groups was maintained to the limit of architectural changes in the joints. Previous treatment had been entirely symptomatic until one year prior to admission, when on two occasions he had received cortisone. Each time there had been marked improvement in his arthritic status, but the rapid development of edema forced discontinuation of therapy, and when the symptoms of arthritis reappeared it was with increased severity.

Past history revealed that several years before the patient had, during several months, experienced a dull epigastric discomfort one half hour after meals, but the pain did not awaken him from sleep. These symptoms had not recurred at the time of the two previous courses of cortisone.

Physical examination showed a man who appeared to be chronically ill and who moved about in bed with obvious discomfort. There was swelling, increased heat and pain in both ankles, knees, and the right elbow which contained a moderate intra-articular effusion. No subcutaneous nodules were palpable. The hands showed no evidence of acuity, but there was typical fusiform swelling at the proximal interphalangeal joints with hyperextension of the fingers. Mild ulnar deviation was present. Muscle wasting was present in varying degrees dependent upon the extent of joint involvement. Limitation of motion ranged from 50 per cent loss in both shoulders to 15 per cent loss of extension of the left elbow. The spleen was not palpable, and there was only a shotty generalized lymphadenopathy. The heart and lungs were normal. Complete neurological examination was normal.

After completion of the control studies, the patient received 500 mg. of cortisone on the sixth hospital day, which was continued until the twenty-fourth day, when the dose was dropped to 200 mg. On succeeding days the dose of cortisone was 300 mg., 500 mg., and 300 mg. The discontinuation of cortisone was prompted by the reappearance of epigastric pain on the twentieth day with x-ray evidence of a duodenal ulcer of superficial type. On the seventeenth day, during the cortisone regime, gastric analysis showed 16 degrees of free HCl in the fasting sample. Accordingly, the diet was changed from 400 mg. sodium to an ulcer regimen containing an equal amount of sodium, utilizing Lonolac as a milk substitute. When the cortisone was discontinued, a routine Sippy diet was given. Although rapid control of the ulcer symptoms was achieved and x-ray showed evidence of healing, with the increased dietary sodium, marked weight gain with dependent edema occurred. This was controlled by mercuhydrin which produced an adequate diuresis (Fig. 2).

The symptoms of arthritis had subsided rapidly under the massive cortisone therapy and at the completion of treatment the patient was reclassified as progression of arthritis, grade III, function, grade I, and therapeutic response, grade I. This remission was maintained for fourteen days, at which time the patient returned to the clinic with pain and increased heat in the right elbow. On the twenty-second day after the last dose of cortisone the patient was readmitted because of complete relapse of the cortisone-induced remission.

Case 5.—E. B., a white woman, forty-eight years old, was admitted to the hospital with rheumatoid arthritis of fifteen years' duration, and classified as progression of arthritis, grade III, function, grade III, Felty's syndrome. Previous therapy had consisted of five courses of gold salts, blood transfusions, "expensive white tablets" of unknown type, liver extract, and salicylates. None had produced a lasting remission, and the disease process continued to progress with articular and extra-articular manifestations.

Physical examination revealed limitation of motion ranging from 60 per cent loss of flexion in the left hand to 30 per cent loss in both ankles. All large and medium-sized joints were involved except the spine. Extra-articular evidence of the disease included anemia, splenomegaly, and rheumatoid nodules. Laboratory investigation confirmed the anemia by a hemoglobin of 9.5 gm. and a red blood cell count of 3.88 million. A leukopenia of 3,550 white blood cells was present, of which 43 per cent were lymphocytes. The sedimentation rate was 69 mm./hr. Psychometric studies failed to show any suggestion of psychosis, but it was the opinion of the psychiatrist that the patient was emotionally immature.

On the nineteenth day after admission, the patient received 250 mg. of cortisone, and from the twentieth day to the twenty-third day, 500 mg. per day. At this time the arthritis definitely improved, but marked depression appeared. For this reason, the dose of cortisone was reduced from 500 mg. to 125 mg. on the twenty-fourth day, and to 100 mg. from the twenty-fifth to thirty-third day. On the thirty-fourth day an oral dose of 75 mg. of cortisone was begun, and the patient was discharged from the hospital with complete relief from depression and improvement of the arthritis, classified as function, grade II, therapeutic response, grade II. On the forty-second day after admission the dose of cortisone was further reduced to 50 mg., where it was maintained until the forty-eighth day, when it was again increased to 75 mg. because of failure to sustain improvement. This dose was continued until the sixty-ninth day when a severe cellulitis of the left foot developed which necessitated hospitalization and discontinuation of the cortisone. While in the hospital, the patient maintained her arthritic remission for a period of fourteen days, after which there was a complete return of symptoms.

During therapy the spleen size decreased only slightly; however, by the fifteenth day of treatment, the white blood cell count had risen to 6,450 with 53 per cent neutrophils. This hematologic improvement in the hypersplenic phenomena of Felty's syndrome persisted following the arthritic relapse.

Case 6.—M. O., a white woman, fifty-four years old, was admitted to the hospital with chronic rheumatoid arthritis, classified as progression of arthritis, grade IV, function, grade IV. She had been well until twelve years before admission when pain and swelling appeared in the fingers and wrists. With periods of spontaneous remissions and relapses the arthritic involvement progressed until the ankles, knees, lumbar spine, shoulders, elbows, and temperomandibular joints were affected. For the past four weeks she had been completely bedridden with severe pain and immobility. Previous treatment included spa rest in Arizona, foreign protein, vitamins B and D, physiotherapy, and gold salts. Six months before admission she had received one routine course of parenteral

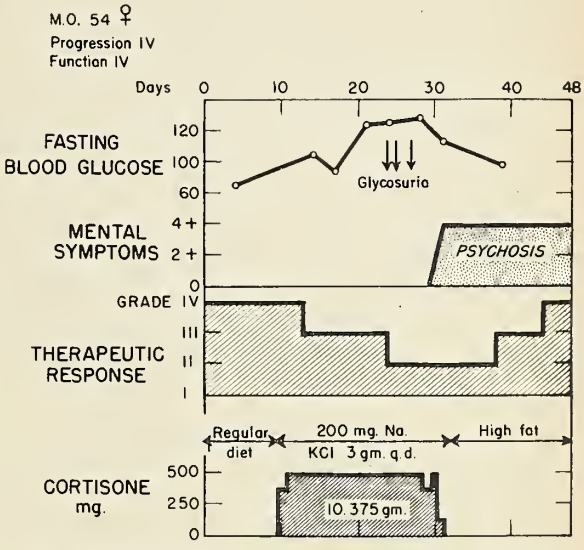


Fig. 3. Patient M. O. Showing glycosuria during third week of therapy followed shortly by development of psychosis.

cortisone, which resulted in marked relief of symptoms during therapy. The remission, however, was not sustained, and the ensuing relapse was of increased severity.

Physical examination revealed an acute and chronically ill woman, unable to assume a sitting position or to care for her needs. In spite of her clinical status, she was cheerful and faced her problems with insight. The hands showed the most marked evidence of chronic disease with severe ulnar deviation of the fingers, flexion of the palm, and hyperextension at the interphalangeal joints. Both knees and ankles were swollen with increased heat and effusion. The right knee was limited to 60 per cent extension and both knees to 50 per cent flexion. Neither hand could be elevated to head level. The left ankle was ankylosed. The lymph nodes and spleen were not enlarged. The cardio-pulmonary system was entirely normal. Laboratory examination showed only a moderate anemia of 10.5 gm. of hemoglobin with 8.82 million red blood cells and a white blood cell count of 14,800 of which 75 per cent were neutrophils. The sedimentation rate was 102 mm./hr. The remainder of the laboratory investigation, including the fasting blood sugar, was normal.

After completion of the control studies, the patient received 375 mg. of cortisone on the tenth hospital day. This was increased to 500 mg. on the eleventh day, and continued at this level until the twenty-eighth day, when the dose was decreased to 375 mg. During the next two days she received 500 mg. and 125 mg. of cortisone, and the hormone was discontinued on the thirty-first day. On the thirtieth day, while the author was visiting the patient, she became hysterical during the examination. This episode lasted approximately five minutes, after

which she resumed a normal behavior. However, on the following day, she had definite flights of ideas and hallucinations. Because of these symptoms, she was transferred to the psychiatric ward. At this time, after 10.375 gm. of cortisone in twenty-two days, she was ambulatory and caring for herself. The arthritis was now classified as progression of arthritis, grade IV, function, grade II, and therapeutic response, grade II. However, the remission persisted only thirteen days, when objective evidence of increased heat and swelling reappeared in the right knee. Subjective response could not be evaluated during this period of psychosis. Accordingly, she was reclassified as therapeutic response, grade IV.

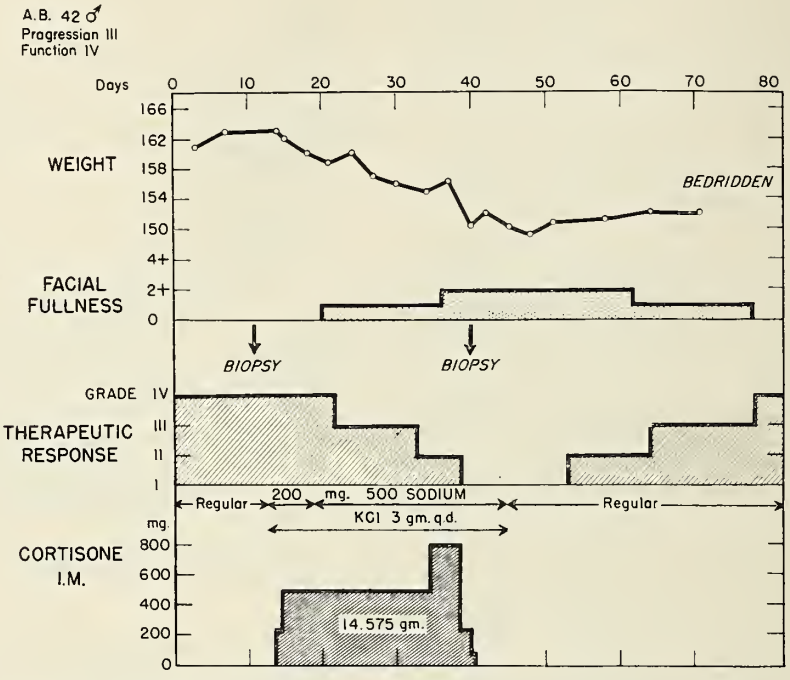


Fig. 4. Patient A. B. Showing excellent therapeutic response with development of facial fullness during cortisone treatment but followed by relapse.

During the course of therapy, the fasting blood sugar reached 128 mg. per cent with glycosuria on three occasions (Fig. 3).

Three months after termination of cortisone, the patient had returned to her pretreatment emotional status and was transferred to a convalescent home from which she makes weekly visits to the Outpatient Clinic.

Case 7.—A. B., a white man, forty-two years old, was admitted to the hospital with a history of rheumatoid arthritis classified as progression of arthritis, grade III, function, grade IV. Until six years previously, he had been well, when the appearance of pain and stiffness in the fingers which gradually spread by exacerbation and remission to involve the wrists and elbows, had forced his retirement as a coal miner. During the following two years, the shoulders, sternoclavicular joints, hips, knees, and ankles were affected by the same process. A year before this admission pain in the lumbar spine was noted for the first time. Subcutaneous nodules had been present for four years. Previous treatment consisted of two visits to spas in Arizona, gold salts, and salicylates, none of which had produced any lasting benefit. Five months prior to admission he had received a course of oral cortisone which resulted in relief of his symptoms, but, unfortunately, relapse occurred one week after cessation of the drug with marked exacerbation and signs of acuity. Past history disclosed the fact that the patient had suffered from seasonal asthma for many years.

Physical examination revealed a chronically ill man with typical bilaterally symmetrical joint involvement. Limitation of motion varied from 85 per cent flexion loss of the right wrist to 10 per cent rotation loss of the ankle. Both knee and ankles were swollen with increased heat and erythema. Effusion was present in both knee joints. The left elbow was slightly swollen with increased heat. There were rheumatoid nodules over both olecranon processes. The heart and lungs were normal. The liver, spleen, and lymph nodes were not palpably enlarged.

After completion of the control study, the patient was given 250 mg. of cortisone on the fourteenth hospital day. On the following day the dose was increased to 500 mg. per day and maintained at this level until the thirty-fifth day. When no signs of toxicity occurred, the dose was increased to 800 mg. per day. On the fortieth day, the patient complained of difficulty in breathing, and examination of the lungs revealed signs of diffuse bronchospasm. Accordingly, the dose of cortisone was decreased



Fig 5. ×21. (a) *(above)* Synovial tissue from right knee of patient A. B. before treatment. (b) *(below)* Synovial tissue from right knee of patient A.B. after 14.575 gm. of cortisone in twenty-eight days. Note the marked reduction in numbers of inflammatory cells.

to 250 mg., then to 75 mg., and discontinued on the forty-second day, at which time the lungs were clear. Articular function had improved to grade I, with a therapeutic response of grade I.

Euphoria, insomnia, and facial fullness were attributed to the cortisone treatment (Fig. 4). The appearance of bronchospasm which caused termination of therapy with cortisone was not associated with changes in venous pressure, cardiac rate, or clinical edema. Rapid and complete control of the bronchospasm with aminophylline would suggest that it was associated with the patient's previous history of asthma.

The patient was discharged from the hospital on the fifty-third day to be followed in the Outpatient Department. Readmission to the hospital was required thirty-seven days after the last dose of cortisone because he was unable to care for himself in an ambulatory status and only 10 per cent of the cortisone-induced remission was maintained.

Results

In this study the seven patients demonstrated the effectiveness of cortisone in producing improvement of arthritic symptoms (Table I). In three, a therapeutic response of grade I was achieved, and in four a response of grade II. The degree of response did not correlate well with either the total dose of cortisone received or the duration of treatment, but did correlate with the pretreatment severity of the disease.

Although the range of total cortisone dosage of from 6.125 gm. to 26.625 gm. emphasized a wide variation in tolerance to the steroid before signs of toxicity appeared, eventually all seven subjects developed some evidence of cortisone side-effect. In no instance did the signs of cortisone toxicity persist beyond three months. Frank psychosis occurred in one instance, marked depression in another; hyperglycemia was seen twice, and a significant degree of facial fullness three times. Severe cutaneous infection required cessation of treatment in one case. Hypertension with normal serum electrolytes and a falling body weight occurred in one woman who had a normal blood pressure upon admission; but changes in the retinal fundi suggested previous vascular disease. One patient developed dependent edema when the sodium restricted diet was changed to a Sippy regimen in order to control duodenal ulcer which had developed under treatment with cortisone. Paroxsymal auricular tachycardia occurred in one case, without signs of cardiac decompensation.

The cortisone-induced remission was partially maintained in one patient for 230 days, and in another for seventy-eight days. The other five patients failed to retain a significant degree of improvement for a period beyond that which might normally be expected in the course of the disease. Of the two patients who continued in remission on a moderate amount of cortisone, one received 8.75 gm. in eighteen days, and the other 12.4 gm. in forty-eight days. However, one patient receiving 26.625 gm. in eighty-nine days was unable to maintain his improvement when the dose of cortisone was reduced below 100 mg. per day.

Six patients had pretreatment biopsy specimens of synovial tissue taken from the knee joint. Two patients were not re-biopsied because of cortisone side-effects. All pre-treatment specimens showed evidence of inflammatory cellular infiltration and fibrous reaction. Two of the four patients who had synovial tissue examined after treatment failed to show a significant change in histopathology. Comparison between pre-treatment and post-treatment specimens from the other two patients, A. S. and A. B., demonstrated a reduction in the degree of inflammatory reaction, but no significant alteration in the density of fibrous tissue. In one patient (A. B.) the decrease in cells was followed by changes suggestive of edema (Fig. 5).

Assay of urine collected before and after treatment demonstrated a rise in the excretion of 17-ketosteroids and gonadotrophins in all five patients where it was possible to collect the samples. Testicular biopsy specimens from the four male patients during therapy failed to show marked alterations when compared with specimens obtained before the treatment.

Discussion

The temporary reversal by cortisone of progressive symptoms of the collagen diseases is paralleled by inconstant changes in the histopathology of the disease as demonstrated by this report and others.[7] On the other hand, the failure to observe changes in biopsy specimens of synovial tissue of two patients may be correlated with the relatively short duration of treatment.

The increase in urinary excretion of 17-ketosteroids and gonadotrophins has been previously reported when large doses of cortisone are administered.[9,10] Because in four male patients testicular biopsy specimens showed no significant damage we conclude that the elevated gonadotrophin levels are not the result of decreased gonadal function

A report on this phase of the investigation will be published elsewhere.

In this study the use of large doses of cortisone has proved to have no advantage over either low dosage, short-term treatment, or long-term maintenance therapy. It has become apparent that cortisone will produce increasingly good results up to a given level, above which no further improvement may be expected. Furthermore, the rapidity with which the benefits are achieved is not accelerated by the size of doses used.

The observation that the side-effects of cortisone are definitely related to the size of the dose and the duration of the treatment[8] seems of particular significance and has been confirmed in this study. Since toxicity can be expected to occur with massive doses of cortisone, and no increased antirheumatic response can be achieved or maintained after the cortisone is discontinued, such a program of treatment cannot be advocated. A similar conclusion has been reached by Bayles.[2]

The criteria of therapeutic response proposed by the American Rheumatism Association have been advantageous in following and reporting clinical cases of rheumatoid arthritis under treatment. We have repeatedly been impressed with the fact that alterations in the functional status of our patients have not been correlated with an appropriate objective change. Moreover, when cortisone or ACTH is given, the problem is intensified because these functional changes are observed so rapidly. Just how many of these changes are due to the altered emotional outlook of the patient, and how many to alteration in the disease process, is difficult to determine. Therefore, we believe that an adequate appraisal of any therapeutic regimen can be made only by using objective changes to determine the therapeutic response.

Summary

Seven patients with severe rheumatoid arthritis were treated with massive doses of cortisone over a short period. This program produced remission of the arthritis in two cases and alterations in the histopathology of the synovial tissue. In every patient side-effects of the steroid appeared, but all were reversible and disappeared after discontinuation of the hormone.

The cortisone-induced remission was not maintained for a significant period of time after therapy in five of the seven patients. The use of short-term treatment with large doses of cortisone in rheumatoid arthritis is not advocated since it offers no advantage over the routine method of low dose-long term administration, and in addition imposes the added risk of cortisone toxicity.

Acknowledgment

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Clinical Trial of 11-ketoprogesterone in Rheumatoid Arthritis

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THE CLINICAL effectiveness of an 11-oxygenated steroid, 11-ketoprogesterone, has been investigated in rheumatoid arthritis and certain laboratory observations recorded. Interest in this steroid was aroused by a report from the Sloan-Kettering Institute[7] which summarized the comparative effectiveness of certain steroids on the development of the chick embryo. The minimal steroidal dose for selective inhibition of embryo growth (mg. steroid per egg) for Compound F-acetate was 0.015; for corticosterone it was 0.15; for 11-ketoprogesterone it was 0.42; and for cortisone acetate it was 0.45. Further interest in a possible antirheumatic effect was strengthened when it was demonstrated that 11-ketoprogesterone possessed some activity in liver glycogen deposition tests, the standard assay for measuring 11-oxysteroid effect.[2] Furthermore, in comparison to cortisone, its potential cost might be expected to be relatively low. The steroid was made available by the Upjohn Company, Kalamazoo, Michigan, for intramuscular administration as a suspension (25 mg./cc.) in physiological salt solution containing benzyl alcohol (1.5 per cent). A 200 mg. tablet was employed for oral administration. An aqueous suspension of cholesterol (25 mg./cc.) and a placebo tablet were used for placebo administration.

Clinical Material and Methods

Five hospitalized patients with rheumatoid arthritis, three women and two men, were selected for study (Table I). Their disease varied in duration from six weeks to twenty-seven years. The outline of the American Rheumatism Association was followed in classifying their disease (in terms of activity, progression and functional impairment) and for grading their response to therapy.[6] The period of steroid administration was preceded and followed, in most instances, by an appropriate placebo. Two patients received the steroid by mouth, in one of whom (Case 2) treatment was stopped at the end of the third day because of the development of dermatitis medicamentosa. The other four patients received the steroid for seven to nine days, with the total dosage varying from 2.2 grams to 7.2 grams. Salicylates and physical therapy, when employed, were kept at a minimum during the study.

The patients were examined daily and symptoms and findings recorded in detail; when possible, objective measurements of joint findings were made with tape measure and goniometer. Sedimentation rates (Westergren), complete blood studies and

TABLE I. CLINICAL MATERIAL AND RESPONSE TO TREATMENT

Case	Sex	Age	Duration	(1)American Rheumatism Association Classification of Disease			Mode of Admin.	Total Dosage	Duration of Treatment	Response to Treatment	Complication
				Activity Grade	Progression Stage	Functional Class					
1. H.K.	F	39	10 years	III	III	III	I.M.	2.2 gm.(2)	8 days	III (Minor improvement)	Local irritation
2. F.F.	M	53	27 years	II	III	III	Oral	3 gm.(3)	3 days	III (Minor improvement)	Dermatitis medicamentosa
3. G.S.	M	48	4-6 weeks	II	I	II	Oral	7.2 gm.(4)	9 days	II(5) (Major improvement)	None
4. F.S.	F	47	8 years	III	II	III	I.M.	2.0 gm.(2)	7 days	III (Minor improvement)	Local irritation
5. I.B.	F	27	6 years	II	II	III	I.M.	2.1 gm.(2)	7 days	III (Minor improvement)	Local irritation

(1) In using the American Rheumatism Association classification, we have found it helpful to grade the activity of the inflammatory process in the joints. This is dependent primarily on the degree of swelling, tenderness, fluid accumulation and increased heat, and is classified from Grade I(Minimal activity) to Grade IV (Maximal inflammation).
(2) 100 mg. q 8 hours—I.M.
(3) 200 mg. 5 x a day—Oral.
(4) 200 mg. tablet (Oral). See text for schedule of dosage.
(5) The strict application of American Rheumatism Association criteria for therapeutic response require that Grade II improvement be maintained for at least one year. This degree of improvement was maintained only a few weeks in this patient.

From the Rackham Arthritis Research Unit, University of Michigan Medical School. The Rackham Arthritis Research Unit is supported by a grant from the Horace H. Rackham School of Graduate Studies. This study was supported in part by grants from the National Institutes of Health and the Michigan Chapter, Arthritis and Rheumatism Foundation.

serum protein fractions were determined at appropriate intervals. Serum proteins were fractionated by the chemical micromethod of Wolfson and Cohn.[9] Urinary histidine was estimated by the colorimetric procedure of Chattaway[1] following preliminary autoclaving as recommended by Wells and Lewis.[8] A modification of the method of Robbie and Gibson[4] was employed to estimate urinary 17-ketosteroid. Urinary Pettenkofer chromogens were estimated in the crude neutral extracts utilized for 17-ketosteroid determinations by means of the modified Pettenkofer reaction described by Munson, Jones, McCall and Gallagher.[3]

Results

Case 1.—H. K. This thirty-nine-year-old woman's rheumatoid arthritis was of ten years' duration. Fairly satisfactory response to gold salts was achieved in 1944, in 1945, and 1947. Recent treatment had included cortisone (25 cc. two times a day for four weeks) and a week of ACTH (dosage unknown). Vitamin C and desoxycorticosterone acetate and pregnenalone were without benefit. She was taking twelve to sixteen tablets of aspirin per day at the time of admission on October 1, 1951. The wrists and ankles were the chief site of a chronic synovitis. Pain and stiffness prevented her from walking but a short distance. Morning stiffness was severe. The general physical examination was satisfactory. She weighed 140 pounds. The temperature ranged between 98.6° and 100° F. There was no anemia. The white blood cell count was 8,500. The sedimentation rate (Westergren) varied between 19 to 25 mm. per hour. Using the classification of the A.R.A., the activity of her arthritis was placed in Grade III, progression Stage III, and function, Class III.

Although appropriate measures of physical therapy were continued through the study, salicylates were withdrawn on October 5, 1951; a placebo (cholesterol, 1 cc. three times a day) was given on October 6, 7, 8, and 9. The sedimentation rate at the end of the control period had increased to 35 mm. An upper respiratory tract infection acquired at this time probably explained, in part, the elevation of her temperature to 100°. Subjectively and objectively no change had occurred in her symptomatology or physical findings.

On October 10, 1951, she was started on 100 mg. (4 cc.) of 11-ketoprogesterone every eight hours; this was continued through October 17, 1951, at which time a total of 2.2 gm. had been injected. On October 18, she was changed to the placebo (cholesterol), which was continued for five days. By the second day of treatment with the steroid she demonstrated slight objective and subjective improvement manifested by slight decrease in pain on weight bearing, decreased night pain; the wrist and ankles were less swollen. On the last day of the treatment period (October 18, 1951), however, she was objectively and subjectively worse. In this period of time there was actually an increase in her sedimentation rate from 35 mm. (October 10, 1951) to 53 mm. (on October 18, 1951). This may very well have been associated with the considerable local inflammation produced by the injections, expressed by soreness, redness, warmth and induration at the injection site, and moderate temperature elevation. In the post-treatment placebo period there was no particular change in her condition except gradual subsidence of the local gluteal inflammation associated with return of the temperature curve to normal. The sedimentation rate at the end of the experiment (October 24, 1951) was still elevated to 45 mm. per hour.

It was our opinion that the improvement (Grade III) demonstrated by this patient during the first few days of administration of the steroid was not different from that often associated with bed rest and physical therapy.

Laboratory Data.—A strict balance study was not made on this patient. She was receiving a general diet. There was no significant fluctuation in her weight. Throughout the study there was a fall of about 1 gm. in the hemoglobin with a corresponding fall in the hematocrit. In the placebo control period the average eosinophil count was 119; during the period of treatment it was 94. There was no consistent change in the serum proteins (chemical fractionation) or the urate/creatinine ratio. The effect of 11-ketoprogesterone upon organic metabolism (Fig. 1) appears to have been definite, however, in terms of increased urinary excretion of histidine, 17-ketosteroids and Pettenkofer chromogens.

Case 2.—F. F. This fifty-three-year-old white man experienced the onset of rheumatoid arthritis in 1924 (at the age of twenty-six) with initial involvement of the toes which lasted for six months. The second episode occurred seven years later, involving the hands, elbows, and shoulders. It was eventually followed by a remission. Seven years later (1940) the third attack developed when he was forty years of age, with involvement of the knees and a flare-up in his hands. In 1942 he was seen at the Mayo Clinic when he was described as being in a state of remission. There was x-ray evidence at that time of cartilage destruction in the hands, wrists, and left knee. Treatment had been largely conservative; a course of gold had been without benefit; cortisone and ACTH (in 1950) had produced no lasting benefit; crutches had been required since 1943. There was no significant allergical history.

Rehabilitation through orthopedic procedures and physical therapy was the goal upon admission to the University Hospital on December 10, 1951. He complained of aching discomfort in the shoulders, hands, knees and feet. All of the joints of the fingers were slightly swollen and tender; he was unable to make more than a 70 per cent fist on the right or a 50 per cent fist on the left. The grip was definitely reduced. There was a slight amount of swelling of both wrists with definite limitation of motion. The elbows were questionably swollen; there was slight limitation of extension on the right. There was very definite limitation of abduction and external rotation of the shoulders. The knees were slightly swollen and slightly tender; they were painful on forced motion.

Flexion was limited to 65 degrees; extension was limited to 125 degrees on the right and 152 degrees on the left; quadriceps atrophy was prominent. The ankles had been relatively spared by the rheumatic process; the subastragalar joints were moderately involved. There was slight

period in which the steroid was administered there was no objective or subjective change. The post-treatment period was characterized by further progressive subjective improvement which appeared to have started coincident with his admission to the hospital.

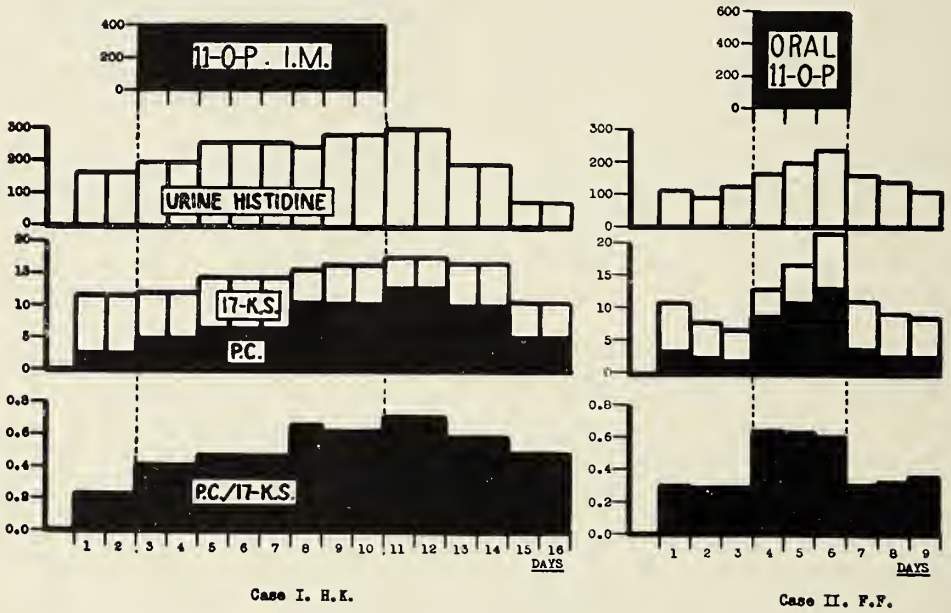


Fig. 1. Increase in urinary excretion of histidine, 17-ketosteroid and Pettenkofer chromogen coincident with the intramuscular injections (Case 1, H. K., thirty-nine-year-old woman) and the oral administration (Case 2, F. F., fifty-three-year-old man) of 11-ketoprogesterone.

tenderness on compression of the toes. X-rays revealed widespread osteoporosis and far-advanced rheumatoid arthritis with secondary degenerative changes. Although many of the finger joints were subluxated, ankylosis was absent. He weighed 133 pounds. The urine was normal; the hemoglobin, hematocrit, red blood cell count, white blood cell count and differential count were normal. The sedimentation rate (Westergren) was elevated to 23 mm. per hour. According to the A.R.A. classification, on the basis of activity, this patient belonged in Grade II; progression was Stage III; functionally, he was placed in Class III.

The observation period of the study was started on December 10, 1951. Medication was limited to chloral hydrate, as required, for sedation; he received no salicylates or physical therapy through the study. On December 14, 1951, he was started on 11-ketoprogesterone, 200 mg. five times a day, by mouth; the last dose was received at 8:00 p.m. on December 16, 1951; the total dosage received was 3 gm. Placebos were not used in the pre-treatment or post-treatment period.

His subjective course, in the four-day period of observation, was essentially favorable. Withdrawal of the salicylates did not appear to increase his discomfort. He slept quite well. In this period there was moderate subjective improvement with increased ease in getting about the hospital. Morning stiffness and soreness of the joints did not greatly change. During the two-day

The study was interrupted because of the development, twenty-four hours after the first dose of 11-ketoprogesterone, of a pruritic erythematous, papular rash. This first appeared in relation to one ankle but within a few hours had spread to the opposite leg and thighs. Consultants in dermatology agreed that the eruption had the characteristics of a dermatitis medicamentosa, most likely due to the steroid. By December 17, 1951, some fourteen hours after the last dose of 11-ketoprogesterone, there had been considerable reduction in pruritus. The rash completely disappeared in the following week.

During the study period there was actually a slight increase in his sedimentation rate. The remaining laboratory values including the eosinophil count were unchanged; his weight did not change. There appeared to be a significant increase in urinary histidine during the period of steroid administration, correlated with an increase in 17-ketosteroids and the Pettenkofer chromogens (Fig. 1).

It was concluded that the clinical course of this patient did not significantly differ from that anticipated in patients treated by only conservative measures.

The period of treatment with the steroid, of course, was too brief to make any valid observations as to antirheumatic effect. His clinical course was not markedly changed by administration of 3 gm. of the drug. The skin rash definitely appeared to be related to this medication.

Case 3.—G. S. This forty-eight-year-old man was first seen at the University Hospital on October 1, 1951, with the chief complaint of swelling and stiffness of the fingers of four to six weeks' duration. Other joints had not been involved. The pertinent findings in the physical survey were limited to the hands where there was slight swelling and tenderness of the proximal-interphalangeal and the metacarpal-phalangeal joints. The periarticular structures were slightly thickened; there appeared to be a slight amount of excess joint fluid. Pain was moderate (three plus) on forced motion. He could make less than a 50 per cent fist, right and left; the grip was markedly reduced (1- plus). X-ray examination of the hands was normal. He weighed 172 pounds. The urine was normal. There was no anemia. The total eosinophil count was 378. It is of some interest that the sedimentation rate (Westergren) was normal and remained so over the period of the next six months. The diagnosis of early rheumatoid arthritis was felt to be tenable on the basis of these findings. The classification according to the A.R.A. was as follows: Stage I with regard to progression, Grade II with regard to activity, and Class II with regard to function.

On October 5, 1951, salicylates and physical therapy measures were stopped. On October 6, a placebo of ascorbic acid, 50 mg. three times a day, was started which was continued through October 9. On the morning of the latter date, he reported joint pain to be less and improvement in his ability to make a fist. On examination, swelling of the fingers appeared less generalized; he could now make an 85 per cent fist.

On October 10, he was started on 11-ketoprogesterone by mouth, 200 mg. three times a day. On October 12 this was increased to 200 mg. four times a day, and on October 13 to 200 mg. five times a day, being continued at this dosage through 8:00 a.m., October 18, 1951. A total dosage of 7.2 gm. of the steroid was administered.

Clinical notes were as follows during this period of time: On October 12, he stated that he was not quite as well as he had been in the preceding twenty-four hours. A day later, he reported no particular change; the improvement manifested earlier, however, had persisted. Objectively at this time there was no definite change. By October 15 (the sixth day of 11-ketoprogesterone) he reported two episodes of uncontrollable twitching of the leg muscles which awakened him from sleep. His hands appeared improved on the basis of reduced morning stiffness. He could now make a 90 per cent fist; the grip had increased to a 3-plus. The fingers were no longer definitely swollen; tenderness was still present in the metacarpal-phalangeal and proximal-phalangeal joints and forced motion was uncomfortable. By October 18, 1951, the patient reported further improvement. He could now make a complete fist; stiffness, aching and pain were definitely less in his hands. On objective examination there was no doubt about the improvement in comparison to the state at the start of the study. Return of the patient to a placebo for a week was unaccompanied by further objective or subjective change and there was no relapse.

During the study there were no significant changes in the urinary findings, the red blood cell count, the hemoglobin, the hematocrit, or serum proteins (chemical fractionation). Sedimentation rate remained normal throughout the study. Daily eosinophil counts revealed no significant change. There was no consistent change in his total white blood cell count nor in the differential count. There was no definite change in the ratio of serum urate to creatinine during the various periods of the study.

The improvement which occurred in this patient (Grade II) became evident during the placebo period. It continued progressively throughout the period of active treatment and persisted during the post-treatment period. He was discharged on October 19, 1951. When he was next seen on November 9, 1951, improvement had persisted, since he could now make a complete fist and the grip had increased to 4-plus right and left. We next saw this patient some four months later, in which period of time he had experienced a moderate exacerbation of symptomatology. His subsequent course left no doubt regarding the diagnosis of rheumatoid arthritis.

Case 4.—F. S. This forty-seven-year-old woman had rheumatoid arthritis of eight years' duration. Treatment had been conservative; a course of gold given five years before had not been of benefit. Hormonal therapy administered in another hospital had produced only partial and temporary relief. The current flare-up of her disease had started in May of 1951, and had been progressive to the time of her admission to the hospital on September 13, 1951. Diabetes mellitus, known for at least ten years, had been fairly well controlled by 35 to 40 units of protamine zinc insulin daily.

The physical findings included moderate obesity (she weighed 172 pounds), early diabetic retinopathy, and marked varicosities. The blood pressure was 150/90. There was swelling of the proximal and metacarpal-phalangeal joints of the fingers. She could make a full fist on the right and an 80 per cent fist on the left. The grip was definitely weak. The right wrist and left elbow were definitely involved; motion of the shoulders was limited and painful. Both knees were similarly involved by a chronic active synovitis. X-rays of the hands and knees revealed juxta-articular osteoporosis with cystic areas within the shaft of the metacarpal and phalanges. The activity of the disease (A.R.A. classification) was Grade III, progression Stage II; functionally, she was placed in Class III.

Laboratory data included evidence for normal renal and liver function; the fasting blood sugar varied from 164 to 86 mg. per cent. The urine was generally free of sugar. There were 11.6 gm. of hemoglobin and a red blood cell count of 5,000,000; the hematocrit was 40 per cent. The white blood cell and differential counts were normal; the total eosinophil count was 228 cu. mm. The sedimentation rate (Westergren) was elevated to 35 mm. per hour.

Upon admission to the hospital, moderate doses of salicylates and appropriate measures of physical therapy were started and continued throughout the experiment. Over a seven-day period (September 13 to September 20, 1951) on conservative management there was no particular change in symptomatology. On September 20, 1951, she was started on a placebo of cholesterol (4 cc.

or 100 mg. every eight hours). In this period improvement occurred in the form of decreased joint pain and morning stiffness. Objectively, there was very little, if any, evidence of change. The laboratory details were essentially unaltered except that there was a drop in her sedimentation rate to 27 mm. per hour on September 21, 1951, and to 21 mm. per hour on September 24, 1951.

On September 24, 1951, the patient was started on 11-ketoprogesterone, 4 cc. or 100 mg. intramuscularly every eight hours; this was continued through 8:00 a.m. on October 1, 1951, a total of 2.0 gms. having been injected. Within twenty-four hours it was apparent that the medication was being poorly tolerated, there being local induration, redness, heat, and 2-plus tenderness. There was no striking change in symptomatology at the time she was switched from the placebo to the active preparation; throughout this period, however, she maintained that improvement was progressive. Her appetite was unchanged, as was her weight. Objectively by September 26, 1951, there was some improvement since the joints of the fingers were definitely less swollen, sore and tender. She could now make a full fist and had a 1-plus grip. The left elbow was less painful and could be more fully extended. The shoulders were unchanged. The left knee was definitely less swollen and less painful on passive motion.

By September 28, 1951, her subjective improvement was evidently sustained. She reported herself now free of night pain and pain on weight bearing and walking. Objectively she was maintaining the improvement noted earlier in the hands and in the grip. The metacarpal-phalangeal joints of the fingers were now less swollen; the wrists and elbows were about the same. The shoulders were less painful. There had been no particular further change in the knees. She continued to tolerate the steroid poorly; there were induration, redness and heat present at the site of injection, associated with a rise in the temperature to as high as 101° and 100.8° on September 29 and September 30, respectively.

From October 1, 1951, to October 5, 1951, the placebo of cholesterol (4 cc. every eight hours) was re-instituted, being gradually decreased until it was stopped on October 5, 1951. In this period there was progressive fall of the temperature curve to normal. While on the placebo, progressive and objective improvement continued. On the last day of the study, October 5, 1951, the proximal phalangeal joints of the fingers were still slightly swollen and the joint capsules were slightly thickened. She could make a tight fist and her grip was a good 3-plus. There was questionable swelling of the metacarpal-phalangeal joints of the fingers and slight thickening of the joint capsule. The wrists were no longer swollen. The range of motion was essentially normal. There was slight discomfort in the right wrist at the extreme range of motion. There was very little discomfort on movement of the left elbow but there was limitation of extension. There was full motion in both shoulders with slight discomfort at the extreme range of motion. The right knee was still slightly swollen; it was still painful (1-plus) at the extreme ranges of motion. It was apparent that there was still active synovitis present in the right knee, right wrist, and questionably in the fingers. A check-up examination was made eleven days later, at which time she appeared to be doing quite well; this state was maintained at the time of her last visit on February 19, 1952.

In association with injection of 11-ketoprogesterone, instituted on October 1, 1951, there was a climb in the sedimentation rate to 48 and 53 mm. per hour (on October 1 and October 3); this was compatible with the degree of local inflammation. Cessation of treatment was associated with a gradual fall in sedimentation rate. There was a slight fall in hemoglobin to 10.3 grams and a concomitant fall in hematocrit to 36 per cent; this was probably associated with the repeated vena punctures. The red blood cell count did not change. There was no change in the white blood cell count. The differential count revealed some increase in the percentage of polymorphonuclear cells (from 73 per cent in the placebo control period to 82 per cent on October 1, 1951). The total eosinophil count did not change. The serum protein pattern (chemical fractionation) did not change.

In summary, this patient in the control period demonstrated subjective improvement. Objective improvement (Grade III) developed during the period of administration of the steroid. Both subjective and objective improvement were maintained in the subsequent placebo period. The changes which took place were quite compatible with those not infrequently produced by hospitalization and a sound conservative program of management.

Case 5.—I. B. This twenty-seven-year-old woman had experienced the onset of joint discomfort six years earlier, five months after parturition. Symptomatology consisted of early morning and late afternoon stiffness; night pain was present, fatigue was prominent and had recently necessitated giving up her employment as a clerk. There had been a 10 pound weight loss in the last year. The physical examination revealed her to be well developed and fairly well nourished. There were shotty lymph nodes palpable in the neck; nodes were also palpable in the axillary and epitrochlear regions. The edge of the spleen was palpable below the costal margin on deep inspiration. A chronic active synovitis was present in the second and fifth left terminal phalangeal joints, in all of the proximal phalangeal joints, and the right fourth and fifth metacarpal-phalangeal joints. There was a 1-plus collection of fluid in the tendon sheath on the dorsal surface of the right wrist; the left wrist was questionably involved. There was a 1-plus swelling at the ankles. All of these joints were definitely tender. Her ability to make a fist was definitely impaired and the grip was weak. She weighed 118 pounds.

The urine was normal. She had a definite anemia, the hemoglobin value being 9.2 grams with a red blood cell count of 4.8 million. The hematocrit was 35 per cent. There was hypochromia and some variation in the shape of the red blood cells. The white blood cell count was 6,373. The differential film revealed 84 per cent polymorphonuclear cells, 14 per cent lymphocytes, 1 eosinophil and 1 monocyte; there were 3 eosinophils per cu. mm. The sedimentation rate was elevated to 53 mm. In accordance with the classification of the A.R.A., her

arthritis as to progression was put in Stage II; activity, Grade II; functionally she was placed in Class III.

On June 14, 1951, 11-ketoprogesterone was started in a dosage of 300 mg. daily (100 mg. every eight hours intramuscularly). Additional medication consisted of 10 grains of aspirin four times a day; specific physical therapy was not carried out during the study. The injections were continued through midnight on June 20, 1951, at which time an intramuscular placebo of cholesterol was started. By the second day the injections of the steroid were associated with considerable aching; locally there was superficial redness, induration, and tenderness. About one and one-half hours after an injection she described a sensation of pressure and tenderness which would last for about six hours; discomfort was sufficient to keep her awake at night.

By June 18, 1951, the third day of the study, the patient reported that she was improved; there was less morning stiffness, aching and pain. The right wrist, used as a joint of reference, disclosed slight but definite decrease in fluid content of the tenosynovitis. The other joints were correspondingly improved; tenderness of the metatarsal joints of the toes had disappeared. By the fourth day of treatment the right ankle was somewhat more swollen; there was now a small collection of fluid about the external malleolus.

At the conclusion of the period of injection of the active material (June 20, 1951) the patient reported that the joint pain, stiffness and soreness had subsided. The general details of the physical examination were unchanged. Objectively there was slight but definite evidence of joint improvement; they still remained slightly swollen. Only the fingers and ankles were slightly tender. There was no longer definite swelling of the right wrist.

In association with change to the placebo (June 21, 1951) soreness and the induration produced by the steroid disappeared rapidly. Within twenty-four hours of the change the patient reported herself less well. Objectively this appeared to be true since the joints of the fingers appeared more swollen; all of the joints were more irritable. The collection of fluid at the ankles was unchanged. For a period of twenty-four hours or so she complained of considerable soreness and distress in the shoulders. By June 27, 1951, however, on the sixth day of placebo injections, she reported that she was doing quite well. Her appetite was good. The local soreness of the joints had largely subsided. Examination now revealed objective improvement inasmuch as swelling and tenderness had decreased. The status of the patient was essentially that described as present on the last day of treatment with the active material.

This patient was closely followed throughout the study, in which a placebo preparation was not used prior to the administration of the steroid. We agreed that convincing improvement had occurred concident with injection of 11-ketoprogesterone. A brief but definite relapse developed while on the placebos, from which, however, she recovered spontaneously with a favorable course thereafter. The degree of improvement, in our opinion, was no more than one might anticipate coincident with hospitalization and institution of conservative therapy.

The pertinent laboratory evaluations throughout this study were as follows: The initial count was so low that the eosinophil response could not be accurately followed. There was no significant change in the total white blood cell count, nor was there any significant change in the differential count. The sedimentation rate failed to correlate with the clinical improvement since it remained elevated throughout the study (ranging from 57 to 40 mm.). The pattern of serum proteins (chemical fractionation), the hematocrit, and weight did not change.

Discussion

Gradual subjective and objective improvement occurred in all five individuals during the investigations; this was not accompanied by convincing changes in sedimentation rates. Improvement, in four instances, has been placed in Grade III (minor improvement); in one patient, it deserved placement in Grade II (major improvement), although the improvement was not maintained long enough to meet the strict requirements for such classification. In general, the degree of improvement was quite compatible with that frequently observed when hospitalization is combined with elementary conservative therapy. As is evident in the individual case reports, improvement generally began during the preliminary placebo period; it was maintained through the period of steroid administration and into the post-placebo interval. In the three individuals receiving systemic treatment and which produced local irritation, the possibility of non-specific foreign protein reaction must be considered in evaluating response to treatment. In no instance were the dramatic effects observed with 11-ketoprogesterone which are so conspicuous both upon starting and discontinuing cortisone or ACTH. None of the characteristic features of the hyperadrenal state, as may be induced by cortisone or ACTH, were observed during the brief period of administration of 11-ketoprogesterone.

The three individuals to whom the parenteral preparation was administered, tolerated the injections very poorly. In view of the considerable local inflammation, further parenteral trial did not appear advisable. In all instances, within a few days of withdrawal of the steroid, prompt subsidence of the inflammation had occurred. The possibility of inadequate absorption exists, of course, in those individuals in whom the parenteral route was employed. Sufficient steroid was absorbed, however, to induce metabolic changes (Fig. 1) in one individual (Case 1) quite comparable to those ob-

TABLE II. LABORATORY DETERMINATIONS IN 11-KETOPROGESTERONE STUDY

Case	Weight Change	Eosinophil Change	Sed. Rate	Gamma Globulin	Albumin Globulin	Histidine	Urinary Excretion		Serum Urate Creatinine
							17-KS	(1)PC/17-KS	
1. H.K.	None	None	Increased(2)	No change	No change	Increased	Increased	Increased	No change
2. F.F.	None	None	No change	—	—	Increased	Increased	Increased	No change
3. G.S.	Loss of 1¾ pounds	None	(Normal) No change	No change	No change	—	—	—	No change
4. F.S.	None	None	No change	No change	No change	—	—	—	—
5. I.B.	Loss of 3 pounds	None(3)	Increased(2)	No change	No change	—	—	—	—

(1) Pettenkofer chromogen/17-ketosteroid ratio.
(2) Probably in association with local inflammation produced by steroid.
(3) Initial eosinophil count only 3/cu. mm.

served in another patient (Case 2) who received the steroid by mouth.

Some of the metabolic indices measured in this study (Table II, Fig. 1) included: change in weight, total eosinophil counts, sedimentation rate of red blood cells, alterations in serum protein fractions (gamma$_2$ globulin and albumin/globulin ratio) and serum urate/creatinine ratio. No significant variations in these values were observed. In two individuals (Cases 1 and 2) measurements were made of the urinary excretion of histidine, 17-ketosteroid and the Pettenkofer chromogen/17-ketosteroid ratio. Significant and characteristic increase in these values following the oral and parenteral administration of 11-ketoprogesterone is interpreted as evidence of an organic metabolic effect by the steroid. The significance of these observations, in the absence of an antirheumatic effect, is unknown; a similar effect upon organic metabolism without antirheumatic effect has been observed upon the administration of corticosterone (Compound B).[5]

The evaluation of the clinical effectiveness of any agent in rheumatoid arthritis is beset with many difficulties. The cases reported in this paper illustrate particularly the necessity of taking into consideration the spontaneous variations in the course of the disease and the degree of improvement which may occur with hospitalization, analgesics and physical therapy. Under these circumstances, observations during periods of placebo medication are indispensable.

Conclusion

On the basis of this study, it appears that 11-ketoprogesterone, an 11-oxygenated steroid, is without significant clinical effect in rheumatoid arthritis. The steroid, however, induces some interesting alterations in organic metabolism in terms of increased urinary excretion of histidine, 17-ketosteroid, and Pettenkofer chromogens.

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U. S. JOBS HIT PEACE PEAK

Upward and upward crept the multi-billion-dollar Federal payroll in the past year—to a new post-World War II peak of 2,596,690.

This was an increase of 112,999 employes in 12 months.

As of June 30, the end of the past fiscal year, one out of every 38 United States citizens twenty-one years of age, or older, was working for the Government. Working, that is, as a civilian—these figures don't include men and women in military uniform.

They do, however, include civilian employes of the armed forces—and that's where the big increase in the last year came.

Observations on the Use of Cortisone and Corticotropin in Rheumatoid Arthritis

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IN A PREVIOUS article* we reported on the use of cortisone in the treatment of sixty-three patients with rheumatoid arthritis. During the past year we have continued our observations on forty-five of these patients and to these have added twenty new patients receiving this same steroid, twelve** treated with corticotropin, and thirteen who were given intra-articular injections of hydrocortisone (Compound-F). The discussion which follows details the results in these three groups of patients and includes, in addition, a report on the measurement of thyroid function by isotope tracer studies in patients receiving anti-arthritic therapy.

I. Cortisone and Corticotropin Treated Patients

In this group were twenty-one males and fifty-three females, ranging in age from eighteen to sixty-seven years. All had multiple joint involvement, with the duration of their illness varying from several months to over thirty-five years. Prior to the institution of steroid therapy, most patients had received a wide variety of treatments with varying response. During the course of our study analgesics and physical therapy were used liberally and frequently in most cases. All patients were provided with a diet having a salt content under 1 gram.

Oral cortisone was used for maintenance in all patients treated with this drug. In most, treatment was started with parenteral cortisone or corticotropin for varying periods of time depending upon the availability of the oral preparation. With the former, 300 mg. were given the first day, followed by 100 mg. daily for four to five days; with the latter, 25 mg. were injected every six hours for several days, followed by a gradual tapering off until the cortisone tablets were started. These were given in doses of three to four 25 mg. tablets a day at equally spaced intervals for several days, then followed by a maintenance dose of one to three 25 mg. tablets a day. While this dosage has been followed quite constantly throughout the entire course of treatment, several patients have had to take an extra tablet during periods of exacerbation of symptoms, while others have been able to reduce the dose to one tablet a day during periods of remission.

In ten patients, corticotropin (ACTH) was continued throughout the course of treatment in maintenance doses varying from 10 mg. daily to 25 mg. three times a week. Generally from 20 to 25 mg. were administered daily in single or divided doses by the patients themselves or by members of their families.

Six patients received the initial injections of corticotropin *intravenously*. When so administered, 25 mg. in 1000 cc. of 5 per cent glucose were injected slowly over a period of six to eight hours. This was repeated the following day; from then on, the dose was reduced to 15 mg. and then to 10 mg. each for two days. Following this, the subcutaneous route was used. In one patient a clinical relapse occurred while on subcutaneous treatment. Intensive intravenous treatment checked the relapse, following which the usual subcutaneous administration became adequate.

Complications

Edema of varying degree developed at some time in the course of therapy in twenty-nine patients receiving cortisone but was of significant degree in only eleven. In none of these had salt restrictions been rigidly adhered to. In one case it was necessary to discontinue the drug at intervals because of dyspnea and marked gain in weight due to fluid retention. None of the corticotropin-treated patients developed significant peripheral edema. Facial edema with the characteristic moon-round configuration typical of Cushing's syndrome developed in fifteen. Two of these had been treated with corticotropin.

Facial hirsutism of mild degree developed in twenty-one and was of moderate degree in an additional six patients. In two there was noticeable thinning of scalp hair. Three patients in this group had received corticotropin.

Cutaneous lesions of several different types were observed. Papulopustular acneiform eruptions ap-

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**Includes three patients previously treated with cortisone.

peared in fifteen patients. In some of these either androgen or estrogen therapy had been administered simultaneously with the steroid, and the acne improved upon withdrawal of the sex hormones. A mild erythema was noted in several and in one this assumed a butterfly distribution resembling lupus erythematosus. This disappeared after withdrawing the cortisone. One patient on corticotropin developed dark pigmentation, almost a bronzing of the skin, principally on the exposed areas, but there was no mucous membrane pigmentation or lowering of the blood pressure.

An increased tendency to bruising was noted in five cases. In three treated with cortisone, purpuric lesions developed spontaneously from time to time. In one of these scleral hemorrhage and epistaxes also occurred. The bleeding and clotting times were not abnormal in these cases. Bleeding from the gastrointestinal tract was observed in one of the patients included in our first report. Here the bleeding time was prolonged to 12 minutes. No cause for the bleeding could be found by careful x-ray studies.

Psoriasis, present in two of our patients, was not altered by steroid therapy.

Gastrointestinal symptoms developed in eleven patients. The highest incidence was among those treated with corticotropin. In four the symptoms consisted mainly of occasional belching and nausea. In the remaining seven there was persistent heartburn or epigastric pain and five of these were studied by x-ray. Only one who had been getting cortisone had a gastric ulcer. A second patient, symptom-free while on cortisone for eight months, was changed to corticotropin and at the end of five months developed acute perforation of a gastric ulcer after very vague and indefinite digestive disturbance of two weeks' duration. At operation the ulcer was acute and entirely devoid of the usual characteristics found in mucosal ulcerations.

Nervous system symptoms, when classified as simple nervous instability, are present in most arthritic patients, probably the result of long continued pain and limitation of activity. Establishing of an etiologic relationship between these symptoms and any therapeutic agent is therefore difficult. When extremes of mood occur, justification for such a relationship is more apparent. Euphoria appeared in thirty-one cortisone-treated patients and in three treated with corticotropin. A mild depression followed the euphoric state in three of the former and an acute depressive psychosis developed in one. In three other patients, a mild depression occurred without antecedent euphoria. One patient, treated with cortisone elsewhere very successfully for one month and then observed by one of us (AEP), developed an acute psychosis of the schizophrenic type, requiring hospital confinement under limited restraint for ten months. At this writing, two years after treatment with cortisone, only moderate depression periods and mild hallucinations occur from time to time.

One patient developed marked nervousness and emotional instability after withdrawing cortisone. In another nerve tension was lessened following the institution of cortisone therapy.

Blood pressure levels were found to vary in most patients during the course of therapy. In only eight was an abnormal elevation found at any time. In two of these, subsequent readings after treatment were found to be less than the initial hypertension. In only one patient was a significant increase in the blood pressure noted.

Reduction in sugar tolerance in patients as the result of steroid therapy has been set forth by many as a contraindication to the continued use of these drugs. In a previous publication we reported our observations in thirty-four patients treated with cortisone for a relatively brief period of time. The results were varied; some appeared to develop a reduction in tolerance while in others this seemed to improve. Of some importance, also, was the revelation that a surprising number were found to have a reduced tolerance before therapy was started. The significance of this in determining the effect of any therapeutic agent is readily apparent.

The observations on carbohydrate metabolism herein reported were made over a much longer period of time (from six to twenty-four months) in sixty patients treated with cortisone and fourteen with corticotropin. Oral glucose tolerance determinations were made once before and usually twice after the institution of therapy in fifty-eight patients; in twenty-two no determinations were made before the administration of steroid.

After from six to twenty-four months of cortisone therapy, over half (57 per cent) were found to have a normal sugar tolerance. In eighteen (35 per cent) the tolerance was definitely reduced, and in five (10 per cent) it was considered borderline. In the eighteen whose tolerance was found reduced after treatment, pre-treatment tests had

shown a reduced tolerance of similar degree in nine and a borderline result in one. In only three had the tolerance been normal previously, and in only one of these was the post-therapy reduction at all significant. In the remaining five patients with post-therapy tolerance reductions, pre-treatment determinations had not been done. Conclusions concerning the effect of the steroid therapy in these five patients would be wholly unjustified since, as was true in our results a year ago, reduced sugar tolerance was also found in a significant number of patients (fifteen) before any treatment was given. Of the five "borderline" cases whose glucose tolerance tests were equivocal after treatment, one had previously been equally questionable and four were unmistakably normal.

Of the patients treated with corticotropin, four were found to have a reduced carbohydrate tolerance after from one to ten months of treatment. In one of these an impaired tolerance had been present before treatment; in the remaining three, as well as in the one "borderline" case, the pre-treatment tests were normal. In only one of these was the reduction in tolerance appreciable. In the remaining nine cases the post therapy tolerance was not abnormal.

From the above, it can be concluded that in only two patients was there an appreciable reduction in tolerance, one in the cortisone and one in the corticotropin treated patients.

As was previously found, an apparent improvement in sugar tolerance was observed in eight patients whose pre-treatment tolerance was impaired. In five of these the glucose tolerance test became normal. Interestingly enough, three of the four patients with lowered tolerance before treatment with corticotropin developed normal curves one to ten months after therapy. In two patients treated with cortisone, there was a further reduction in tolerance; this was not observed among those treated with corticotropin. In one case treated with corticotropin, an apparent improvement was noted after two weeks of therapy, but eight months later there developed a noticeable reduction in tolerance. Likewise, of five pre-therapy "borderline" cases, one showed a definite diabetic curve after from nine to twenty-two months of treatment and four developed normal curves.

The effect of the duration of steroid therapy on the production of significant change in the sugar tolerance of these patients was not remarkable, although the incidence of change was slightly greater in those treated for longer periods of time. Similarly, complete cessation of treatment did not produce a reversal in the reduced tolerance of any of the five patients in whom treatment had been stopped for from one to fourteen months before the final study was made.

Results of Therapy

The immediate beneficial effects of cortisone and corticotropin were quite similar. In practically all patients these became apparent about the third day. The improvement noted was both subjective and objective, with a loss of pain and stiffness, as well as a reduction in size of the affected joints. The improvement in the general sense of well-being was essentially the same in those treated with corticotropin as in those treated with cortisone. As previously indicated, this amounted to a true euphoria in 41 per cent of the patients. As might be expected, the use of corticotropin intravenously produced a more prompt and complete effect than did the usual subcutaneous injection.

As long as the optimum dosage was maintained, the prolonged use of these drugs resulted in continued improvement in the majority of patients. It is our impression that this was especially true with cortisone when given parenterally, although maintenance therapy with oral tablets (cortisone) was equally favorable in the majority of patients. The effect of corticotropin in maintenance doses was usually less spectacular although it maintained a satisfactory remission of symptoms in most instances. This was especially true when administered twice daily although daily injections were adequate in several cases.

Of the sixty-five patients treated with Cortone, 74 per cent were considered to have had a *good* result. Included in this group was one patient with a malum coxae senilis, and two with a Marie Strumpel spondylitis. In 22 per cent the results were regarded as no better than *fair*. In the remaining two cases, cortisone was considered a *failure*. In both of the latter, the drug was administered for less than three months, highly nervous reactions making continuation of the drug inadvisable.

In the twelve patients receiving corticotropin, the results were similar to those noted above. In 77 per cent, the improvement was regarded as *good*, and in 15 per cent only *fair* results were obtained. One patient who had experienced initial

improvement suffered a relapse, necessitating discontinuation of therapy. The subsequent use of cortisone has resulted in complete control of symptoms. This case was regarded as a corticotropin failure.

The differentiation of "good" from "fair" results was not made by any fixed or specific criteria. Consideration was given not only to the local joint effects, but also to the degree of restoration of the patient to an active life. In practically all patients regarded as having achieved a "good" result, whether treated with one or the other drug, daily occupations were resumed or were carried on with greater ease than formerly. Many of this group were classified as having moderately advanced arthritis with multiple joint involvement.

In the group of seventeen patients (fifteen cortisone, two corticotropin), with only "fair" results, the improvement was most noticeable in the local joint symptoms. Pain and soreness were at least partially relieved, although the relief was less dramatic and usually less marked than that observed in the other group. This was generally not sufficient to enable the patients to resume their former activity. In some, irreversible fibrous ankylosis and bony union in the joints made this impossible. As would be expected, most patients of this group had far advanced arthritis. Six were bed-fast.

Summary

Forty-five patients have been treated with cortisone continuously for two years and twenty patients for one year or less. Twelve patients have been treated with corticotropin for one year or less.

Edema of significant degree developed in only eleven of the cortisone-treated patients. None of the corticotropin treated developed this complication.

Moderate facial hirsutism developed in six patients. Two patients showed noticeable loss of scalp hair.

Acneiform eruptions of the face appeared in fifteen. One patient on corticotropin developed bronzing of the skin on the exposed areas. Three patients on cortisone developed transient purpuric patches without changes in bleeding or clotting time.

One cortisone-treated patient developed a gastric ulcer. Acute perforation of a gastric ulcer occurred in one corticotropin-treated patient.

Euphoria developed in thirty-one cortisone-treated and in three corticotropin-treated patients. A mild depression appeared in three and an acute depressive psychosis developed in one of the former group.

Blood pressure changes occurred in only one patient. Impaired glucose tolerance developed in one patient from the cortisone-treated and one patient from the corticotropin-treated groups. The effect of the duration of therapy was not remarkable.

In so far as the effect on the arthritis is concerned, as long as the optimum dosage was maintained, the prolonged use of these drugs was followed by improvement in the majority of patients. Good results were encountered in 74 per cent of the cortisone-treated and in 77 per cent of the corticotropin-treated. Fair results were observed in 22 per cent of the former and 15 per cent of the latter. Two patients failed to respond to cortisone and one to corticotropin.

II. Intra-Articular Hydrocortisone

We started using hydrocortisone or Compound F shortly after Hollander's report[5] appeared in December, 1951. To date, thirteen patients have been given a total of ninety-four injections of Compound F, and most of these have been in knee joints. We have also injected several other joints of the body, including shoulder, hip, elbow and wrist joints. The knee injections were given just below the medial edge of the patella without local anesthesia. In most instances variable amounts of fluid were aspirated. On occasion, however, there was a dry tap, and although subjective improvement was noted in these patients, the overall response was not as good as in those where synovial fluid was obtained. Synovial fluid cell counts were carried out wherever possible, and as has been reported by Hollander, the total cell count and polymorphonuclear count were reduced in number after Compound F instillations. It was observed that where the arthritic involvement was most severe with swelling and increased heat, the synovial fluid was paler than normal, somewhat cloudy, and less viscid. Viscosity studies reported by Robinson and Duff[6] indicate a definite increase in viscosity of the synovial fluid in the hydrocortisone-treated joints. Clinical improvement seems to coincide with the increase in viscosity.

The clinical response to intra-articular hydrocortisone has been variable. Several patients re

ceived immediate benefit from one injection, lasting in some from four to twelve weeks. Others received no benefit until two or three injections had been given at weekly intervals and then maintained their improvement for from three to eight weeks. Another group of patients reported improvement within twelve hours after the initial injection which lasted three to four days and was followed by relapse. With repeated injections maximum duration of relief may extend for from ten to fourteen days. We have been unable to correlate the degree and duration of clinical improvement with any other objective or subjective factors.

Of the thirteen patients treated, eleven have returned for repeat injections when pain returned, definitely indicating satisfactory subjective benefit from the drug. Clinically, eight of the thirteen had an excellent response, with decreased joint swelling, improved motion and reduced joint heat that followed each injection and continued for from two to twelve weeks. Three of our patients received only moderate benefit with decrease in swelling, stiffness and subjective pain lasting only several days up to two weeks. We have had but one patient who received no benefit at all from Compound F intra-articularly. In this instance the knees were in 75° flexion contracture with dry joint spaces. Another patient received only slight benefit from her first two hip injections and subsequently was unwilling to have this repeated in view of the limited response.

We have used hydrocortisone in conjunction with cortisone and corticotropin in several patients where small maintenance doses of the systemically effective steroids were inadequate to maintain one or two joints symptom free. The addition of intra-articular Compound F in these cases has made it possible to reduce and, on several occasions, entirely eliminate maintenance therapy with cortisone and corticotropin.

Control studies were also carried out in several patients for a total of fifteen injections, using 1 cc. sterile saline solution or 1 per cent procaine solution. In several patients where there was bilateral knee involvement, hydrocortisone was injected in one knee, and the control material, either saline or procaine solution, was administered in the opposite knee. Initially, two patients testified that they had received very substantial benefit from the injections of the previous week and did not indicate any difference in improvement in either knee. Repetition of saline or procaine solution in one knee and hydrocortisone in the other knee soon proved that the control solutions were no longer beneficial, whereas Compound F continued to give improvement. Those patients who received procaine solution failed to obtain greater benefit than those who received saline, whereas Compound F was of some benefit almost each time it was used.

From our studies we have concluded that intra-articular hydrocortisone is a valuable adjunct to the treatment of rheumatoid arthritis.

III. Thyroid Function in Arthritics Treated With Cortisone and Corticotropin

The project for measurement of thyroid function by serial isotope tracer studies in patients receiving anti-arthritic therapy originated by bringing two fields of interest together. On November 16, 1950, the isotope laboratory had conducted a tracer study on a private patient and had obtained a result indicative of carcinoma of the thyroid.[3] The patient had been receiving cortisone for some time and it was noted in the report that this was the first such case studied and that an inter-relationship might exist. It was generally believed[7] that cortisone had some depressing effect on the thyroid function but at that time the form of depression produced, or the quantitative factors involved, were not known. Permission was asked of the Arthritis Committee to allow the study of some rheumatoid arthritics prior to and during cortisone therapy.

The first case, R. M., studied specifically to detect the influence of cortisone, received the first tracer study on November 20, 1950. This study showed a somewhat abnormal thyroid with a hyperactive focus in the central thyroid region and depression of activity in the lobe areas with a total function well within the normal range, and no evidence of malignant or other degenerative change in the gland.

Nine days later, after the patient had received cortisone at the rate of 300 mg. the first day and 100 mg. per day thereafter, a repeat tracer study showed an almost perfect artificial reproduction of a malignant tracer pattern. The total function in the thyroid was not particularly changed, although the initial rate of uptake in some areas appeared to be slightly accelerated and the total function slightly depressed. The study indicated, therefore, that this pattern could be simulated, and a route

was opened for studying the fundamental chemical and physiological phenomena involved.

In general agreement with the later reports in the literature it was demonstrated that the administration of cortisone in clinically satisfactory quantity depressed the total thyroid function in a reversible manner. It was also shown that some fundamental change in thyroid function takes place. The results of this study have already been published,[4] and, in summary, it was shown that the chemistry of carcinoma of the thyroid can, in part, be simulated reproducibly by the administration of cortisone.

Meanwhile, the Arthritis Committee, as will be reported elsewhere, had observed that thyroid function as indicated by the basal metabolic rate and clinical observations tended to increase in the early stages of ACTH therapy. At their request the tracer procedure was extended to take in all the new arthritic patients before beginning ACTH and at intervals after therapy was instituted.

The second case, R. F., studied was a patient with an advancing rheumatoid arthritis of twelve years' duration who, however, had had toxic diffuse hyperthyroidism for more than a year. This had been controlled with propylthiouracil, but it was discontinued because she developed a rash. She had received cortisone therapy beginning in July, 1950. The tracer study on January 22, 1951, showed a typical cortisone pattern but also showed a toxic hyperthyroidism. Subsequently, on August 13, 1951, with the patient cleared of all medication, as far as possible, a tracer study was run. It showed a diffuse toxic hyperthyroidism with an entirely normal type of uptake, retention and excretion pattern. The cortisone effect definitely had cleared.

The patient was then given ACTH beginning at the rate of 100 mg. per day and reducing gradually to 25 mg. per day. On the tenth day following institution of this therapy, a tracer study was again performed. In this case the hyperactivity of the gland was so far advanced that very little increase in total function could be demonstrated. It was demonstrated, however, that the abnormal tracer pattern found eight months before had not returned and only the usual pattern indicating toxic hyperactivity remained. Thereafter all available cases were studied.

The number of patients studied is not statistically significant and only gives indication rather than demonstration of the results to be expected. Nineteen arthritic persons received serial tracer studies before and after anti-arthritic medication.

An evaluation of their thyroid status before any medication was given showed that only two of these could be said to have a "normal" thyroid in the sense that there was no clinical evidence of abnormality and the tracer study showed a uniform normally functioning gland. Three others would be considered "euthyroid" in the sense they had no clinical thyroid abnormality but did show demonstrable abnormality on tracer study. One was a clinical non-toxic nodular goiter and one had a frank toxic diffuse goiter of several years' standing. Twelve of the arthritics were frankly "hypothyroid." Five of the grossly hypothyroid patients had one or multiple concealed toxic adenomata, and of these two had enlargement into the retromanubrial space without grossly evident superficial enlargement.

In all of the cases studied where any clinical benefit was reported from the anti-arthritic therapy with ACTH, the total excretion of the radioiodine increased and the soft tissue retention decreased. This is an extremely important point, as it explains some of the misunderstandings present in the literature and, again emphasizes the fact that tracer studies which do not take into account all of the factors and end by accounting for all of the tracer are utterly worthless and can be dangerously misleading.

Only ten of the fifteen patients treated with ACTH had valid basal metabolic rate determinations before and after treatment. Eight of these showed a definite increase in the basal metabolic rate, ranging from a gain of + 1 per cent, which, of course, is questionable, to a gain of +28 per cent, with an average gain of 12.4 per cent. The two who did not show any improvement had very definite thyroid disease, one a non-toxic nodular goiter with hypothyroidism and the other an undetermined condition which clinically was suspected of being carcinoma of the thyroid. This patient, however, responded very badly to all medication and throughout the studies had so much edema that tracer study was never satisfactory.

One patient had undifferentiated carcinoma biopsied in a cervical node. Clinically this patient was suspected of having carcinoma of the thyroid with cervical metastases. Three tracer studies were performed in the course of six months, in each case resulting with a report of "no evidence of thyroid malignancy." This patient came to autopsy and was found to have carcinoma of the tonsil. This

is also the patient who showed only a +1 per cent increase in his basal metabolic rate on ACTH therapy, and it should be noted that at this time his general body economy was degenerating badly.

Midway in the project it was discovered that all of the ACTH being distributed throughout the country, including our own, contained a trace of TSH. This may explain the thyroid stimulation. With this in mind, the preponderance of evidence indicates that:

1. The compound or mixture administered as ACTH definitely stimulated function in the thyroid glands, or parts of the glands capable of responding to stimulation. Clearcut demonstrations were made of the fact that where a hyperactive nodule existed, its intrinsic function was stimulated, sometimes at the expense of the rest of the gland.

2. The relief of muscular tension and increase in mechanical mobility with its accompanying improvement in fluid balance decreases the trapping of the radioactive tracer in the extracellular spaces and tends to increase the urinary excretion even in the presence of an increased thyroid function. Exactly this same phenomenon on a purely mechanical basis has been observed in one case of a catatonic schizophrenic. The similar condition as an accompaniment of cardiac decompensation is well known.[2]

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Intra-articular Hydrocortisone in Treatment of Arthritis

Present Status

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RECENT LAY PRESS accounts dealing with the use of intra-articular injections of hydrocortisone (Compound F) for the treatment of various types of joint diseases have brought fresh hope to the victims of arthritis, and have led many of these patients to inquire of their physicians the value of this therapy. While this therapy is under investigation at present in many centers, to date, there have been few medical reports. For this reason this brief review of our experience seems justified.

By far the greatest experience with this method of treatment has been that of Hollander and his associates,[2] originally reported in the *Journal of the American Medical Association.* Their experience, to date, was presented at the meeting of the American Rheumatism Association, June 6 and 7, 1952.[1] Approximately 2,000 intra-articular injections have been administered to approximately 400 patients with various types of joint disease. Improvement sufficient to warrant the procedure as therapeutically practical was observed in 90 per cent. Failure was recorded in approximately 5 per cent. The only unfavorable results were transient exacerbation of symptoms and signs following about 2 per cent of injections. Probable aggravation of disease was noted in one joint which later proved to be tuberculous.

Our own experience with this form of treatment extends over the past six months. One hundred and fifty-two intra-articular injections of hydrocortisone have been made in thirty-one patients, twenty-two of whom have rheumatoid arthritis and nine osteoarthritis. The dose at each injection has ranged from 25 to 50 mg. (1 to 2 cc. of the suspension) in knee joints, which have been injected most frequently. Smaller joints, such as metacarpophalangeal or interphalangeal articulations, require much smaller amounts.

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Wrists, ankles and elbows respond less well to this form of treatment. The hip joint, because of the technical difficulty in approach and the uncertainty that the material is being injected directly into the joint space, is even less adapted to this therapy. In some instances satisfactory results have been reported with periodic injections. In general, this form of treatment is practical only in patients in whom major symptomatology is confined to one or two joints. It is also applicable to oleocranon bursitis and has been used by Hollander and his associates in subdeltoid and prepatellar bursitis as well.

In rheumatoid arthritis, the patients we have found most suitable for intra-articular hydrocortisone have been those who have had a good response to general measures plus chrysotherapy or steroid therapy or a combination of both, but in whom rheumatoid activity remains in one or both knees. Such patients, as a rule, derive definite benefit for periods ranging from seven to twenty-one days, after which re-injection is usually required. Occasionally improvement persists for as long as six weeks, but this is unusual.

Of particular interest to us have been two patients with rheumatoid spondylitis, treated satisfactorily by radiation therapy. Both of these patients had peripheral rheumatoid arthritis limited to the knees. Both responded promptly to intra-articular hydrocortisone, but re-injection has been necessary every three or four weeks.

We have found no way to predict in advance the relief a given patient may expect from intra-articular hydrocortisone, or how long the improvement will last. Occasionally, there will be poor response to the initial injection, with satisfactory improvement following subsequent injections. In no case has a patient developed a refractory state to later injections. For the most part, a good index of the degree of improvement is the patient's willingness to submit to repeated injections as necessary.

In patients with osteoarthritis of the knees, who have not responded satisfactorily to the usual methods of weight reduction, protection of the knees, physiotherapy and salicylates, the intra-articular injection of hydrocortisone offers another approach to therapy. In most instances a very worthwhile symptomatic response occurs, especially in patients of the older age group who otherwise might have required synovectomy or patellectomy to achieve symptomatic relief. It has been our impression that patients with osteoarthritis of the knees get more prolonged relief from hydrocortisone than do patients with rheumatoid arthritis.

In co-operation with Dr. Fred A. Henny of the Oral Surgical Division of the Henry Ford Hospital, fourteen patients with temporomandibular joint disease have been treated with intra-articular hydrocortisone successfully. Thirteen of the above fourteen patients have osteoarthritis, and one patient a rheumatoid type of involvement. This group of patients will be made the subject of a detailed report at a later date.

The more important advantages of intra-articular hydrocortisone therapy may be summarized as follows:

1. It allows "specific" though temporary therapy to be applied to otherwise refractory joint disease.
2. It permits early ambulation and constructive physical therapy in many cases when joint motion has been limited by pain and swelling.
3. It is particularly useful as a form of local therapy in cases where only one or two joints are involved, without necessitating systemic treatment such as chrysotherapy or oral or parenteral steroids.
4. In other cases it may be used in conjunction with other forms of therapy without conflict.
5. No systemic hormonal effects develop, and no serious local complications have occurred.

A word of caution should be added. Accuracy of diagnosis is of fundamental importance before using intra-articular hydrocortisone. It has been found to be of benefit in rheumatoid arthritis, osteoarthritis, acute gouty arthritis, and traumatic arthritis. It should certainly not be employed in infectious arthritis (tuberculosis, gonorrheal, pyogenic, et cetera).

Time and further experience will clarify the usefulness of intra-articular hydrocortisone. At this time, however, it would appear that in properly selected cases it has a definite though limited place in our armamentarium.

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Corticotropin, Protamine Supplement and Plasma Fibrinogen Levels in Chronic Arthritis

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RHEUMATIC DISEASE is largely chronic in nature due to the fact that a cure has not yet been found. Practically all of the acute cases later on reach a chronic state, regardless of the type of treatment used during the acute phase. At the present time, and until a cure for rheumatic disease is found, the continued search for better methods of controlling the chronic forms of the disease over a long period of time is of the utmost importance.

Many methods and many treatments have been proposed and used for the control of chronic rheumatic disease, but none have continued to hold as much promise for the future as the hormones. Corticotropin offers fair possibilities of being one of the key substances necessary to the control of rheumatic disease. It cannot be considered a cure in itself, but when its proper place is finally found in this complex disease, other key substances may then be fitted into the picture, and eventually an adequate control program may be evolved.

The effects of corticotropin in acute rheumatic disease are now well known. The acute symptoms are dramatically alleviated, only to quickly return again when the hormone is discontinued. Attempts to control rheumatic disease with corticotropin over a long period of time have met with partial success. Holbrook et al[4] found that 20 per cent of the patients could be maintained in complete clinical remission on relatively small doses of corticotropin without any toxic effects. Another 40 per cent of their patients were able to maintain worthwhile improvement estimated at more than 50 per cent, when the corticotropin was administered up to the first signs of adrenal cortical overstimulation. Unsatisfactory results were obtained in the other 40 per cent of their patients because of troublesome side effects.

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The present report deals first with the results obtained in a group of twenty-six patients who received worthwhile benefit from the long term administration of corticotropin and secondly, this report deals with the results obtained when the corticotropin was supplemented with protamine sulfate and the changes in the laboratory data, especially the plasma fibrinogen levels produced by the protamine supplement.

Procedure

Twenty-six arthritis patients were maintained on sustained corticotropin[7] treatment over a long period of time in order to determine the efficacy of corticotropin alone as an arthritis control measure. After a sufficient length of time had elapsed to be certain no further benefit could be obtained from the corticotropin alone, the treatment was then supplemented with protamine sulfate* given intravenously or protamine** given intramuscularly in the same gelatin menstruum as the corticotropin.

The usual routine clinical laboratory determinations were made frequently. The erythrocyte sedimentation rate was determined by the Westergren[12] method using the 200 mm. tube, because it is less likely to be affected by changes in packed cell volume than any other technique.[9]

As added correlates of disease activity the serum glucosamine,[11] plasma fibrinogen[8] and blood glutathione[13] values were also determined.

Theoretical Considerations

The cause of the increased plasma fibrinogen levels, so consistently found in rheumatoid arthritis, has not been explained. Information regarding this mechanism might possibly be of importance in a better understanding of the actual etiological mechanism of rheumatoid arthritis itself.

Laboratory and clinical data have been obtained to support the hypothesis that the increased plasma fibrinogen is produced by a compensatory mechanism brought into function because of a deficiency of thromboplastin, which deficiency in turn is produced by an overproduction of heparin or heparin like substances.

Theoretically, the increased plasma fibrinogen may be a manifestation of one of nature's many protective mechanisms. The increased plasma fibrinogen may be an attempt on the part of na-

*Supplied by Eli Lilly and Company, Indianapolis, U. S. A.

**Sulfate radicle removed with barium carbonate.

TABLE I. DATA ON TWENTY-SIX PATIENTS GIVEN LONG TERM CORTICOTROPIN TREATMENT FOLLOWED WITH SUPPLEMENTARY PROTOMINE SULFATE

No.	Case	Age	Sex	Diagnosis	Weeks of Treatment	Av. Daily I.U. Dose	Sed. Rate	Plasma Fibrinogen	Serum Glucosamine	Glutathione			Days of Treatment	Protamine Total	Sed. Rate	Plasma Fibrinogen	Serum Glucosamine	Glutathione			Remarks
										Total	Reduced	% Oxidized						Total	Reduced	% Oxidized	
1	R.F.	60	M	Rheumatoid arthritis 11 years	55	22	57	397	145	46.4	44	5.1	23	.590	43	262	75	40	32	20	Clinically improved
2	J.G.	46	F	Rheumatoid arthritis 8 years	54	21	20	1370	195	53	48	5	10	.190	6	255	155	50	45	10	Clinically improved on relatively small dosage
3	M.Q.	64	F	Rheumatoid arthritis 9 years	52	26	24	810	155	58	50.4	13.1	12	.510	9	410	120	54	46	14.8	Clinically improved
4	E.S.	52	M	Rheumatoid arthritis 5 years	54	14	83	707	105	43.5	42	3.5	27	1.200	15	435	105	60.5	48.5	19.8	Marked clinical improvement
5	D.M.	42	F	Rheumatoid arthritis 23 years	54	17	26	480	75	54.8	45.5	13.3	30	.160	32	390	120	61	58	5.1	Treatment inadequate No clinical change
6	M.C.	43	F	Rheumatoid arthritis 9 years	53	24	84	1100	120	47.9	41.4	13.6	18	.530	49	505	120	51	49	3.9	Clinically improved
7	R.M.	48	M	Rheumatoid arthritis 12 years	52	25	25	1200	80	52.8	51.8	1.3	27	1.480	17.5	450	110	58.5	55	5.9	Marked clinical improvement—See Fig. 1
8	B.M.	49	M	Traumatic arthritis knee 2 years	52	12	4	526	120	53	51	3.7	22	.850	5	280	120	59	57	3.4	Clinically improved
9	N.G.	50	F	Rheumatoid arthritis 20 years	52	16	50	551	175	52.8	48.4	9.1	34	1.100	47	955	170	56	50	10.7	Excess protamine clinical exacerbation
10	B.M.	54	F	Rheumatoid arthritis 7 years	51	19	34	767	130	51.8	50.6	2.3	30	.770	4	490	110	44.7	42.6	4.7	Clinically improved
11	A.B.	40	M	Marie—Strumpel "Poker spine" 16 yrs.	49	18	13	730	105	49.8	48.5	2.6	2	1.350	35	611	70	46.1	39.2	17.8	Excess protamine but clinically improved—See Fig. 2
12	M.C.	46	F	Rheumatoid arthritis 22 years	46	16	8	444	80	47.5	43.5	8.4	15	.180	6	310	75	51	44	12.9	Clinically improved
13	O.W.	51	F	Rheumatoid arthritis 19 years	46	17	44	448	105	52.2	50.2	3.9	13	.140	14	370	115	53	51	3.7	Clinical improvement continuing
14	R.C.	30	F	Rheumatoid arthritis 6 years	45	18	33	381	105	40.5	36.8	9.6	14	.460	45	216	110	58.5	43.5	25.6	Clinical improvement continuing
15	V.B.	59	F	Rheumatoid arthritis 16 years	44	13	47	839	130	47.2	41.4	12.2	22	.520	62	835	105	43.5	39.8	8.5	Excessive protamine clinical exacerbation
16	B.M.	59	M	Mixed arthritis 16 years	34	12	9	631	95	54	51	5.5	29	.520	28	396	80	56	51	9.8	No clinical change
17	W.M.	56	M	Arthritis psoriasis 15 years	34	22	58	1200	195	48	47	2.1	11	.480	22	233	110	49.9	33.3	33.2	Marked clinical improvement
18	E.W.	39	F	Rheumatoid arthritis 9 years	32	21	40	505	70	51	46	9.8	28	.440	22	321	105	54	46.5	13.7	Clinically improved
19	C.G.	51	F	Mixed arthritis 9 years	30	18	3	377	130	61	54	11.4	26	.740	8	960	180	59	56.5	3.5	Excessive protamine clinical exacerbation—Fig. 3
20	R.W.	48	F	Mixed arthritis 11 years	19	20	30	338	70	51	49	3.9	10	.170	20	290	70	50	46	8	Clinically improved
21	A.S.	41	F	Mixed arthritis 2 years	16	21	44	450	105	51	46	9.9	30	.260	68	395	170	44	37	15.9	No clinical change
22	D.G.	35	M	Mixed arthritis 11 years	16	17	39	353	170	59.2	47	20.6	21	.850	46	394	130	62.5	60	3.9	Excessive protamine clinical exacerbation
23	V.E.	56	F	Rheumatoid arthritis 10 years	15	22	94	1442	140	63	57	9.5	18	.630	28	930	80	69	62	10.1	Marked improvement
24	M.K.	49	M	Rheumatoid arthritis 17 years	14	14	16	396	115	51.2	49.4	3.4	27	.290	10	345	170	51	46.5	8.9	Treatment inadequate No clinical change
25	M.M.	56	F	Rheumatoid arthritis 12 years	8	21	24	574	118	50.6	46.3	8.4	21	.290	20	320	130	66	58	12.1	Clinically improved
26	I.G.	49	F	Rheumatoid arthritis 10 year	6	24	16	314	95	50	44	12.	25	.180	10	285	155	52.7	44.8	14.9	Clinically improved

ture to maintain the clotting qualities of the blood, so necessary to life, in the absence of sufficient thromboplastin. Both fibrinogen and thromboplastin in normal amounts are necessary to the proper clotting of blood and it is conceivable that a deficiency of one might cause a compensatory increase in the other.

Heparin is present in the blood at all times to safeguard against the intravascular clotting of the blood (thrombosis), but the reason for the presence of excessive heparin or heparin like substances in the blood of rheumatoid arthritis is not clear. However, the employment of protamine sulfate to neutralize these substances would be the most logical way to therapeutically correct the theoretical imbalance in the circulating media.

Both heparin and protamine are powerful antithromboplastins, but they have a greater affinity for each other than they have for thromboplastin. For this reason protamine sulfate may be used clinically as an antidote for an overdose of heparin if such should be given therapeutically.

According to the above hypothesis, the plasma fibrinogen level should gradually drop to normal as the excessive heparin-like material is cautiously neutralized by repeated intravenous injections of small amounts of protamine. The theoretically correct amount of protamine would be that amount which is just sufficient to neutralize all the heparin-like substances present. When these are all neutralized and the protamine injections continued, the excessive protamine itself would then act as an anti-thromboplastin. This would be manifested by the plasma fibrinogen returning to its previously high level.

Results

The accompanying chart gives the pertinent data on the twenty-six patients studied with sustained corticotropin. There were nine men and seventeen women, ranging from thirty to sixty-four years of age and having the disease for from two to twenty-three years. Ten of these patients were under corticotropin treatment for one year or longer, but from a clinical as well as the laboratory standpoint they progressed no farther toward a complete remission than did those treated for a lesser period of time. They all seemed to reach a certain stage of worthwhile improvement and then remain about the same regardless of how long the corticotropin was continued. These patients all showed the early or mild signs of Cushing's syndrome, even though the dosage of corticotropin was small. The clinical signs and symptoms had a tendency to vary somewhat with the source of the corticotropin,† as each manufacturer's product varied a great deal in spite of their attempts to standardize it according to the international unit. However, this difficulty will be overcome in the future as the more highly purified product becomes more generally available.

The clinical signs and symptoms were used as a guide for adjusting the dosage of corticotropin up or down, inasmuch as the laboratory data did not reach normal at any time. In those cases where the sedimentation rate came to a normal value, one or more of the other indices indicated continued rheumatic activity. Any attempt to bring all indices to normal by increasing the corticotropin only resulted in undesirable side effects.

The figures for the upper limits of normal for the serum glucosamine compare favorably with the figures for the sedimentation rate, although a closer correlation is obtained in this series when the upper limit of normal is considered to be 90 mg. per cent instead of 110 mg. per cent as used by the authors of the method. The figure of 90 mg. per cent also correlated more closely with the clinical condition of the patient.

No definite conclusions could be drawn from the data on blood glutathione. However, it was noted in a general way that those patients with the higher percentage of oxidized glutathione seemed more able to adjust themselves to their affliction than those in the lower percentage of oxidized glutathione group. Only two patients developed an increase in the blood sugar during treatment. Case No. 9 developed a fasting blood sugar of 330 mg. per cent, and Case No. 15 developed a fasting blood sugar of 189 mg. per cent, but neither patient at any time gave rise to glutathione data which would distinguish them from other members of the series.[2]

The plasma fibrinogen level in this series proved to be the most reliable index of clinical rheumatic activity. All twenty-six patients had fibrinogen levels considered to be elevated above normal and all cases had definite clinically active rheumatic disease. This is in contrast to the six cases reaching a normal sedimentation rate, giving a 23.1 per cent error in this series for that index.

†Supplied by Wilson Laboratories, Chicago; Armour and Co., Chicago; Parke Davis and Company, Detroit; Organon, Inc., Orange, New Jersey.

When corticotropin was supplemented with protamine sulfate according to the theory given above, the results were very much as expected. As little as 30 mg. intravenously each day was usually

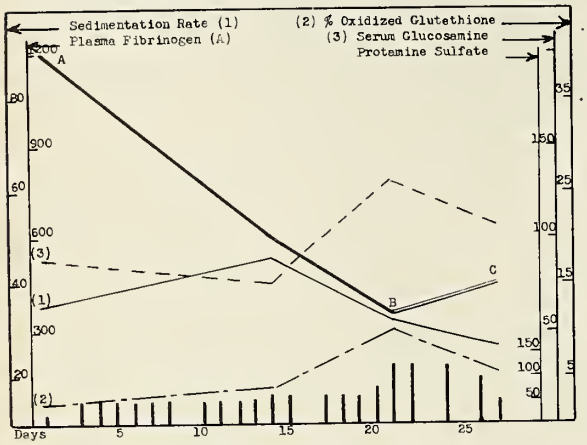


Fig. 1. Physiologic effect of protamine supplement (Case 7), showing decrease in plasma fibrinogen (line A B), as the protamine neutralized the theoretical excessive heparin and heparin-like substances in the blood. With these all neutralized at B, the protamine itself then acted as an antithromboplastin, which in turn produced a compensatory increase in plasma fibrogen shown by double line B C.

enough to produce a continuous lowering of the plasma fibrinogen to the normal level, and in practically all instances the patients volunteered the information that they felt much better even though they had no knowledge of a change in treatment. The patients with the higher fibrinogen levels required from 50 to 75 mg. per day, to maintain a continuous drop, and in some instances where 100 mg. or more were given daily the drop in fibrinogen levels became so rapid that the end point could not be determined in time to prevent a complete exhaustion of the patients' store of heparin, as indicated by a very rapid reversal of the fibrinogen curve, which rose again to levels considerably higher than the original. Theoretically, the ideal dosage would be that amount which would be just sufficient to maintain the plasma fibrinogen at just the normal level. Any more or any less would cause the fibrinogen level to rise.

There were no untoward symptoms evident at any time from the administration of such a small amount of protamine. Even in those cases having a severe reversal of the fibrinogen curve, the prothrombin time, clotting time and bleeding time all remained within normal limits.

In those cases having a reversal of the plasma fibrinogen level due to overstepping the ideal protamine dosage, the sedimentation rate and the serum glucosamine levels also rose to new highs, while the percentage of oxidized glutathione dropped markedly.

In all instances there was noticeable clinical improvement in the patient when the plasma fibrinogen level was receding. Four of the five patients receiving a slight excess of protamine had a sudden reversal of their fibrinogen, sedimentation rate and glucosamine curves and a concurrent return of clinical symptoms. One patient (Case 11, Fig. 2) had no recurrence of symptoms although his curves all showed a new temporary high, due to excess protamine.

Figure 1 is a graph constructed from the actual laboratory data of a forty-eight-year-old male factory worker, extensively crippled by rheumatoid arthritis for the past twelve years. He had been receiving sustained corticotropin up to the point of adrenal cortical overstimulation for about one year (Case 7). At the time protamine sulfate was started in his treatment, his plasma fibrinogen level was very high. He received eleven intravenous injections of 50 mg. each during the first two weeks. His clinical condition improved markedly and his fibrinogen level dropped about 50 per cent. While his serum glucosamine value dropped, his sedimentation rate rose slightly higher. There was a slight rise in the percentage of oxidized glutathione. For the following week, the protamine sulfate was increased to 70 mg. daily. The plasma fibrinogen showed a further decrease and the sedimentation rate also dropped. The serum glucosamine value and the percentage of oxidized glutathione jumped to higher levels, and the patient was doing remarkably well, clinically. At this point the protamine sulfate was increased to 130 mg. daily. By the fifth day, after three treatments had been given, the patient noted a slight return of clinical symptoms. These persisted and the protamine was discontinued on the twenty-seventh day. There was a slight but definite rise in the plasma fibrinogen level and a decrease in the sedimentation rate as well as the percentage of oxidized glutathione. This slight rise in the plasma fibrinogen level was interpreted as being caused by a slight excess of protamine sulfate, hence its discontinuance. The corticotropin was continued as usual and by the third day after discontinuing the protamine, the patient was symptom free. All

his laboratory data came within normal limits for the first time.

Figure 2 is a graph constructed from the actual data of a man, aged forty (Case 11), with Marie-

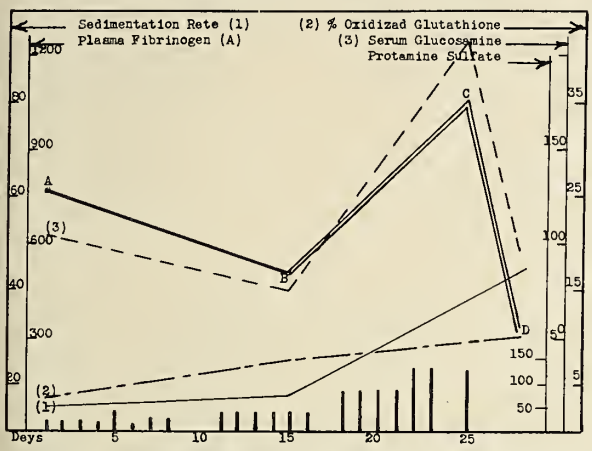


Fig. 2. Physiologic effect of protamine supplement (Case 11), showing result of excess protamine administration. Line A B represents the plasma fibrinogen level presumably elevated by excessive endogenous heparin or heparin-like substance while double line B C D represents the increased plasma fibrogen due to excessive exogenous protamine.

Strümpel type of arthritis ("poker spine") present for sixteen years. This graphically illustrates the sudden rise in the plasma fibrinogen to a point higher than the original when a relatively large excess of protamine was present and the sudden drop to practically normal level when the protamine was discontinued. This was the only patient who did not suffer a recurrence of arthritic symptoms when an excess of protamine was given. His arthritic activity stopped during the first fifteen days of treatment, and has not returned up to the present writing. His prothrombin time, bleeding time, and clotting time all remained normal. The only significant finding was a drop in platelet count from 396,900 on the day of the last protamine treatment to 199,600, three days later (50.4 per cent). Theoretically, this might be expected as the platelets are mobile concentrates of thromboplastin.

Figure 3 is a graphic record of the data obtained from a fifty-one-year-old female office worker slightly crippled by the presence of both rheumatoid and hypertrophic arthritis (Case 19). Her plasma fibrinogen level was only slightly increased after seven and one half months of sustained corticotropin treatment. All other indices were normal and her clinical complaints were slight but nevertheless quite real to her. Without giving her any indication of a change in treatment, small amounts of protamine were added to the gelatin menstruum of the corticotropin as shown on the graph. The day after the second protamine sup-

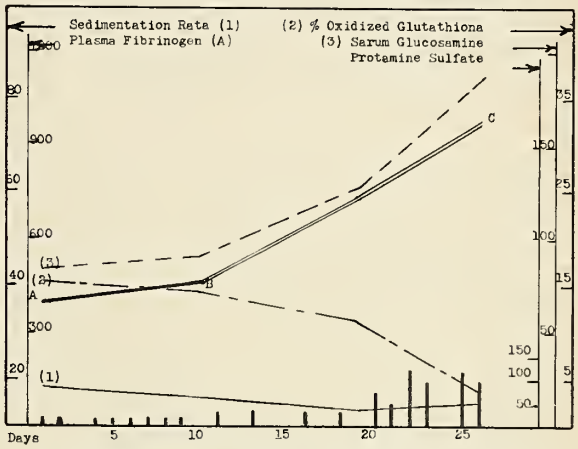


Fig. 3. Graphic presentation of data on Case 19, showing physiologic effect of small amount of protamine supplement when the plasma fibrinogen level is near normal and demonstrating that an exacerbation of acute symptoms with laboratory data corresponding may be produced under these circumstances by comparatively small amount of protamine.

plementation she volunteered the information that she felt unusually good. This lasted for about one week, until the protamine was increased. With each additional increase in protamine her clinical symptoms became worse until she was experiencing the most severe attack of arthritis since the beginning of her corticotropin treatment. As soon as it became definite that she was receiving an excess of protamine, even though the total amount was relatively small, the protamine was discontinued. The corticotropin was continued and by the third day the clinical symptom had subsided completely. This graph illustrates many things, chief of which are that an acute arthritic attack can be produced with protamine under the right conditions and that arthritis individuals having a normal or near normal plasma fibrinogen level are extremely sensitive to the action of protamine. It also illustrates the effectiveness of protamine when given intramuscularly.

When this graph is compared with Graph 1, it can readily be seen that patients with a high plasma fibrinogen level require much more protamine to reduce the level to normal or to develop signs of excess protamine.

Figure 4 is the graphic presentation of data illustrating the fact that exogenous corticotropin is not necessary to the action of protamine. This data

was obtained from a sixty-three-year-old housewife whose chief complaints were severe persistent occipital headaches and stiffness of the neck. X-rays of the cervical spine showed the typical bony spurs

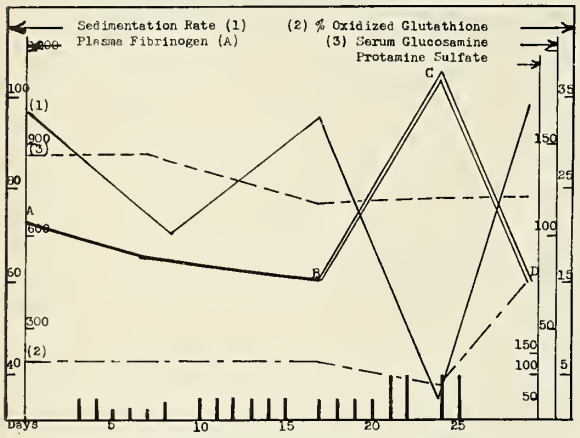


Fig. 4. Graph constructed from data obtained from chronic hypertrophic arthritis patient, not previously standardized on corticotropin, showing that exogenous corticotropin is not necessary for the protamine action.

of hypertrophic arthritis. Her headaches were completely relieved following the second injection of 200 mg. of Alpha Tocopherol, 25 mg. of testosterone proprionate and .5 mg. of mixed natural estrogens all in oil. The protamine was started after the severe headaches had been relieved; otherwise the protamine might erroneously have been given credit for the dramatic relief of pain. A study of the data obtained in this case shows a clear correlation with the data obtained from the patients receiving corticotropin at the same time.

Discussion

Figure 5 is a composite graph constructed from data and information assembled from the entire group. It is presented for the purpose of more clearly visualizing the effect of protamine administration on the plasma fibrinogen, sedimentation rate, glucosamine and oxidized glutathione levels as observed in this study.

The solid black line from A to B represents the effect of protamine on the plasma fibrinogen level, which had been elevated supposedly by excessive heparin or heparin-like substances in the circulating blood of the arthritis patient. The double line continuation from B to C represents the effect of excessive protamine on the plasma fibrinogen level, after the circulating heparin or heparin-like substance has been neutralized. The double line from C to D represents the fall in the plasma fibrinogen level when the protamine is discontinued. The solid black line represents, then, the plasma fibrinogen level which has been elevated

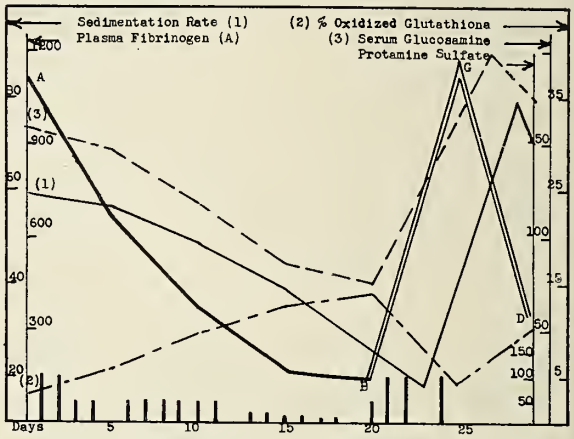


Fig. 5. Composite graph, constructed from segments of data from group studied, illustrating physiologic effect of protamine supplement in rheumatoid arthritis patients previously standardized on sustained corticotropin. The plasma fibrinogen (A B) drops presumably because of the neutralization of excess heparin or heparin-like substance in the circulation, requiring very small amount of protamine (10 to 30 mg. daily) to maintain the plasma fibrinogen at the normal level. If excess protamine is given when the plasma fibrinogen level is at or near normal (B) then the fibrinogen level rises sharply and may even exceed its original level (B C). The plasma fibrinogen level drops again when the protamine is discontinued (C D). The heavy line for A B illustrates that part of the curve during which presumably increased endogenous heparin or heparin-like substance is responsible for the increased plasma fibrinogen and the double line continuation B D illustrates that part of the curve during which exogenous protamine is responsible for the increased fibrinogen.

or maintained by heparin or heparin-like substance and the double line represents the plasma fibrinogen level which has been elevated by protamine.

This emphasizes the fact that both heparin or heparin-like substances and protamine neutralize thromboplastin, which, when reduced below a normal content, theoretically initiates a compensatory increase in the fibrinogen in an effort to maintain the life-preserving clotting qualities of the blood. The composite graph for the sedimentation rate, glucosamine levels and the percentage of oxidized glutathione are self-explanatory.

In order to better understand the correlation between the theory and the laboratory data obtained when sustained corticotropin therapy of chronic rheumatoid arthritis was supplemented with protamine sulfate, a review of the pertinent known facts about the principal substances and tests involved is very helpful.

Corticotropin.—First of all, corticotropin itself has been shown[1,5] to produce a drop in the plasma fibrinogen level when the treatment is first started and the larger dosage is used. However, as the treatment is continued and the dosage is necessarily reduced the plasma fibrinogen seeks a higher level. Therefore, in order to distinguish between the fibrinogen drop produced by corticotropin and that produced by the protamine, the patients must necessarily be more or less standardized on one of the substances first before the other is used.

Protamine.—Protamine is a very complex protein-like substance occurring in combination with nucleic acid and obtained commercially from the sperm of salmon and other fish. Its therapeutic uses have been in the preparation of protamine zinc insulin and as an anticoagulant. For the latter use amounts up to 300 mg. per day have been given intravenously without any untoward results, and so one would not expect any harmful side effects from one fifth of that amount, which is all that is necessary to produce a good therapeutic result in conjunction with corticotropin.

Protamine is used as an anticoagulant because of its ability to neutralize thromboplastin. However, it has a stronger attraction for heparin which also neutralizes thromboplastin than for any other substance in the blood, and so for this reason it is used therapeutically to neutralize any overdosage of heparin when that substance is used as an anticoagulant. The powerful attraction protamine and heparin have for each other is said to be due to the fact that protamine carries the strongest positive electric charge and heparin carries the strongest negative charge of all biological substances known.

Heparin.—Heparin is a complex mucopolysaccharide resembling chondroitinsulfuric acid. Its powerful negative electric charge is in some way associated with its ability to prevent the action of thromboplastin on prothrombin to produce thrombin, and it may also inactivate thrombin itself. Heparin occurs in many organs, but especially in the liver and lungs. It greatly resembles, and may be identical with, the granular substance observed in the mast cells of Ehrlich, which occur mainly in fibrocytic nodules and in connective tissue in the walls of blood vessels and in the vicinity of capillaries.

Thromboplastin.—Thromboplastin is a phospholipoprotein, the exact chemical structure of which is still in dispute. Regardless of that, the substance is found in all body cells. It is especially abundant in brain, lung, thymus, testicular tissue and above all in blood platelets. It is released when the cell wall is broken by trauma or disintegration.

Fibrinogen.—Fibrinogen is a labile protein which is presumably formed in the liver. It is acted upon by an enzyme, thrombin, to produce fibrin which separates from the blood as a netlike gel in the process of blood coagulation. Expressed in its simplest terms, the clotting of blood takes place in two stages:

1. Prothrombin + thromboplastin + calcium → thrombin.
2. Thrombin + fibrinogen → fibrin.

When the plasma fibrinogen level is elevated, the plasma labile factor,[10] which takes part in the conversion of prothrombin to thrombin, may be low. It is not yet determined which level is altered first.

Laboratory Data.—In addition to the usual clinical laboratory determinations, the serum glucosamine, plasma fibrinogen and blood glutathione studies were made a part of the routine, largely because of a desire to find useful correlates to the erythrocyte sedimentation rate as an index of disease activity. The erythrocyte sedimentation rate values have long been established by clinical experience as a useful index of rheumatic activity, and its discrepancies are widely recognized.[9]

The serum glucosamine values are also nonspecific for rheumatic disease and are usually found elevated in inflammatory processes and malignant tumors. In the main the serum glucosamine values parallel those for the sedimentation rate in rheumatic disease with frequent variations and discrepancies. A study of the data chart shows that the discrepancies in relation to the clinical condition of the patient do not always occur simultaneously, and when both indices are used in the evaluation of the patient the misleading effects of the sedimentation rates values, when used alone, are reduced by about one half. The serum glucosamine values, while not always reliable, appear to be quite useful as a correlate of disease activity in conjunction with the time honored sedimentation rate values.

The percentages of oxidized glutathione holds some promise of being a useful index, although its implications are far more general than the sedimentation rate and the glucosamine levels. Further study will need to be done before any reliable conclusions may be drawn.

Elevation of the plasma fibrinogen level has been a constant finding in active rheumatic disease. Fearnley[3] and Ogryzlo[6] independently observed that the plasma fibrinogen levels closely paralleled the sedimentation rate values during the rapid changes produced by corticotropin.

Using a 12.5 per cent sulphite precipitation technique, Fletcher, Kelly and Dauphinee, as quoted by Ogryzlo,[6] found that a plasma fibrinogen level of 200 mg. per cent was usually associated with a normal sedimentation rate in over 100 patients with rheumatoid arthritis. With higher levels of plasma fibrinogen, there was a corresponding increase in the sedimentation rate until the fibrinogen level reached 700 mg. per cent. Beyond this figure, the sedimentation rate values did not continue to follow the higher fibrinogen levels.

Comments

A great deal more data is desirable in order to properly evaluate the use of protamine supplement in corticotropin therapy. However, it does appear certain that corticotropin alone will not adequately control the manifestations of chronic rheumatoid arthritis, although its use does produce a very well worthwhile benefit. The results of this study so far shows there is a good likelihood that supplementary substances may be found which when used judiciously in their proper places, along with corticotropin, will maintain the rheumatoid arthritis patient in a remission which can be confirmed by several different laboratory indices.

Regardless of whether or not protamine therapy eventually proves to be of any long term benefit to the arthritis patient, the study of its effects on plasma fibrinogen opens up a very fruitful field for arthritis research. Changes in plasma fibrinogen are closely associated with all forms of rheumatic disease and a persistent and widespread inquiry into these changes might reveal something of the actual mechanism producing the disease.

Summary

A series of twenty-six chronic arthritis patients, mostly rheumatoid, were given sustained corticotropin therapy up to the point of cortical overstimulation for a period of eight to fifty-four weeks. Worthwhile improvement was experienced in all cases although none developed a complete clinical remission.

All twenty-six patients had a persistent increase in their plasma fibrinogen level. This was postulated to be due to a compensatory increase in fibrinogen because of a decrease in thromboplastin, which was brought about by an oversupply of heparin or heparin like substances in the circulating blood.

After the patients had been standardized on corticotropin therapy, and it appeared certain that a further drop in their plasma fibrinogen level would not occur from corticotropin, protamine supplementary therapy was instituted with good clinical results.

The plasma fibrinogen level in all cases began to drop to normal, but when the protamine therapy was increased beyond the point of ideal maintenance, the plasma fibrinogen, sedimentation rate and the serum glucosamine curves all reversed and rose to new highs, only to drop again when the protamine was discontinued. This was in complete accord with the theoretical expectations.

The supplementary protamine therapy enhanced the partial clinical remission started by corticotropin in twenty-one of the twenty-six cases.

Conclusion

1. Corticotropin by itself is inadequate for the complete control of chronic arthritis.

2. Protamine sulfate therapy in conjunction with corticotropin may complete the clinical remission started by the corticotropin and this may be substantiated by laboratory data.

3. The increased plasma fibrinogen levels found in association with rheumatic disease may be reduced to and maintained at normal by corticotropin and protamine therapy.

4. The determination of the serum glucosamine and the plasma fibrinogen levels along with the erythrocyte sedimentation rate are useful correlates of rheumatic disease activity.

Acknowledgment

Grateful acknowledgment is made to Donald H. Kaump, M.D., for his valuable counsel and to Ruth Davis McNair, Ph.D., for her valuable technical assistance, and also to the entire technical staff for their sympathetic and helpful co-operation.

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BASEBALL AND POLITICS

Although baseball is a more popular game than politics, it is not nearly as remunerative for those who participate in it. The mink coat is not a baseball symbol. The average pay of the 400 players in the big leagues is $13,842 or $1,158 less than that of a congressman. Moreover, none of a ballplayer's salary is tax-exempt and $2,500 of the congressman's is. Then, too, it is a lot harder to stay in the big leagues than in congress, and no ballplayer can put his wife on the team payroll as a secretary. Finally, it isn't only a question of what you get but how long you get it. Some men have played at being congressmen until past 80, but only the rare exception like Cy Young and Satchel Paige plays ball after forty.

The Intra-articular Injection of Hydrocortisone (Compound F) in the Treament of Selected Cases of Arthritic Diseases

By Hugo A. Freund, A.B., M.D.
Detroit, Michigan

IT IS GENERALLY accepted that with the exception of monoarticular infections and traumatic conditions, arthritides should be classified as systemic diseases. Morphologic evidence of this is found in frequent observations describing inflammatory lesions in heart, muscles, and nerves, as well as biochemical changes in body fluids.

Although periods of remission and even reversal of arthritic diseases are sometimes observed, the tendency is a progressive course that sooner or later leads to marked disabilities and invalidism.

The advent of ACTH, cortisone and hydrocortisone[2] has, under controlled guidance, provided spectacular relief in some cases, partial improvement in many, and no change whatsoever in a few. Restoration of synovia, cartilages, and atrophic muscles has not been accomplished, although disappearance of joint inflammation, diminution of pannus, and improvement in mobility and general well-being may be accomplished. Much remains to be desired.

Although improvement in many cases, especially early ones, is general, often individual joints continue to handicap and create the only obstacle to a greater degree of usefulness. This is especially seen in rheumatoid arthritis where, after careful management, an ankle, knee, wrist, or elbow do not improve sufficiently to restore a desired amount of function. It is in these instances that hydrocortisone has been of value.

Hollander[1] gives an excellent summary of the usefulness of the substance when injected directly into the diseased joint. It should not be assumed however that this procedure gives relief in every instance.

It has become increasingly apparent that some

These clinical studies were supported in part by funds from the National Foundation of Rochester, Michigan. Hydrocortisone was generously supplied by Merck and Co. of Rahway, New Jersey.

rheumatoid joints will respond favorably; in others no attempt should be made. Those in which a satisfactory response may be predicted are the acutely inflamed joints, and those containing some free fluid. Where ankylosis or fibrous changes are evident, little improvement can be expected. This applies also to those joints heavily infiltrated with thick pannus that has not diminished much during the previous course of systemic treatment. Occasionally, a joint that has improved sufficiently to permit introduction of a needle may be x-rayed after oxygen injection, to determine the amount of adhesions and space occlusion. In two such instances, 50 mg. of hydrocortisone resulted in a moderate degree of improvement. As a rule, however, when no fluid is recovered after the needle is in the joint space, no striking benefit results. In general, less satisfactory improvement results from instillation of hydrocortisone into phalangeal joints than into the larger joints.

One of the striking benefits of this method of administration is seen in acute exacerbations of gout. Two cases in point, are the following:

Case 1.—J. P., aged forty-six, has had a hyperuricuria for eight years. During this time, he has had several acute attacks in the right great toe. Patient was hospitalized because of an attack of coronary thrombosis. He made an uneventful recovery, except for the fact that on the twenty-sixth day of his hospitalization he developed an acute episode of pain, redness, tenderness and swelling characteristic of a typical attack of gout. At 6:00 in the evening, 25 mg. of hydrocortisone was injected into the joint. The patient states that at midnight the pain was gone. At 8:00 the following morning no evidence of the acute attack could be seen.

Case 2.—E. H., aged forty-eight, has had recurrent attacks of acute gout for several years. These always incapacitated him from three to five days. Colchicine usually gave him relief. The patient was placed on Benamid and had been on it for one month, during which time he spent his vacation in Florida. He was called home suddenly and proceeded to drive the distance. After driving continuously for seventeen hours, his right foot suddenly swelled with continuous intense pain, characteristic of the usual gouty seizure. He immediately began colchicine, and at the time he arrived in Detroit, forty hours after leaving Florida, the right great toe and foot were badly swollen, red, and exquisitely painful. He had a temperature of 101°. Apparently colchicine had given no relief up to this point. Hydrocortisone, 50 mg. in two separate injections, was given. In twenty-four hours, the attack had completely subsided. Meantime, colchicine had been discontinued.

In gout, the acute episode is completely aborted by hydrocortisone. No further treatment has been required in six cases observed up to this time. In all of these cases, it should be mentioned that the blood uric acid did not fall following the injection of the hydrocortisone. This probably is because its action is anti-inflammatory and anti-allergic, in addition to a gradual deterrent effect on the formation of fibroblastic tissue.

The technique of injection is simple. The point selected is where the maximum amount of fluctuation can be elicited after active flexion. With a small hypodermic needle, the area is anesthetized with 2 per cent procaine. Then 50 mg. of hydrocortisone is made ready in a 2 cc. syringe. First, a No. 20 needle on a 10 cc. syringe is introduced into the joint space, and an attempt to withdraw fluid (as much as possible, if obtained) is made. The 2 cc. syringe is then attached, and the hydrocortisone injected very slowly: 50 mg. for the larger joints, and at least 25 mg. for smaller ones. No after care is required. If a favorable result is not obtained at the first injection, subsequent ones rarely give much more relief, although there is no contraindication to repeat the instillation after several days.

Favorable results following treatment of every type of acutely inflamed joints, bursitis and a variety of non-arthritic states are being reported in current literature. All of these support the general clinical experience of the value of this form of intra-articular therapy.

Summary

Acutely inflamed joints and carefully selected chronic joints in rheumatoid arthritis that have improved on systemic treatment, and acute joint involvement in gout, respond satisfactorily and ofttimes dramatically to intra-articular injections of hydrocortisone.

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Negative bronchoscopic examinations, regardless of number, do not disprove the presence of cancer.

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Negative cytologic examinations do not disprove the presence of cancer.

The Conservative Management of Chronic Recurrent Low Back Pain

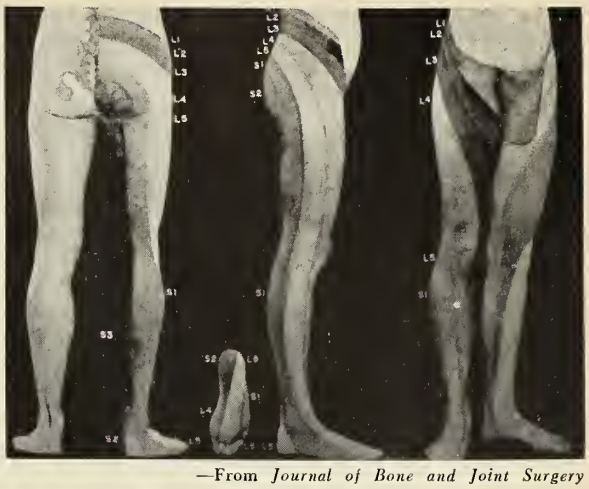
By Charles H. Frantz, M.D.
Grand Rapids, Michigan

DURING THE LAST twenty years, clinicians, physiologists and psychologists have contributed much to our knowledge concerning the nature of low back pain. There continues to be a lack of information, which were it known, might answer many of the problems we are not at present able to solve.

Approaching the chronic low back pain problem from a conservative standpoint, it is well to remember that all parts of the body are subject to variations in structure and development. This is particularly true of the lumbosacral joint. There are so many variations at this level that we sometimes wonder what is normal. These variations are probably due in part to the fact that the lumbosacral level is the last portion of the vertebral column to become segmented, chondrified and ossified.

It has been stated that between 25 per cent and 30 per cent of people complaining of low back pain demonstrate skeletal abnormalities at the lumbosacral level. It has also been the observation of clinicians, in reviewing large series of cases, that 30 per cent of people with back pain are suffering from some degree of disc degeneration.

In view of these observations, it would seem that a goodly proportion of cases cannot be attributed to environmental trauma. Contrarily, the physician is faced with degenerative processes within the disc wherein extrinsic trauma is incidental. Practitioners are integrated to accept without question the demonstrative changes at the sacro-iliac joint attributed to rheumatoid arthritis. The proliferative subchondral bone changes in vertebral bodies and facets are evidences of wear and tear. Demonstrated in the roentgenogram, they are immediately recognized as hypertrophic or degenerative arthritic changes. The intervertebral



—From *Journal of Bone and Joint Surgery*
Fig. 1.

disc also undergoes degeneration with definite sequelae.

The lumbosacral disc is subject to more trauma, both acute and chronic, than any segment above it. This trauma is not only extrinsic (environmental accidents) but also is intrinsic or physiological due to the demands of everyday living. Its vulnerability is due to the fact that this joint is in more lordosis than any segment above it and carries a greater load. The lumbosacral disc is found to be narrowed more frequently than its higher brethren. Man assumed the upright or orthograde position at the expense of this joint, and it is felt by anthropologists that the lumbosacral level has been and is continuing to undergo transitional changes. This contention may in part explain the frequency of skeletal abnormalities as revealed by roentgen examination.

Despite progress in understanding low back pain, no one to date is able to solve satisfactorily all of the perplexing clinical problems. Many entities have held the limelight. Gynecological conditions, sacro-iliac subluxation, spastic pyriformis muscle, fascitis, hypertrophic ligamentum flavum, fascial contractures, to name but a few, have been overemphasized and gradually settled back to their proper places. There continues to be cases which confound us. There is myriad of causes for back pain, and we must constantly think of systemic disease, local inflammatory processes and neoplasm.

From a clinical standpoint, gynecological conditions in the female and genitourinary conditions in the male are seldom the cause of backache. If there is backache, other symptomatology and a

Read at the Michigan Clinical Institute, Detroit, Michigan, March 13, 1952.
From Blodgett Memorial Hospital, Grand Rapids, Michigan.



Fig. 2. Sclerosis of the right sacro-iliac joint.



Fig. 3. Unilateral sacralization of the fifth lumbar transverse process; pseudo-arthrosis, producing pain.

careful examination will lead away from the vertebral column.

Confronted with a patient complaining of low back pain, one is obligated to evaluate carefully the type of person complaining of the pain as well as to endeavor to determine the nature and location of the pain.

The examination is designed to arrive objectively at the correct diagnosis. If the story evolves in "injury on the job," with implications of liability and compensation, particular attention should be focused on the exciting episode and a detailed record made.

Is there a hollow or flat back? Is spasm present? Is forward bend limited? How much? Is recovery to the erect difficult or painful? Where is the pain? Localize it. Does hypertension aggravate it? Are the knees flexed during the back maneuvers? Are lateral bending motions painful and limited? Is trunk torsion painful? Is there tenderness in the sciatic notch? Is there atrophy of the thigh and calf musculature? Are the straight leg-raising maneuvers painful? Is this pain sciatic neuralgia or hamstring tension? Are the reflexes present at the knee and heel? Are the dorsiflexors of the foot and great toe weakened? Complaints of tingling and numbness must be verified by touch and pin prick tests. Leg length equality must be verified. Positive findings can only be observed with the patient disrobed. Roentgen examination should include anteroposterior, right and left oblique projections plus a true lateral view.

The major sensory components of the sciatic nerve arise from the fourth and fifth lumbar nerves, and the first sacral nerve (Fig. 1). Their dermatome pattern is a familiar one. These major components supply touch, pain and temperature fibres to their respective skin areas. Fibres also present are concerned with position sense and a sense of pressure to muscle and tendon groups. These nerves also send branches to the ligaments and capsule of the small joints of the foot, the ankle, knee and sacroiliac joints. They also supply the posterior joints, annulus fibrosa and adjacent ligaments of the lower lumbar vertebrae. It is noteworthy here that these major components of the sciatic nerve supply few or no pain fibres to the abdominal and pelvic viscera.

Sacroiliac arthritis (Fig. 2) produces low back pain. In the presence of these localized changes it is well to examine carefully the movements of the entire spine, major extremity joints and the chest expansion. One may be dealing with an early rheumatoid spondylitis. A firm bed, local application of heat, x-ray irradiation, salicylates and a spinal support aid in relieving symptoms.

Partial sacralization of the fifth lumbar transverse process (butterfly type) is not an uncommon

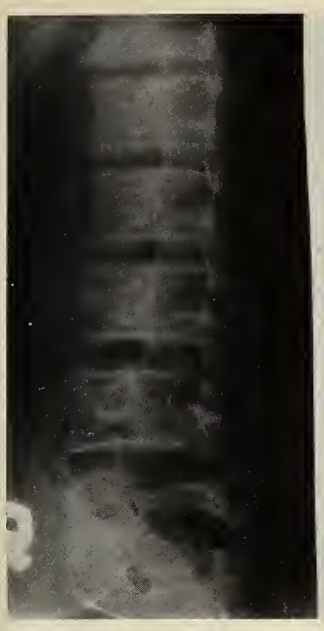


Fig. 4. Spondylolysis of the fifth lumbar posterior elements in a young person.

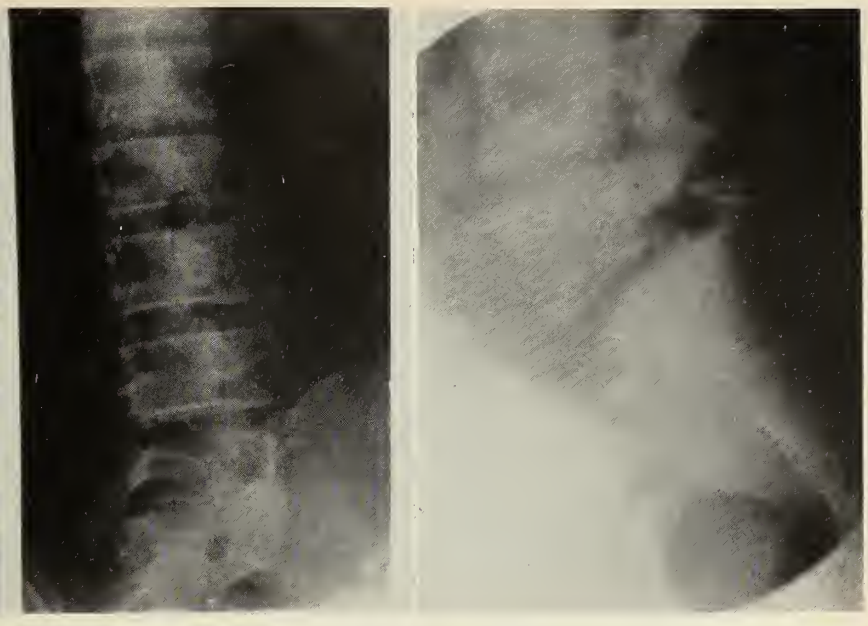


Fig. 5. Spondylolisthesis, second degree.

cause of low back pain. Pseudo-arthrosis exists and the pain is usually on the side of the abnormality. Most cases can be relieved by observing work habits carefully, a firm bed, heat in acute attacks and a spinal support. The frequency and severity of attacks are only partial indications for surgical intervention (Fig. 3).

Hypertrophic degenerative changes in the older age group not infrequently cause backache. There is loss of motion in the lumbar, if not the entire, spine. Discomfort may be diffused with few localizing areas. Again, a firm bed is helpful. Local applications of heat, a spinal support and salicylates relieve the patient to a great degree. Senile or post-menopausal osteoporosis may be present in these patients. In such cases, in addition to general supportive measures, urinary calcium excretion tests may serve as a guide to the judicious use of steroid hormones. However, careful periodic re-examinations are most necessary to combat side effects of these hormones.

Defects in the posterior elements of the fifth lumbar vertebra give rise to low back pain on exertion (Fig. 4). Proper postural training and working habits will in many cases alleviate symptoms. In the presence of spondylolisthesis (Fig. 5) the working capacity of an individual may be markedly reduced. Such a problem may be met with spinal support, proper sitting, lifting and recreational precautions. A spinal support in the form of a chair back brace or spinal corset may be necessary. The severity of symptomatology will determine necessity of surgical fusion.

Narrowing of the lumbosacral intervertebral disc with its sequelae of facet over-riding and degenerative changes may in numerous instances be handled conservatively (Fig. 6). The settling of the fifth lumbar facets downward encroaches on the fifth lumbar nerve root by decreasing the size of the foramen of exit. The lower lumbar nerve roots are covered by a dural prolongation and have little if any latitude of motion. During leg maneuvers, the lumbar roots are drawn distally and are under tension. Any decrease in the size of the foramen, hypertrophic changes in the facets or disc protrusion will contribute to discomfort, as the hip is flexed with a straight knee.

One will over a period of years be confronted with various degrees of degeneration (Fig. 7). At times it is difficult to understand the adaptation to slowly progressive degeneration, producing comparatively mild symptomatology.

The mechanism of many of these problems is due to the load placed upon the erector spinae as it gains the upright position from forward bend. This massive anti-gravity muscle contracts in its long axis, aided by the gluteii and hamstrings. Its contraction compresses the posterior elements of

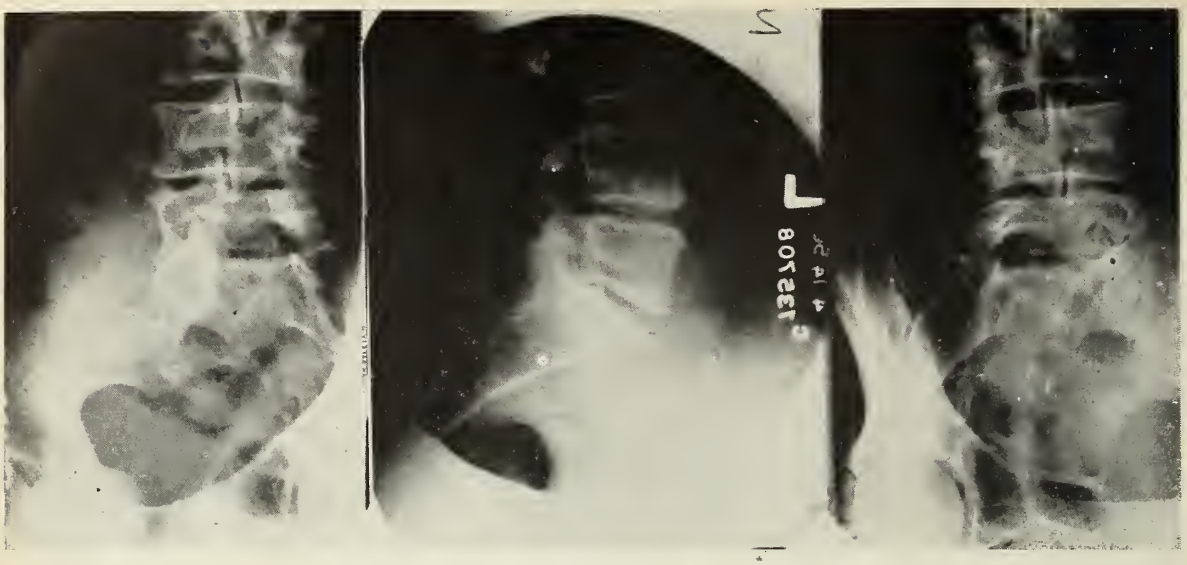


Fig. 6. Reduction of lumbosacral joint space. Facet overriding.

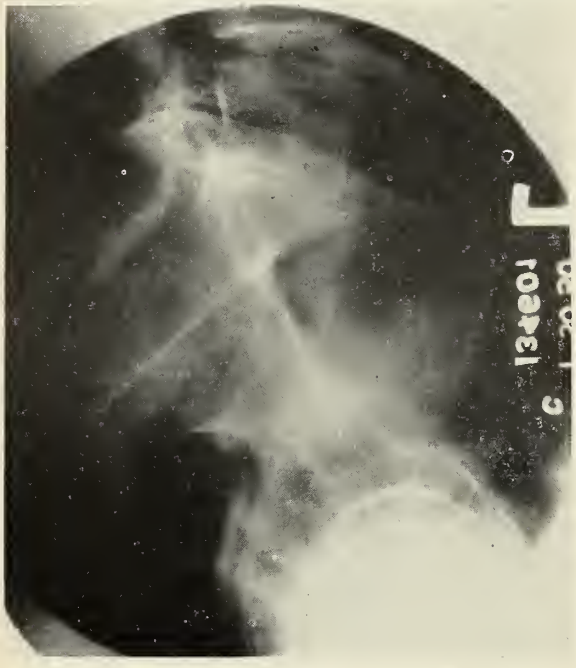


Fig. 7. Complete degeneration of lumbosacral disc.

the lower lumbar vertebrae with the maximum compressive force on the facets of the fifth lumbar vertebra and the first sacral segment.

The kinesiology is briefly illustrated in Figure 8. The pelvis rotates on the axis of the hip joints. The sacrospinalis maintains the veterbral column in the erect position by extending the lumbar spine. It is aided by the hip flexor group which from a fixed point in the low thigh and distal insertion, pulls downward from the anterior superior spine, tending to produce lordosis. Thus, the sacrospinalis and hip flexors are synergistic in producting lordosis.

The gluteus maximus from its insertion into the fascia lata and gluteal tuberosity tends to flex the lumbar spine by pulling downwards. The rectus abdominus aids this rotation by pulling the symphysis pubis upwards; thus, the gluteus maximus and rectus abdominus correct lordosis. A flexed lumbar spine with good abdominal tone and strong gluteii tend for good posture. Most adults in our present-day life will demonstrate an overdeveloped erector spinae, a relaxed abdomen and atrophied gluteal muscles.

A patient with severe muscle spasm should be put to bed. On the back, the erector spinae is in the position of rest. The bed must be firm to support the lower trunk and back. The knees are flexed. This is easily accomplished in the conventional hospital bed. In the home, boards placed longitudinally between the mattress and springs will serve well. Plywood is commonly used. Knee flexion may be accomplished by rolling two or three pillows firmly in a blanket, or utilizing a dresser drawer between the mattress and spring at knee level.

Sedatives and antispasmodics may be given freely. Local heat in the form of lamps, heating pad or moist hot packs aid in relieving pain and spasm. If physical therapy is available, one may hasten recovery from an acute bout of pain and spasm by the addition of massage.

When pain has decreased, the patient may begin stretching the sacrospinalis by grasping the knees in each hand; keeping the head and shoulders relaxed, the knees are gently and slowly pulled toabdomen do well with a firm canvas corset with paraspinal struts and an uplifting abdominal binder. Resistant cases, or those seen for the first time with a history of long duration and no specific

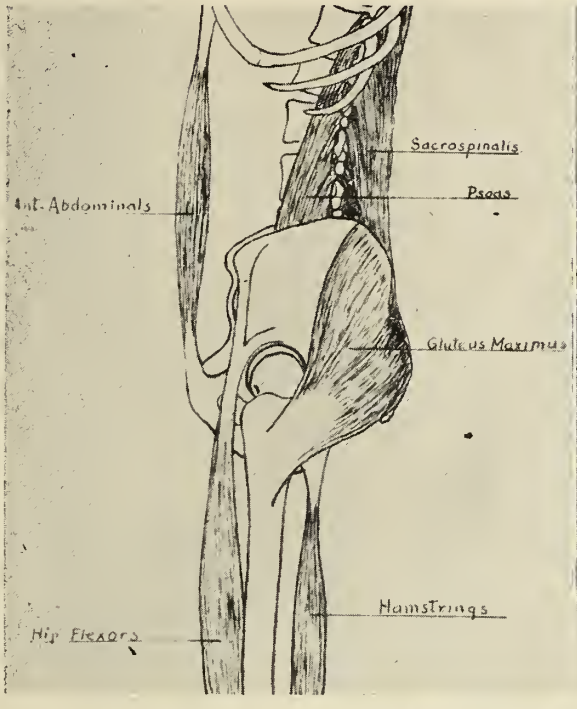


Fig. 8. Schematic drawing of muscles controlling posture.



Fig. 9. Note arching of low back. Elbows at level of umbilicus.

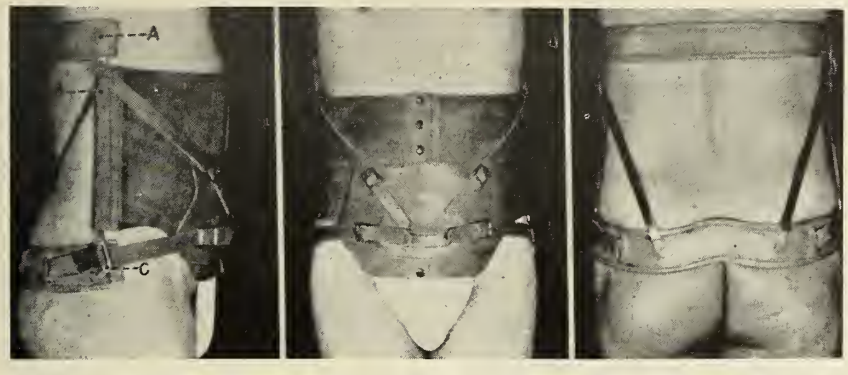


Fig. 10. Williams' lordosis brace. The brace is hinged at B, tightens at C to correct lordosis. It is stabilized against the rib cage at A.

ards the axillae, flexing the lumbar spine. As omfort allows, this maneuver can be practiced our or five times each hour, gradually increasing ie latitude of flexion. When the patient is ambunt, he is instructed in selective exercises and ostural correction.

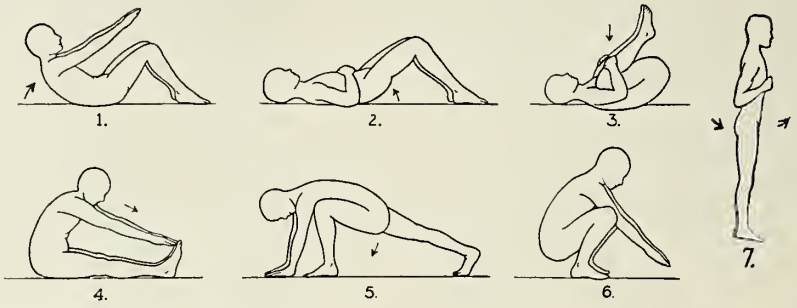
The various spinal supports may be prescribed seem necessary. Obese women with a redundant program, may do well in a plaster of Paris standing flexion cast (Fig. 9). The patient stands with the elbows resting on an appropriate support. The abdomen is retracted and the lumbar spine flexed. The plaster is applied from the third sacral level to aproximately the eighth rib. It is well molded about the iliac crests. On assuming the upright position, the buttocks are forced under the lumbar

spine, decreasing lordosis. Cut away the lower anterior portion of plaster to enable the patient to pursue his prescribed exercises. The cast may be bivalved at the end of the six or eight weeks. He may gradually divorce himself from this support and continue exercises.

Patients over forty-five years of age may need a permanent support. The Williams' lordosis brace will aid in affording support and limiting motion (Fig. 10).

It has been the practice of the group at Blodgett Memorial Hospital in the Orthopedic and Physical Therapy Departments to give the patient an exercise and instruction sheet (Figs. 11 and 12). Figure drawings and precautions are well received and seem to stimulate patients to follow the "prescription."

POSTURAL INSTRUCTIONS



Exercises should be taken on a padded floor.

Exercise 4 should be omitted unless otherwise instructed.

Start exercises by doing each one_____times morning and evening, increasing the series one a day until you are doing each one_____times morning and evening.

Exercises are essential in obtaining a proper muscular balance but a correct posture is acquired only through conscious effort.

Remember—

1. When standing or walking, toe straight ahead and take most of your weight on heels.
2. Try to form a crease across the upper abdomen by holding the chest up and forward and elevating the front of the pelvis.
3. Avoid high heels as much as possible.
4. Sit with the buttocks "tucked under" so that the hollow in the low back is eradicated.
5. When possible, elevate the knees higher than the hips while sitting. This is especially important when driving (driver's seat forward) or riding as a passenger in an automobile.
6. Sleep on your back with knees propped up or on your side with one or both knees drawn up. Bed should be firm.
7. Do not lift loads in front of you above the waist line.
8. Never bend backwards.
9. Do not bend forward with knees straight. Always "squat."
10. Avoid standing as much as possible.

Learn to Live 24 Hours a Day Without a Hollow in the Lower Part of Your Back

(Over) (after Williams)

Fig. 11. Face of exercise sheet.

The figures on the postural and instruction she are designed for specific muscle stretching an building. Exercise 1, back lying with the kne flexed, is designed to tone the rectus abdomini Exercise 2, lying on the floor with the knees flexe then raising the buttocks and keeping the lumb spine flat, thus rolling the pelvis, develops t

gluteii. Exercise 3, back lying knee axillary flexion, is designed to stretch the sacrospinalis and roll the lumbar spine into flexion. Exercise 4 is designed for hamstring stretching. Exercise 5 is designed to

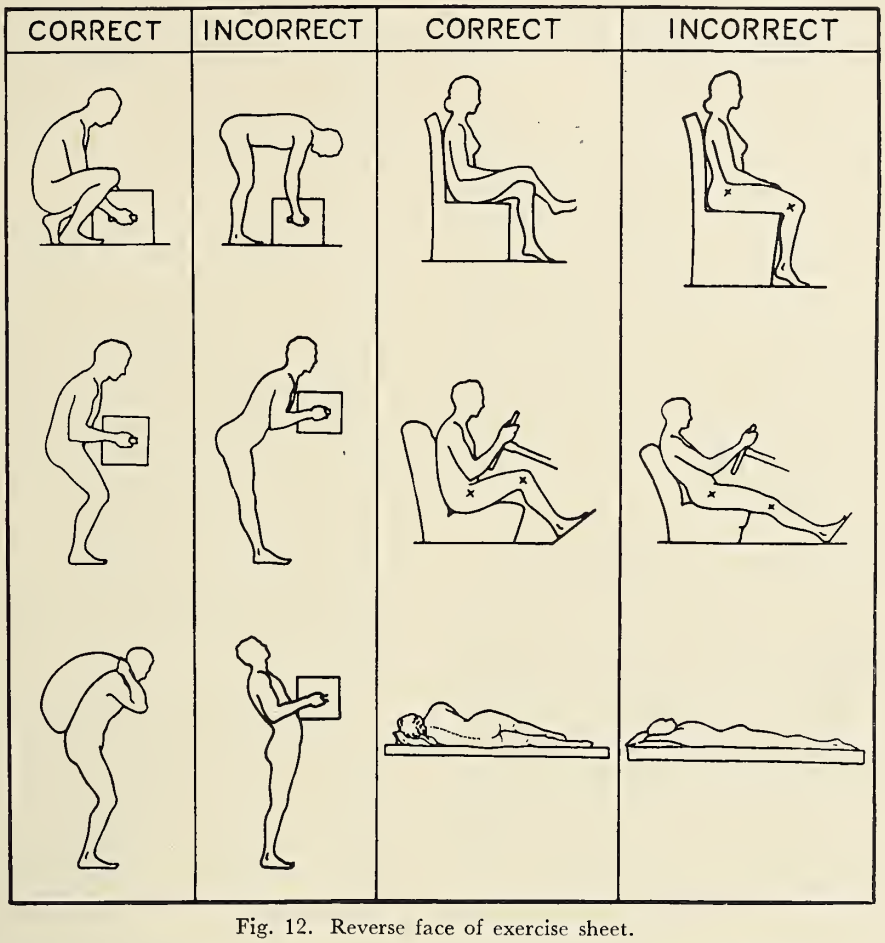


Fig. 12. Reverse face of exercise sheet.

stretch the hip flexors. Exercise 6, squatting exercise, is designed to roll and flex the lumbar spine. Exercise 7 is the standing pelvic roll, wherein the patient retracts the abdomen, contracts the gluteii and the rectus abdominis, rolls the pelvis into lumbar flexion and puts the buttocks up and under.

Conclusion

There is universal interest in low back pain problems. The principles of "rest, heat, and immobilization, followed by postural rehabilitation" are the essentials of a conservative regime. Probably some of us are remiss in failing to instruct patients properly in postural precautions and protective habits. The results of surgical procedures in large series of cases fall significantly short of the 100 per cent cure figure. It behooves us as practitioners of medicine to offer as complete a conservative program as possible and "carefully" evaluate the patient as well as his back before considering him a surgical candidate.

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Problems Relating to the Structure and Function of Joints

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THE INCREASING interest in rheumatic disorders has been accompanied by a similar expansion of interest in the physiology of connective tissue. Experimental studies of this tissue have for the most part been carried out in the basic science fields, and it is only within recent years that there have been any serious attempts to correlate this work with knowledge derived from the clinical fields. The pertinent literature, particularly that which deals with joints, has been covered in recent reviews[1,2,4,5,6] and no attempt will be made to duplicate it in the present paper.

Mechanical Features of Freely Movable Or Diarthrodial Joints

The main function of joints is so obvious that it is usually taken for granted and, indeed, often forgotten. Joints make it possible for muscles to translate their work into movement. Joints are the bearings and the transmissions of the living body. As such, they are particularly remarkable because the bearing and moving surfaces, made up mainly of articular cartilage, cannot be replaced to any significant extent in the adult and yet they can last for decades, or even a century. This does not mean that they show no wear. They do, because just like any moving mechanical system, joints are subject to friction and other forms of trauma. The resulting changes create difficulties which constitute a field of particular clinical importance. In order to illustrate this, it is necessary to discuss in some detail certain features of normal movement in joints.

Movement and Hydrodynamic Lubrication.—The articular surfaces of most joints are ordinarily considered to be closely fitting, particularly in the case of the so-called ball and socket joints. Actually, this is not the case, as even the most casual observation will demonstrate. It has been known for many years that joint surfaces are incongruous. The head of the femur, for example, does not fit the acetabulum perfectly. The condyles of the femur have quite different curvatures than do the condyles of the tibia. A model of a joint constructed so as to have perfectly fitting surfaces is not an accurate representation of that joint. This incongruity is of considerable importance in the normal functioning of a joint, particularly in hydrodynamic lubrication.[13,14]

Hydrodynamic Lubrication.—This is lubrication between moving surfaces, as distinguished from hydrostatic lubrication in which the surfaces are relatively at rest. The efficiency of any lubricant depends upon its ability to minimize friction. Hydrodynamic lubrication does this by shifting the effects of friction from bearing surfaces to lubricating fluid. In living joints it also provides a mechanism for supporting weight and transmitting force. Hydrodynamic lubrication is most efficient when certain conditions are fulfilled. These conditions are (1) incongruous bearing surfaces, (2) viscous lubricating fluid, and (3) a relative speed of surfaces.

1. If two plane surfaces, parallel to each other and separated by a film of lubricating fluid, are pushed toward each other, any resistance encountered is due to the fact that fluid is incompressible. A counter pressure actually develops, that is, a pressure which acts perpendicular to the surface and in a direction opposing the push. If one of the two surfaces is moved in a direction parallel to the other one, any existing perpendicular pressure is the result of gravity acting upon the upper surface. In addition, the lubricating fluid tends to be "pulled" or "dragged along" with the moving surface. This is because the fluid next to the moving surface actually sticks to that surface and therefore moves along with it, while the fluid next to the fixed surface sticks to it and therefore remains stationary. There is, therefore, a continuous gradation in rates of movement within the lubricant. One can express the result by saying that layers of lubricant are moving against each other so that friction acts against them rather than against the bearing surfaces. In the example cited, however, the perpendicular pressures are equally distributed throughout the lubricant and the mere weight of the upper surface tends to force fluid from between them. As a result, thi

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type of moving system is liable to "seizing" or "binding" as the bearing surfaces come in contact. Suppose, however, that the upper surface is so inclined that its trailing end is closer to the lower surface. This forms a wedge-shaped space filled with the lubricant. As the upper surface moves, lubricant is forced from the large part of the wedge back through the narrow part or apex. Since fluid is incompressible, a volume of fluid filling a large space cannot enter a smaller space without having an accompanying increase in pressure and rate of flow. The net result is that a very large counter-pressure appears at the apex of the wedge-shaped space. It is a pressure sufficient to support weight and resist thrust. The curvatures of the articular surfaces of practically all diarthrodial joints are such that, during movement, the surfaces are in potential contact at but one point. Here they are quite close to each other, perhaps but a fraction of a millimeter apart, but nevertheless still completely separated by a film of synovial fluid. Elsewhere the surfaces are more widely separated. Thus the incongruity of articular surfaces actually provides the physical conditions necessary for the formation of wedge-shaped spaces in which, during movement, counter-pressures can develop. The mechanism is so efficient that very thin films of synovial fluid may resist loads up to 1000 pounds per square inch.[11,12]

2. The more viscous a lubricating fluid, the greater is its ability to resist shearing forces. Normal synovial fluid is quite viscous, and it therefore fulfills the second of the conditions.

3. The third condition has to do with the rate of movement of a joint. When a joint is at rest, articular surfaces are actually in contact with one another so that when movement begins there is, for a short time, an actual rubbing of articular cartilages against each other. Provided the rate of movement reaches a certain critical value, hydrodynamic forces develop, counter-pressures appear and the articular surfaces become completely separated by a thin film of synovial fluid. Friction is minimal during this phase and is taken up mainly by synovial fluid. Comparable changes occur in the reverse order as movement slows down.

It is thus apparent that joints are extremely complex and that they are ideally constructed so as to minimize friction and at the same time support weight and transmit force.

Practical Considerations.—Unless one assumes that joints are immune to the laws of friction, there must be some wear and tear in joints, even during normal activity. Such wear and tear, or use destruction, has been known for many years and has been described in detail, as, for example, by Meyer.[15,16,17,18] The most common change is wearing away of articular cartilage, even to the extent of exposing, eroding and polishing underlying bone. This and other changes in joints, bursae and associated structures are frequently called osteoarthritis. This does not mean that osteoarthritis is solely the result of use destruction. It does mean that wear and tear resulting from normal activity can form a large part of what is ordinarily called osteoarthritis. Any moving mechanical system wears out with time, and human joints are no exception. Nor does one have to postulate a special factor due to age. Increasing age simply gives increasing opportunity for use. The degree and severity of use destruction in a given joint mainly depends upon the type of movement to which that joint was most heavily subjected during life. Of course, any additional pathological or senile changes within a joint will complicate and aggravate the picture.

Use destruction will be exaggerated by any alteration in joint surfaces which might result from trauma or disease. Likewise, any decrease in the viscosity of synovial fluid will be followed by an increase in friction.

It is beyond the scope of this paper to go into further detail. The main point is that a certain amount of wear and tear is to be expected as a result of normal activity. This wear and tear will be increased as a result of trauma or pathological processes so that the picture of use destruction will be superimposed upon the picture specifically due to the pathological change.

Synovial Tissue and Synovial Fluid

One of the characteristic features of freely movable or diarthrodial joints is that the inner surface of the joint capsule is lined by a connective tissue called synovial membrane or synovial tissue. This tissue is concerned with the formation of synovial fluid, the viscosity of which is one of the major factors in the lubrication of joints.

Structure of Synovial Tissue.—The structure of synovial tissue has been studied and reported on many times. Most of the recent papers and reviews emphasize the fact that it is a connective

tissue, basically similar to connective tissue elsewhere in the body. Connective tissue is comprised of formed elements such as cells and fibers, together with ground substance which, under the optical microscope, appears to be an amorphous substance which stains metachromatically with dyes such as toluidine blue. This ground substance is important because it is the primary site of involvement of many pathological processes, including rheumatic disorders.

The various kinds of connective tissue differ in their arrangement of formed elements and in the relative ratios of fibers and cells. They also differ in ground substance constituents. For example, some of the important substances in this material are mucopolysaccharides, of which at least five different kinds are known to occur.[19] One kind is hyaluronic acid, a sulfate-free type found in synovial fluid, vitreous humor, umbilical cord, skin and in certain tumors but not in hyaline cartilage. Other mucopolysaccharides are sulfate-containing and are found in a variety of tissues, including cartilage. There is as yet no accurate way of distinguishing these substances microscopically. Chemically, they all have certain characteristics. They are complex, asymmetric, long-chain compounds of high molecular weight which form viscous sols or even gels. They are attacked by a variety of enzymes, generally called hyaluronidases or spreading factors. It is likely that some type of precursor, such as a basic disaccharide, is formed elsewhere, brought to the connective tissue by the blood stream and there bound together or polymerized into a more complex compound by connective tissue cells. This entire process, about which little is known in detail, represents part of the group of changes comprising intermediary metabolism. Many phases appear to be under the control of the pituitary-adrenal system.

Synovial tissue is a connective tissue modified so as to have a relatively smooth surface lining the joint cavity. A variable number of folds and villi project from the surface. The tissue contains different types of cells which have no consistent arrangement and which, with ordinary staining methods, are indistinguishable from connective tissue cells elsewhere. In addition to cells and fibers, there are blood vessels, lymphatics and a few nerves. If there is any morphological feature which characterizes this tissue, it is its rich blood supply which forms an extensive capillary network directly adjacent to the joint cavity. The similarity of this tissue to other connective tissues is stressed by the fact that if synovial tissue is removed it can be reformed from underlying connective tissue.

Synovial Fluid and Mucin.—Synovial fluid is really a liquid ground substance formed from the blood flowing through synovial vessels. Studies of synovial fluid in man have been made almost solely upon material obtained from the knee joint.

One of the characteristic features of synovial fluid is its sticky or viscous nature. This is due almost entirely to hyaluronic acid which, when precipitated with acetic acid, forms what is called a mucin. This is quite different from mucins of epithelial origin, and the ordinary mucin stains do not affect any of the mucopolysaccharides. Aside from its mucin content, synovial fluid is a filtrate or dialysate of blood plasma, that is, most of the constituents diffuse from blood through connective tissue into the joint cavity. Synovial fluid also contains a few cells which are derived from the lining tissue. They are mainly mononuclear and reflect the cytology of synovial tissue. Pathological processes affecting synovial tissue naturally alter the cellular content.

The presence of hyaluronic acid in synovial fluid cannot be explained on the basis of filtration. As mentioned above, all mucopolysaccharides, hyaluronic acid included, are probably formed by the linking together or polymerization of basic units. This implies that actual work is done by connective tissue cells. The viscosity of hyaluronic acid is dependent mainly upon polymerization. Any of the enzymes which attack these compounds first break down the intramolecular linkages without actually affecting the chemical structure. This depolymerization is accompanied by a very severe loss of viscosity. Thus, in some of the rheumatic disorders, synovial fluid contains what appears to be a normal amount of mucin but it is really an abnormal mucin, not as highly polymerized, so that it is more watery.

On the basis of present information, it must be admitted that the essential mechanisms in the formation of hyaluronic acid are unknown. So far as functions are concerned, synovial fluid provides the necessary viscous lubricating fluid. A number of other secondary functions have also been ascribed to this fluid. It is said to aid in the nourishment of articular cartilage. It may, but certain factors indicate that other means are also available. For instance, the ground substance o

cartilage is a sulfate-containing mucopolysaccharide, chondroitin sulfate A, but no sulfate groups of any significant amount have ever been found in synovial fluid. These groups must come from elsewhere, perhaps from perichondral or adjacent medullary vessels. Synovial fluid may also be concerned in water transfer because the mucin has a high water-binding capacity. Changes in this property may be factors in the production of watery joint fluids or effusions.

General Considerations.—There are two major features of joints which are of both academic and practical significance. One has to do with joints as functioning mechanical units which show wear and tear as a result of use. Secondly, joints contain an important type of connective tissue which is primarily responsible for the production of a lubricating fluid and which is subject to the same endocrine and metabolic control and to the same types of disorders as are other types of connective tissues.

One of the major difficulties in studying connective tissue has to do with the difficulty of devising adequate methods of investigation. There is no need to go into detail regarding the many research programs involving connective tissue. The majority concern mainly the clinical and therapeutic aspects. In basic science fields the methods of study are extremely varied, encompassing, for example, chemistry, histology, embryology and others. One of the fruitful fields has to do with the study of connective tissue in the embryo, when it is in the process of formation. For example, histochemical studies of hyaluronic acid might profitably be carried out when this substance is first appearing, that is, when cavitation is just starting in embryonic joints. But before this can actually be done there must be an accurate knowledge of the normal developmental processes. There is under way in the Department of Anatomy at Wayne University a study dealing with normal development of joints. It might be well, in the process of presenting preliminary results, to outline some of the basic mechanisms in joint development.

Development of Diarthrodial Joints

The available evidence indicates that the processes of development are basically similar in all forms so far studied, including amphibian, avian and mammalian material. Nevertheless, certain features pose a number of difficulties, especially those pertaining to embryonic age or degree of development. Without going into detail, the difficulties can be illustrated by pointing out that two human embryos at comparable stages of development can differ in crown-rump length by as much as 100 to 150 per cent. As a corollary, one cannot assume that two embryos of equal crown-rump length are necessarily comparable in the degree of either external or internal development.

The development of human joints has been described in detail in recent papers[3,7,8,9] and the findings reported illustrate certain important processes. In brief, the initial development of joints is rapid and a form and arrangement resembling that of the adult is reached before the embryonic period is over, that is, by approximately the seventh week of intra-uterine life. This is an extremely rapid process, it being estimated that the total time from the first indication that joint formation is under way until all nerves, ligaments, muscles, tendons, et cetera, are present, may be no more than a few days.

All joint components, such as ligaments, develop *in situ*, that is, in the same relation they will occupy in the adult. Thus, while it is commonly held that the cruciate ligaments of the knee form posteriorly and then migrate inwards to reach their position between the condyles, this actually never happens. When the cruciate ligaments can first be recognized, they are in the same relative position they will occupy in the adult.

There is no phylogenetic recapitulation in development, that is, there are no stages in which there are structures resembling those normally present in adult lower forms. Thus, while it is often stated that the menisci of the knee joint pass through a stage of development in which they have a discoid form resembling that of menisci found in certain adult reptiles, this does not normally occur. This lack of phylogenetic recapitulation is true of all species so far studied. Development proceeds from an initial, relatively indifferent form directly to the characteristic, genetically determined adult type form.

Cavitation does not begin until initial articular form is well established and even then, in the case of smaller joints, it may be delayed. When it does begin, it proceeds very rapidly and apparently involves the breakdown of connective tissue, perhaps by enzymatic processes. Within a short time the

lining tissue is structurally similar to that of the adult. The beginning of cavitation is a very important stage, at least in the larger joints, because it marks the increasing deposition of collagenous fibers, the growth and maturation of the joint, including the subsequent formation of a number of intra-articular structures, such as synovial villi.

Although the chick embryo is widely used in experimental and morphological embryology, there are, surprisingly enough, no accurate studies of the development of joints. O'Rahilly[20] has recently found that the early differentiation of synovial joints in the chick embryo resembles that described in the human embryo. He has correlated the microscopic appearance of developing joints with the external staging devised by Hamburger and Hamilton[10] and has found that the joints resemble the adult in form and arrangement before cavitation actually is well under way. Cavitation begins peripherally in the knee joint by stage 35 (approximately 8 to 9 days after fertilization) and is fairly exact in onset. By selecting stage 35 on the basis of external features, one can be reasonably sure that cavitation is just under way. There is, therefore, no necessity of actually sectioning joints for microscopic study in order to determine this point. This is important, because in view of the improbability of being able to carry out chemical and histochemical studies on human embryos, lower forms must be used. If it is necessary to collect a large number of chick embryos so as to analyze chemically the joints at a specific internal developmental stage, it is now possible to select that internal stage on the basis of external characteristics. Thus the morphological bases for chemical and histochemical studies are fairly well established for the chick embryo. A comparable study of joint development and embryonic staging in mammals is now under way.

It should be emphasized that the findings cited above pertain to the larger diarthrodial joints, such as the knee and hip. There have been few, if any, complete studies of smaller joints in any species. There have been relatively few experimental investigations of joint development. Undoubtedly these will be forthcoming. They will have to be because many of the problems pertaining to joints can be solved only by embryological investigations. This is especially true as regards the genesis of connective tissue.

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MSMS

IN FOREIGN LANDS

In recent crucial elections
90% of Belgians VOTED
89% of Italians VOTED
82% of Englishmen VOTED
70% of Japanese VOTED

BUT IN THE U. S. A.

51% of Americans voted in the last presidential election!

LET'S BE 100% AMERICANS
LET'S REGISTER
and
LET'S VOTE!

Application of Ultrasonics in Chronic Rheumatic Diseases

By Max K. Newman, M.D., and
Alma J. Murphy, Ph.D.
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THE STRESSES and strains of our industrial civilization have engrafted on the musculoskeletal system a terrific traumatic burden, resulting in varying degrees of breakdown of the muscles, nerves and osseous tissues. The prolongation of life through the magnificent development of medicine, surgery and miracle drugs has produced a further stratum for degenerative changes. As we well know, fully eight million individuals are affected in varying degrees by rheumatic changes, so that it is not uncommon to find tremendous surges of the populace toward methods of control, relief and cure. Witness the recent fiasco of large sums of money being expended for the privilege of sitting a mile below the ground in so-called radioactive contaminated atmosphere, and then finding occasional individuals being relieved of their rheumatic complaints.

Our problem is one of evaluation as well as discussion of a new therapeutic agent in the management of rheumatic states. It was not uncommon during the height of steroid exuberance; many claims were made in both scientific and lay publications as to the curative qualities of cortisone, ACTH, dihydrocortone and the like. However, through the years, physical medicine and rehabilitation, in conjunction with various drugs, procedures and methods, have consistently achieved the objectives of improvement of rheumatic states. We believe that it is most appropriate at this time to present a physical agent, namely high frequency sound, or ultrasound, as an adjunct physical method in the therapeutic management. It is not to be considered as the sole modality with the exclusion of general management, but rather to show its scientific application in these disturbances of the collagen system.

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Physical and Physiologic Aspects of Ultrasound

Well known to the medical profession is the use of various segments of the electromagnetic spectrum in clinical application, i.e., radiant heat, diathermy and ultraviolet. Especially used is roentgen therapy. In a similar manner, ultrasound, a mechanical wave produced by vibrations of specialized apparatus, is transmitted through solid or liquid media, and produces a physical and physiological effect. It is not the purpose of this paper to go into adequate details of ultrasound, but suffice it to say that it is produced by an apparatus similar to a short wave diathermy. A pizoelectric crystal is cemented on an applicator head, called a transducer, and is made to vibrate by rapidly alternating current to produce vibration of the frequency of one megacycle. The ultrasound energy is conveyed to the body by the transducer through a solid or liquid medium, reproducing the wave within the tissue. The noted effects are cavitation (which is the compression and rarifaction of component particles producing an intermolecular strain, resulting in splitting of the media, producing cavities which collapse and add further vibrations causing physical changes); mechanical effects of dispersion and aggregation; thermal effects—most important in therapy; chemical effects (influencing oxidation, luminescense and depolymerization); biologic effects; physiologic effects (such as analgesia, hyperemia, increased cell permeability, vasodilatation and vasoconstriction, relaxation of muscle spasm, et cetera).

Literature

Most of the early literature on the medical application of ultrasonic waves originated in Europe. In a surprisingly short time the foreign medical literature became filled with exaggerated and uncritical claims and assertions concerning the benefits and cures made possible with ultrasound. It is not the purpose of this paper to review the entire field published on ultrasonics, but to present some of the more recent foreign and domestic publications pertinent to the field of rheumatic diseases.

Hintzelmann[6] presented a review of 347 patients with lesions of the vertebral column that were treated by ultrasonics. The findings were those of increased mobility of the vertebral column and a definite analgesic effect. In 1948, Buchtala[3] added another small group of arthritic patients to the increasing numbers of treated cases. Good results were reported when arthritic extremities

were treated. He also felt that the analgesic and thermal effects were predominent but that the neural effects on terminal neurons were also worth examination. The treatment of spondylosis deformans with ultrasound was reported by Demmel.[4] proved in those cases of rheumatic diseases of a less chronic nature in which bony anklyosis and severe deformities have not occurred. Most of the literature published in this country has been of a laboratory research nature and has uncovered some

TABLE 1. EFFECT OF ULTRASONIC ON RHEUMATIC DISEASES

Disease	No. Cases	Swelling	Tenderness	Stiffness	Motion	Pain	Comment
Rheumatoid Arthritis	4 Wrist	2—▼	2—▼	4—O	2—▲	2—▼	Temporary improvement (2)
		2—O	2—O		2—O	2—O	No response (2)
	2 Elbow	2—O	2—▼	2—▼	2—▲	2—▼	Asymptomatic (2)
	8 Knee	6—▼	8—O	6—▼	6—▲	6—▼	Fair to good response (6)
		2—O		2—O	2—O	2—O	No response (2)
Osteoarthritis	5 Fingers	5—▼	5—▼	5—▼	5—▲	5—▼	Good response (5)
	4 Knee	2—▼	2—▼	2—▼	2—▲	2—▼	Good response (2)
		2—O	2—O	2—O	2—O	2—O	No response (2)
Epicondylitis	9	3—▼	6—▼	None	No	5—▼	Cured (1) Dramatic relief (4)
		6—O	3—O	Present	Limitation	2—O	Slight response (2)
						1—▲	No response (2)
Bursitis	11	8—▼	7—▼	7—▼	7—▲	7—▼	Non calcified bursae all relieved (3)
		1—▲	4—O	4—O	4—O	4—O	Calcified bursae
		2—O					2 Cured
							2 Good
							2 Fair
							2 No results

▲increased
O no change
▼decreased or reduced

His good results were dependent upon the selection of the younger patients. Senile kyphosis, if not too chronic, also responded well to ultrasound with its analgesic effects. Scholtz[8] reported on the effects of sound waves on periarthritis humeri and spondylarthritis and was able to produce considerable relief of pain. However, in ankylosing joint processes the results were very poor. Fuchs and Buchtala[5] in 1949 again reported on the ameliorative effect following sonic therapy of periarthritis, polyarthritis, arthrosis, and arthritis deformans. They report improvement in 80 per cent of all cases treated, but express concern when the cervical ganglion of cardio-labile patients are treated with ultrasonics. In the treatment of osteoarthritis and other rheumatic diseases of joints, Bauer[1] feels that the use of sonic waves should not be started until the blood sedimentation rate returns to about normal and lists a number of rheumatic diseases that have been shown to respond well to sonic treatment. In 1952 a symposium was published in England that included reports from Bauer, Buchtala, Tchannen and Theo de Preux.[2] These men, writing under their separate titles, seem to feel that pain is decreased, joint function is increased, and the gait pattern is improved in those cases of rheumatic diseases of a less chronic nature in which bony anklyosis and severe deformities have not occurred. Most of the literature published in this country has been of a laboratory research nature and has uncovered some interesting findings.[7] Ultrasound waves are capable of destroying young bone cells and causing necrosis of the spinal cord, skin, or nerve fibers. However, no specific selective effect on tumor cells has been demonstrated, contrary to the European literature.

The following report is an evaluation of the effects produced by ultrasonics when applied to rheumatic states. A random selection of patients was made so as to utilize the therapeutic possibilities of ultrasound in the management of rheumatic states. The reasons for this selection were that all patients were ambulant, easily accessible, and had failed to respond to routine measures.

Method

The apparatus used for the treatments was an ultrasound generator of 3.5 watts per square centimeter output, with a frequency of one megacycle. The transducer or sound head was slowly moved over the area to be treated, with a film of lanolin spread between the head and the joint areas. In this manner very little loss of energy occurred. A treatment would require twenty minutes of continuous application, with an intensity of 2.5 to

watts/cm.^{2} An average of three treatments was given per week for a period of one month. During treatment it was noted that a hyperemia occurred, with some edema of the tissues if the intensity was too great. No burns or paralysis resulted.

Previous to treatment, a routine history and physical was done. Laboratory work is not included in this report. Diagnosis was based upon examination, x-rays and findings of the involved areas. The groups consisted of: (1) rheumatoid arthritis, fourteen patients (divided into wrists, elbows and knees; (2) osteoarthritis, nine patients (divided into finger and knees); (3) epicondylitis, nine patients; (4) bursitis, eleven patients (eight showed calcifications in the subdeltoid area).

Results

In all observations, the effects on swelling, tenderness, stiffness, range of motion and pain were noted (Table I).

In rheumatoid arthritis, it was found that four patients with wrist involvement showed two temporary improvements and two failures. Both patients with elbow involvement became asymptomatic. In the knee involvements, six patients showed fair to good response, and two patients were failures.

In osteoarthritis, all patients (five) with heberdens nodes showed a good response (not morphologically). Two patients with knee involvement showed a good response, and two patients were failures.

Epicondylitis is characterized by pain at the epicondyles when the fingers are forcibly flexed. It seems to occur in athletes, machinists, stenographers and housewives, and cannot be diagnosed by x-ray alone because of negative findings. Of the nine patients treated, one was cured, four showed a good response, two showed only slight improvement and two showed no improvement. This syndrome is usually quite stubborn to therapy and frequently requires long immobilization to effect a recovery.

Bursitis, a form of periarthritis of the shoulder, had eleven cases. Three cases of non-calcifications all cleared during therapy. This might be expected since the grinding and traumatic effects of the foreign body is not present. Eight cases with calcification showed: two cured (of symptoms and signs), two good results, two fair results and two failures.

Comment and Conclusions

The use of ultrasound as a standard method or procedure must be undertaken with caution. Severe damage of tissue, bone, peripheral nerves, generative tissue, hair follicles and growing bone and tissues may occur with the application of high intensities. However, penetration and beaming are excellent, with good absorption in muscle rather than fat, making a case for localized heating. Nevertheless, these dangers are not too apparent with the present types of instruments that have been developed. There is also danger from the reflective qualities of ultrasound causing localized heating of muscle-bone interfaces, and care must be used in treating bony prominences. At the present time, dosage is determined by pain sensation and excludes the treatment of parethetic areas.

The efficacy of ultrasound as a therapeutic adjunct to the treatment of rheumatic diseases is limited by the still undetermined dose to be used on each type of case, the immediate presence of the therapist or physician in the application of the modality, the high cost of the apparatus, and the necessity for a selection of cases that would benefit from the procedure. Perhaps from a practical standpoint, because of the coupling effect, the therapist must be constantly present, providing a distinct disadvantage. It is a fact that the values derived from the thermal qualities of ultrasonic therapy are those similar to the application of local heat, local joint injections, immobilization or other medical measures available to the practicing physician. However, it may be stated that there is inherent value in the use of this physical modality in the control of pain associated with rheumatic states. Where morphological change of tissue is present, the results are attenuated. The degree of improvement noted with ultrasound is similar to that of other medical and physical procedures, and it forms again a valuable addition to the therapeutic armamentarium of the physiatrist.

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Protrusion of the Intervertebral Disk

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IT IS but within recent years that the medical profession has become cognizant of the existance of a clinical entity known as "the slipped, or protruded, intervertebral disk." Up to that time, the origin of many so-called sciaticas had remained obscure, or were relegated to the general category of "rheumatism," of which there were numerous and sundry manifestations. The conscience of the physician was fully appeased when he applied the term "sciatic neuritis" to the malady of the patient suffering from pain in the leg. Little effort was made to differentiate between the primary neuritides and the secondary, or reflex, neuralgias. The appearance of the disk-concept upon the medical horizon revolutionized the physician's attitude toward this all-too-common complaint of "pain in the leg," and led to many a cure which was hitherto unthinkable. For, if we can apply the elusive term "cure" to any therapeutic procedure, the relief following appropriate treatment for protruded intervertebral disk justifies that application. In few other maladies are cause and effect so intimately related.

History.—Prolapse of the intervertebral disk was first described by Luschka in 1858. Kocher, in 1896, called attention to injury of intervertebral disks. Dandy, in 1929, described a prolapsed cartilage simulating a spinal cord tumor. Later Goldthwait, Middleton, and Teacher identified the protrusions as being nuclear material. In 1934, ruptured intervertebral disk was described by Mixter and Barr as a clinical entity. Since then, many others have added observations and details which establish ruptured intervertebral disk as a common cause of low backache and sciatic pain.[2]

Anatomy.—The intervertebral disk consists of an elastic fibrocartilagenous envelope, called annulus fibrosus. Within it is contained the nucleus pulposus, a mucoid or gelatinous mass. The elastic disk with its contained nucleus is attached above and below to the vertebral bodies by cartilagenous plates.

Pathology.—As a result of either attrition, degeneration or trauma, the cartilage tears. This forces the nuclear material to the periphery of the annulus. A bulge at this point develops in the posterior circumference of the disk. The bulge, due to pressure of the nuclear material, in turn causes pressure against the posterior ligament, which is strongly attached to the posterior wall of the vertebral bodies. The ligament, due to its firmness and strength, usually forces the bulge laterally, causing pressure upon roots as they descend in the spinal canal. This is responsible for the sciatic pain. In over 90 per cent of cases, this protrusion occurs at the fourth or fifth lumbar interspace.

Symptomatology.—In the great majority of cases, there is low backache, with unilateral sciatic extension; there is accentuation of pain on coughing, sneezing and straining; a variable degree of paresthesia may be present; there is a history of trauma in at least 50 per cent, and a history of remissions and exacerbations in over 75 per cent, of the cases.

Physical Findings.—The characteristic findings are: spasm of the lumbar muscles, with limitation in motion in this region; diminution of the normal lumbar lordosis; limitation in straight leg raising; a positive Lasegue sign (pain in the back of the thigh or near the sacro-sciatic notch on extension of the knee, after the hip joint has been fully flexed); sciatic scoliosis in about one-third of the cases; and diminished or absent Achilles reflex.

Roentgen Findings.—Suggestive findings include narrowed intervertebral joint spaces, osteophytes, sciatic scoliosis, obliteration of normal lordosis, and the occasional finding of a Schmorl nodule (deposition of calcium in the body of a vertebra). The presence, however, of a protruded intervertebral disk can be demonstrated by a lipiodol x-ray, which makes such finding pathognomonic of this condition.

Laboratory Findings.—The most important laboratory finding is an increase in the protein content of the spinal fluid.

Treatment.—When, after a careful history, physical examination, x-ray and laboratory confirma-

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ion, a diagnosis of protruded intervertebral disk has been made, one is justified in giving a conservative regime a trial, for a limited period of time. Among the conservative measures to be instituted are: rest in bed on a firm mattress, with the use of fracture boards between mattress and spring; traction to the affected leg, using 5 or 6 pounds of weight, with the extremity in about 15 degrees flexion and the same amount of abduction of the hip joint; analgesics; local heat and sciatic nerve block. When the patient is ready to get up, he should be fitted with a low back support. In many cases the above regime may be sufficient to allow the patient to carry on in comparative comfort. However, should conservative treatment prove unavailing, one should resort to surgical removal of the protruded portion of the disk. The results following laminectomy are almost 100 per cent effective. "The entire group of fifty-eight patients were immediately relieved of pain in the leg following operative removal of the ruptured disk."[1] Love and Walsh reported only two hospital deaths and five recurrences in a series of 500 patients operated on.[3] Barr and Mixter reported good results in 80 per cent of patients, fair results in 10 per cent, and poor results in the remaining 10 per cent.

Case Reports

In the past six years, we have had occasion to observe and follow six cases of protruded intervertebral disks, verified by lipiodol x-ray, four of whom underwent surgery, and two were treated conservatively. We shall report them in the order of their occurrence.

Case 1.—M. H., a man, aged forty-two, first seen April 3, 1946, complained of pain in the left sacroiliac region, with radiation down the left leg. He gave a history of having fallen off a horse sometime previously. He had been told he had herniation of the disk, although x-ray confirmation was lacking. He made moderate improvement after the application of adhesive tape to the lower back, bed rest, and the injection of procaine in the under sacroiliac region. The improvement, however, was not sustained, and he was eventually operated on, with complete recovery. Six years later, he was still free from pain.

Case 2.—T. S., a woman, aged forty, was seen February 10, 1949, with pain in the right leg, of eight weeks' duration. Conservative treatment with heat, salicylates, and procaine injection in the sacroiliac spine were unsuccessful. Flat plates of the pelvis revealed a mild lumbar scoliosis, with some assymetry in the lower sacral region, and a thinning of the disk between the fifth lumbar vertebra and the upper sacrum. She was hospitalized and a lipiodol x-ray made, which revealed a definite protruded intervertebral disk. Laminectomy was performed on March 4. The pain in the leg disappeared the next day, and on March 10 she was discharged, fully recovered. Three and a half years later, the pain had not recurred.

Case 3.—H. S., a woman, aged thirty-six, first seen on May 5, 1949, complained of pain in the left sacroiliac region and left leg, of five months' duration. She was a mild diabetic. Procaine into the sacroiliac area, sciatic nerve block, and typhoid vaccine intravenously failed to give more than transient relief. At the University Hospital, where she was referred, a prolapsed disk was demonstrated. Control of the diabetes and a well-fitted support relieved the pain considerably, and the patient has been fairly comfortable, without an operation, up to the present time.

Case 4.—On April 21, 1949, M. S., a woman, aged thirty-three, was literally carried into our office, with severe pain in the lower spine and right leg, of one week's duration. A similar condition existed four years previous to this attack, and also one year ago, the latter attack lasting about one month. There was pronounced sciatic scoliosis, tilting of the pelvis, shortening of the affected leg, and marked tenderness on pressure over the sacroiliac and lumbrosacral joints. Straight leg raising was painful. The Lasegue test was positive. The pain was so severe, the patient had to be taken by ambulance directly to the hospital. Flat x-rays revealed semisacralization of the fifth lumbar vertebra, asymmetry of the lumbrosacral segments, and irregular synchondrosis and synostosis between the fifth lumbar vertebra and the sacrum. A myelogram revealed a protruded intervertebral disk, predominantly midline and on the right, at the intervertebral space between the fourth and fifth lumbar vertebra. On April 30 she had a laminectomy, and on May 2 was completely free from pain. On May 7 she was discharged from the hospital fully recovered.

Case 5.—T. H., a man, aged fifty-eight, consulted us on March 6, 1950, for pain in the left leg, of five weeks' duration. He gave a history of sustaining an injury to his back on January 31, while lifting tires. The pain was aggravated by coughing, sneezing, straining, and bending. There was an absent Achilles reflex on the left. He was treated with physiotherapy, salicylate, nerve blocks, and was moderately improved for about nine months. He returned on Fabruary 1, 1951, with a recurrence of the pain in the left leg. Three more sciatic nerve blocks failed to relieve the condition, whereupon he was hospitalized and a myelogram done. The results were nonconclusive, as "the caudal sac ended at a high level." Because of the classical symptoms and clinical findings, however, the patient was operated on, March 1, and a herniated disk was removed at the fourth lumbar interspace on the left side. Following the resection, the patient made a very satisfactory recovery, and has been free from pain ever since.

Case 6.—J. S. D., a man, aged forty-eight, was seen on May 23, 1952, at his home, with severe pain in the left leg. He was a moderate alcoholic, and gave the impression of suffering from alcoholic neuritis. However, he was not relieved by thiamine and procaine nerve block, and was hospitalized on May 26. He was seen in consultation with a neurosurgeon, and a diagnosis of protruded intervertebral disk was made. Leg traction was applied and continued for several days. The condition improved somewhat, and the patient was advised to obtain a sacroiliac belt, and continue under observation.

The above reports illustrate the satisfactory results that follow laminectomy for protruded intervertebral disk, and the improvement that sometimes follows conservative regime, although it is impossible to predict the duration of such improvement, as many cases have spontaneous remission of the symptoms, probably due to regression of the nucleus pulposus and release of pressure upon the lumbosacral plexus. It is for this reason that a long period of observation is essential, and that surgery may eventually have to be resorted to.

Differential Diagnosis

Since, as stated above, protruded intervertebral disk constitutes only one of the causes of sciatic pain, it may not be amiss to consider the other conditions in which sciatic pain is an original or complicating factor.

Among the most common causes of sciatic pain are: lumbosacral or sacroiliac strain, with reflex sciatic radiation; arthritis of the spine; fibrositis of the posterior sacroiliac ligaments and gluteal region, often with spasm of the muscles; spasm or irritation of the hamstring muscle (from arthritis, sacroiliac disease, et cetera); increase in weight, faulty posture with exaggeration of the normal lumbosacral angle, flat feet, knock knee, neoplasm of the spine, et cetera.

Other causes of sciatic pain include diseases of the pelvic organs (inflammation or tumors of the prostate, rectum, uterus or ovary); constitutional disease (syphilis, diabetes, pernicious anemia, vitamin B deficiency, alcohol or lead poisoning); lesions of the spinal cord, meninges or cauda equina, thickened ligamenta flava; spondylolisthesis; arthritis of the hip; contracted fascia lata or iliotibial band; late stages of pregnancy (from pressure); exposure to cold or dampness; congenital abnormalities of the lumbosacral joint, and psychoneurosis.

It is apparent, therefore, that the discovery of the cause of sciatic pain is not a simple process. A thorough history must be taken, with special stress on traumatic onset and remissions of symptoms. Physical examination must include search for infected foci, diabetes mellitus, perineuritis from metallic poisoning, pelvic and abdominal pathology, et cetera. A rectal examination should always be done (to rule out tumor of the prostate); also a complete blood count, urinalysis and Kahn test; orthopedic and neurologic examinations; finally, roentgen examination of the lower spine and pelvis, and lipiodol x-ray, if a protruded intervertebral disk is suspected.

To rule out reflex sciatic neuralgia from sciatic neuritis, a 1 per cent procaine hydrochloride solution is injected at the site of tender "trigger points" in the low back. In reflex sciatic neuralgia, the pain in the leg temporarily disappears.

Treatment of Sciatica due to Other Causes than Protruded Intervertebral Disk.—It is obviously impossible to establish a specific routine for a condition which has so many varied causes. The primary consideration is to find the original cause of the sciatic pain. Possible causative factors, such as diabetes, syphilis, alcoholism and vitamin B deficiency should be treated specifically. Pelvic pathology—inflammation or tumor of the prostate, rectum, uterus or ovary—should be eliminated. Traumatic or infectious conditions of the lumbosacral or sacroiliac joints, fibrositis of the lumbar muscles with sciatic radiation should be treated by adequate support, rest in bed on a firm mattress, and if necessary, with boards between the mattress and the spring, with local heat and traction. Analgesic—aspirin, phenacitin, and codeine—should be used as needed. Local infiltration of "trigger points" with 1 per cent procaine or sciatic nerve block give symptomatic relief, which at times may last over a long period of time. X-ray irradiation over the lumbosacral region or over the distribution of the sciatic nerve may prove of benefit in some cases.

Technique of Sciatic Nerve Block.—With the patient in Sims position and the leg to be treated uppermost on the table, a line is drawn connecting the posterior superior spine of the ilium with the upper border of the greater trochanter. Midway on this line a one-and-a-half inch line is dropped perpendicularly downward. At the end of this line a wheal is made by intradermal injection of a

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Investigation of Steroids in Postpartum Plasma

By E. B. Smith, Ph.D., and
Hugo A. Freund, A.B., M.D.
Detroit, Michigan

AT THE MEETING of the American Rheumatism Association in 1951 Granirer[1,2] recited his experiences with the use of "postpartum plasma in suitable amounts" in the treatment of rheumatoid arthritis. At that time, he reviewed the previous favorable results which were first announced at the International Congress on Rheumatic Diseases in 1949. Because these effects were not universally observed by others who had followed this method of treatment, it seemed desirable to fractionate postpartum plasma and try to find the component that might be responsible for the reported clinical improvement. Chiefly because of the work on cortisone, corticotropin and other steroids, it was thought that the active component might be of steroid nature. Such a search for the presence of the specific substance in increased amounts during pregnancy seemed justifiable because, as Hench[3] has said, "Despite the clinical efficacy of corticotropin, cortisone and hydrocortisone, it remains to be proved to what extent, if any, these particular hormones are responsible for the antirheumatic effects of pregnancy and jaundice."

Methods

The steroid fraction from blood and urine was separated by dialyzing[4] the sample against 0.4 per cent sodium chloride, then concentrating the dialysate in the desivac. The concentrated material was then hydrolyzed by adjusting to a pH of 1 to 2 and autoclaving at 15 pounds pressure for two hours. The hydrolysate was extracted with ether and the chromatograms for the component steroids developed according to the method of Zaffaroni[5] et al. The procedure was as follows: The steroid was incubated with Girard's T Reagent at 38° C. for two hours. The spot was then placed on the paper and developed with a water saturated solution of butanol. The color of the spots was developed with a potassium iodoplatinate solution, which gave a purple color with the steroids.

The steroid fraction of placenta was studied by grinding the placenta in a Waring Blender, then completely dialyzing and following the same procedure as above.

Results

The chromatograms on the steroid fraction of pregnancy urine (five to six months) can be found in the *Enzyme Research Notebook.* Components with an Rf value of 0.569, 0.288 and 0.168 were found in the urine. These are average values from three chromatograms. The components probably correspond to estrone and progesterone for the first two. The third component is not definite but might be similar to adrostene 3.17 dione, which has an Rf value of 0.15. The placenta only revealed one component steroid by this method. This steroid had an Rf value of 0.20 and is probably progesterone. The postpartum plasma did not show any significant steroid spots. It must be remembered that this method is limited to ketonic steroids and different steroids with the same number of ketone groups, and will travel at approximately the same rate.

Discussion and Summary

The analysis of pregnancy urine and placenta did not reveal much beyond estrone and progesterone components. The postpartum plasma did not show even these. Hence, the steroids in the plasma are in too small a concentration to be analyzed for by this method, or are of a non-ketonic nature. It should be mentioned that the postpartum plasma used in these studies was a clear yellow straw color, as is normal plasma; Granirer has reported the postpartum plasma he used has a green opalescent color. In an article published in *Science,* he states he believes that the responsible factor in question is something besides a steroid.

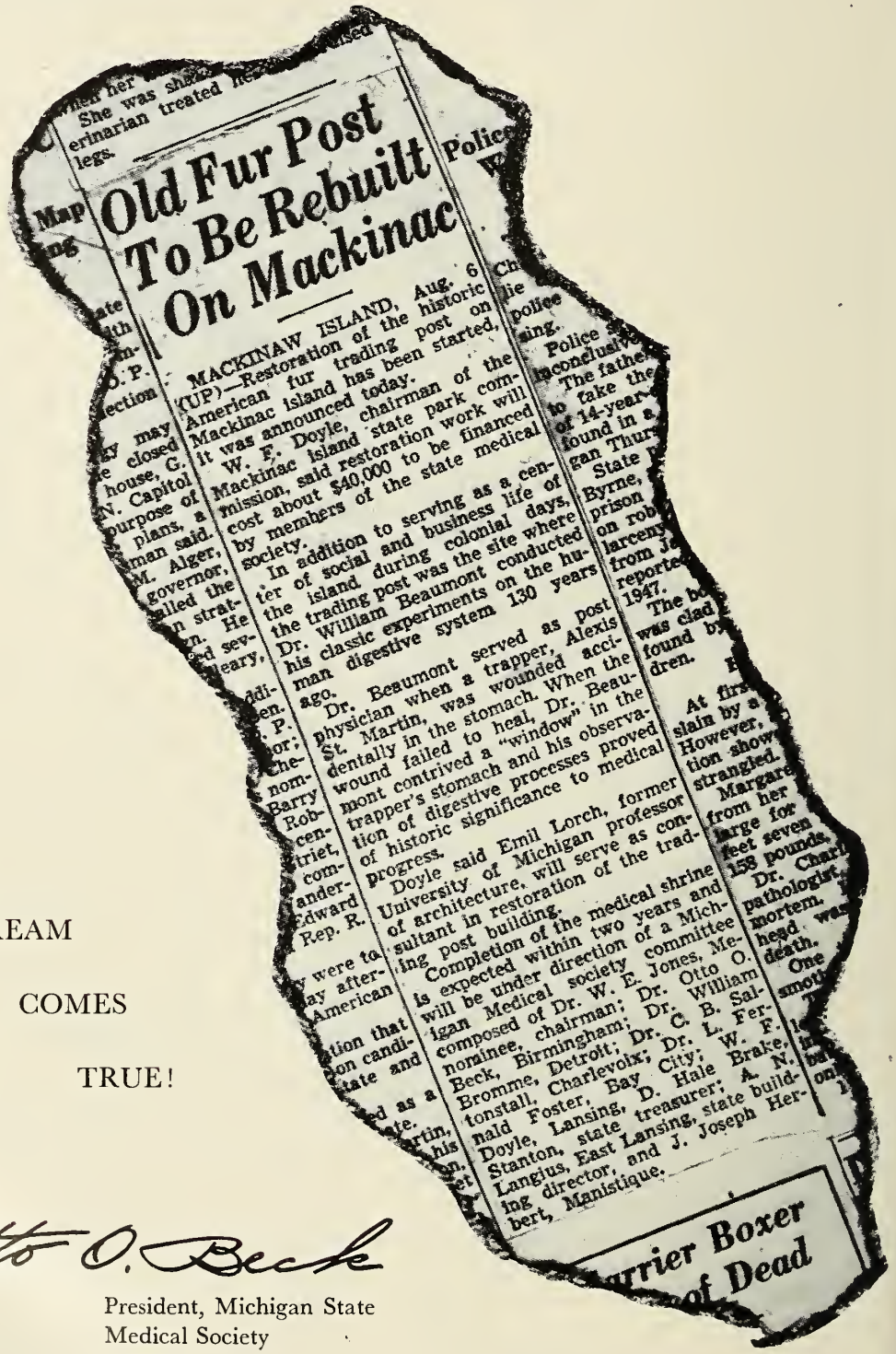
Recent reports add further evidence to the assumption that there are other factors that influence remissions in rheumatoid arthritis.

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This report is a part of one phase of arthritic research supported by funds of the Michigan Chapter of the Arthritis and Rheumatism Foundation.

President's Page



OUR

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Otto O. Beck

President, Michigan State
Medical Society

Editorial

TRIBUTE

THE EDITOR wishes to express his appreciation to James J. Lightbody, M.D., for his invaluable assistance and enthusiasm in preparing and assembling the scientific papers in this number of THE JOURNAL. Again we have presented to our membership the very latest information of the subject of arthritis and rheumatism. The papers are a complete coverage, and an evidence of the interest of our profession in the subject. Together with the rheumatic fever diagnostic centers conducted by the Society this makes an outstanding contribution.

We thank Dr. Lightbody and his committee.

BREATHING SPELL?

CONGRESS is not in session and no legislative action can now be taken. We therefore have a breathing spell during which the threat to independent practice of medicine is less obvious, and our members might get the idea we need not continue to fight. The immediate threat is being held in check by the phenomenal success of our voluntary health insurance. We have approximately eighty-five million persons protected for hospitalization, and sixty-five million carrying protection for medical or surgical services. Fundamentally, the efforts of the medically sponsored health plans have been and are still, to care for the unexpected or unusual illness, the large or catastrophic costs of illness. At first Michigan Medical Service attempted to cover all illness, but found it was too unpopular, too costly, too uncertain, too unpredictable, and not necessary.

Blue Cross and Blue Shield plans are now available to every person who needs protection, to every person who wants protection, but must never be forced on any person who does not want it. Such is the ambition and purpose of all the voluntary health service plans, whether sponsored by the medical profession, the hospital groups, or insurance companies. Health service is a new development of the past two decades, born out of necessity, and growing rapidly. The program has ridded off the drive to socialize the nation through its health professions. The plans grew as they must, and could, to accomplish their objective. The people have been protected, the socialistic trend has been temporarily thwarted, and the "planned" economists are, just for the moment, in hibernation. Now is the time for our plans to readjust, to find and correct abuses, to study methods of rendering better and more complete care to our public. We must build for stability and for security.

The medically sponsored plans actually belong to the profession. They are our pledge to the people that the profession is conscious of their needs, or necessities; that we are both willing and able to give our best thought and efforts to bridge the trying times. We have done a herculean job, but it is not complete. Every abuse, every day of overhospitalization, every unnecessary cost adds to the risks of not being able to fulfill our obligations. To the profession the medical or hospital plan is not just another insurance company to pay and pay. It is our own creation, our own bulwark against socialism, our pledge to our patients. An attack upon its stability is an attack upon ourselves, our pledges and our sacred honor.

WILLIAM BEAUMONT AND MACKINAC ISLAND

THE MICHIGAN State Medical Society has for many years been interested in the work of William Beaumont, M.D., pioneer in research on digestion. A committee of our Society, after years of study and effort, succeeded in buying what remains of the old American Fur Trading Company headquarters where Alexis St. Martin was shot and his stomach laid open. President Otto Beck has made as his chief objective this year a complete restoration of this building as a memorial to William Beaumont.

It is the hope that sufficient money, about $40,000, might be raised to complete this project. About one-quarter of our members thus far have contributed, giving an average, to date, of $11.06 per person. We hope that many more members will join in this very worthy project.

We wonder if our members appreciate what an opportunity the doctors of Michigan have. Mackinac Island is a storehouse of colonial and pioneer history. No other place in the state can compare; in fact, there is more historical interest in this little beauty spot of Michigan than there was in Williamsburg which the Rockefeller Foundation restored and made into a National Shrine. Hopefully, the same thing will happen at Mackinac Island. By a strange coincidence, the Michigan doctors are presented with an opportunity again to be pioneers in a project which might have a far-reaching and very interesting outcome. We hope you, our readers, will have an inspiration to become an integral part of this movement; will have the urge to join in, and will immediately, while the thing is fresh in mind, send a check to the headquarters office in Lansing or to Dr. Otto Beck in Birmingham.

This memorial is a fine project, worthy of endorsement. If you agree, why not send a small check right now, before you forget, to the Lansing headquarters of the Society or to President Beck in Birmingham. The small check will not be missed after it is sent on, but the ultimate good will be lasting. It might even be a preliminary to a wonderful historical restoration in a most historic and delightful small island in our proud State.

Write that check now, please!

HOSPITAL OVER-USAGE AND EXPENSE

MOST of our older doctors remember when to hospitalize a patient required some argument with him—sometimes some definite persuasion. Never would one go to the hospital unless very seriously ill or if surgery was necessary. Modern times and philosophy have changed all that. Now the effort seems to be rather to discourage many with trivial ailments from going to the hospital and to get others to return home sooner.

Many of our patients argue that they have carried the insurance just to have it available in case of need, and now that they can use it they are going to the hospital; it is their right. The fact that the hospital plans were established not for diagnostic, but for remedial services, makes no impression.

We admit it is easier to care for patients in the hospital; also, in many instances, much easier to work out a diagnosis in an obscure case. This recent trend has filled our hospitals to overflowing and has increased their costs to the breaking point. Many services are expected that are new and costly; many that are helpful or pleasant, but not entirely indispensable. The result has been increased hospital costs and scarce hospital beds.

Our patients complain not only of this expense but also of the lack of available beds. Of late many have blamed this situation on health service plans. We believe such a charge is not justifiable. We have gone through a revolutionary change in our economy. Our homes are not planned to care for the sick; our people would much rather pay for a trained attendant to give the indicated care. Costs have necessarily increased.

Patients frequently complain, but have our doctors explained—taken the time to satisfy the families, or attempted to defend the health worker from unjust criticism?

Hospital costs have multiplied. Especially those of us who have paid such bills recently know that! No one can blame the patients for concern but the medical attendant many times may ease the discontent by careful mutual discussion.

Our doctors have a double duty in such cases. Explanation of costs, and their reasons are available for the patient, and protection of the insurance service plan and hospital from over-use of its facilities is an equal obligation.

Recent government reports show that general living costs have gone way over 190 per cent, labor earnings much more; but medical costs barely 40 per cent. Hospital costs are increasing with living costs because they constitute food, shelter and service, all of which are part of living costs.

Whatever the cause, whether increased illness, over-utilization, too many hospital days, too many non-essential services ordered; whether the demands of the patient and his family, the negligence of the doctor; or his overzealousness in caring for his patient—whatever the cause, we have reached a situation where the build-up of hospital costs has made hospital usage a real problem. The independent family who must foot its bills is having a difficult time, and the service plan is being subjected to a severe financial strain. There is one answer—increase in assessments. That we do not wish, but both the doctors and the patients must face facts.

EAPPORTIONMENT PLAN No. 3

ACCORDING to the Constitution of the State, the Legislature is supposed to be reapportioned ch ten years. This has not been done for many ars because it was actually the responsibility a group which could not agree. In order to rrect this situation and effect a regular reap-ortionment, two provisions will be submitted to e voters at the November election.

Plan No. 2 sponsored by the labor groups would apportion both the Senate and the House of epresentatives on a purely numerical basis. If is were done, four counties (Wayne, Oakland, enessee and Macomb) would control the whole ate legislature.

Plan No. 3, sponsored by the Michigan Com-ittee for a Balanced Legislature, seems to be haracterized by good common sense. It is based n the geographical distribution, controlled by population formula, and would give representa-on to all rather than a few chosen by virtue of opulation density.

Thirty-three States and the Federal Government ave adopted the Balanced Legislature plan.

If you are in favor of a balanced legislature, be re to vote on both plans. The count will be ade on a percentage of all votes cast for that easure. If you vote NO on No. 2 and YES on o. 3, you will have registered twice. You will ve registered your opposition to the one you do t favor, and your approval to the one you do vor. If you vote on only one, you have not gistered your disapproval of the other and a naller number of YES votes will carry. A No te takes a Yes to cancel and another to carry.

Be sure to vote on both plan No. 2 and plan o. 3. Plan No. 2 gives four counties control of e Legislature. Plan No. 3 is for a Balanced gislature.

ICHIGAN CRIPPLED CHILDREN'S OMMISSION

THIS YEAR the Michigan Crippled Children's Commission is faced with decreased appropria-ns for medical care and treatment for the State's al year, July 1, 1952 to June 30, 1953. The mmission can take care of only four persons ere previously five received attention under the mer appropriation. In other words, 10,000 es were cared for last year, but this year only 00 will receive care.

Economies in ordering out-patient extras is therefore needed, as well as continued cooperation in discharging patients from the hospital as soon as conditions permit.

At the recent joint meeting with the Council of the Michigan State Medical Society, the Michigan Crippled Children's Commission differentiated between hospital care for true medical need, and boarding house care because of social problems.

The Commission also invited attention to the sixty-day billing clause in the afflicted children's laws of the State of Michigan. If no billing is submitted within sixty days, the account cannot be paid. To make the physician's billing easier last year, the Commission developed an entrance report. This does not relieve the responsibility of the attending physician to notify the consultant, and for all physicians to send their bills to the Commission, in order that they may be paid, within the sixty-day limitation.

The Commission also reported that in a large number of counties, the Commission is paying the limit of fees allowed by law—that is, the Uniform Fee Schedule for Governmental Agencies —up to the legal ceiling of $90.00. However, there are a number of counties receiving less because of another provision of the law which prohibits paying more than any other government agency in a given county. This involves payments by the Social Welfare departments in individual counties, some of which pay less than the Uniform Fee Schedule rate, although the State Department of Social Welfare has accepted the Schedule. In such counties negotiations should eliminate this discrimination.

SHORTAGE OF PHYSICAL THERAPISTS

HUNDREDS of drugs have been used in the treatment of arthritis and rheumatism and allied diseases, but the one medium of treatment that has lasted through the years is physical therapy. Arthritics throughout the world have attended varieties of "mineral" springs, health resorts and spas, and have continued to take the "baths" to receive some measure of relief from the pain, discomfort and disability caused by these diseases. There are still many places in Europe and the United States where disabled arthritics make their pilgrimages each year for therapeutic baths, massage, rest and dietary therapy.

In the last ten years, modern medicine has

made an effort to study the benefits derived from these treatments and have developed extensive departments of physical therapy in our large modern hospitals. Numerous types of equipment associated with the use of short wave therapy and various heat lamps have been added in the new field of physical medicine which is now reaching a point of importance comparable to that of any of the other major departments in our hospitals.

No matter what program of specific medication is used in tablet, capsule or injectible form in the treatment of arthritis, there should be a continuous program of physical therapy and rehabilitation and re-education of the patient, as very few arthritics will improve satisfactorily without regular physical therapy.

The discovery of Cortisone and ACTH reawakened an interest in the field of arthritis and the medical profession has accepted a responsibility which they had previously sloughed off to other practitioners, particularly in the realm of the cults. With this increased interest in the treatment of these diseases, there has also arisen a demand for increased utilization of the implements of physical medicine in an extensive program of rehabilitation. This renewed interest has brought to light a series of deficiencies in available professional personnel, particularly a shortage of trained physical therapists—and also a shortage of Doctors of Medicine who have shown a specific interest in this new specialty.

There are only two physiatrists in the State of Michigan who by training and experience are properly qualified to assume the responsibilities of heads of departments of Physical Medicine. There has not been any college or university in the State of Michigan where young men or women may go to study to learn about the problems of the arthritics and where they can remain over a period of time to attain a degree in physical medicine. A school of Physical Medicine will be started at the University of Michigan this Fall, and we hope that the Doctors of Medicine will attempt to stimulate young men and women to go into this field to assist and coordinate the activities of the physicians and nurses and physiatrists. We are sure that the obvious advantage of having a school of physical medicine available in the State of Michigan will eventually greatly improve the treatment of the arthritic. It is a long term program, and the need is great.

James J. Lightbody, M.D.

PROTRUSION OF THE INTERVERTEBRAL DISK

(Continued from Page 1218)

per cent procaine solution, and through that whea a 4-inch needle is directed inward, and probec until the sciatic nerve is touched. At this point the patient signals a sensation of an electric shock and 20 cc. of 1 per cent procaine is injected. Th patient feels a numbness creeping over the entir leg, which may persist for about two hours. Afte an interval of five days, the injection is repeated When properly injected, the relief is instantaneou No untoward results—such as paralysis of the leg— have followed repeated injections, in our experi ence, over a long period of time.

Summary and Conclusion

Six cases of protruded intervertebral disk wer discussed, of which four were operated on, wit highly successful results, and two were treate conservatively with a fair degree of improvemen The history, symptomatology, physical finding x-ray and laboratory findings were described i detail, as well as the differential diagnosis an treatment. Finally, a brief discussion was given sciatic pain due to causes other than protrude intervertebral disks, and a regime of general trea ment suggested where no specific etiology w apparent. The foremost consideration, howeve must be given to the discovery of the *cause* sciatic pain, and its systematic elimination. painstaking search for such cause will, more oft than not, prove a highly rewarding experience.

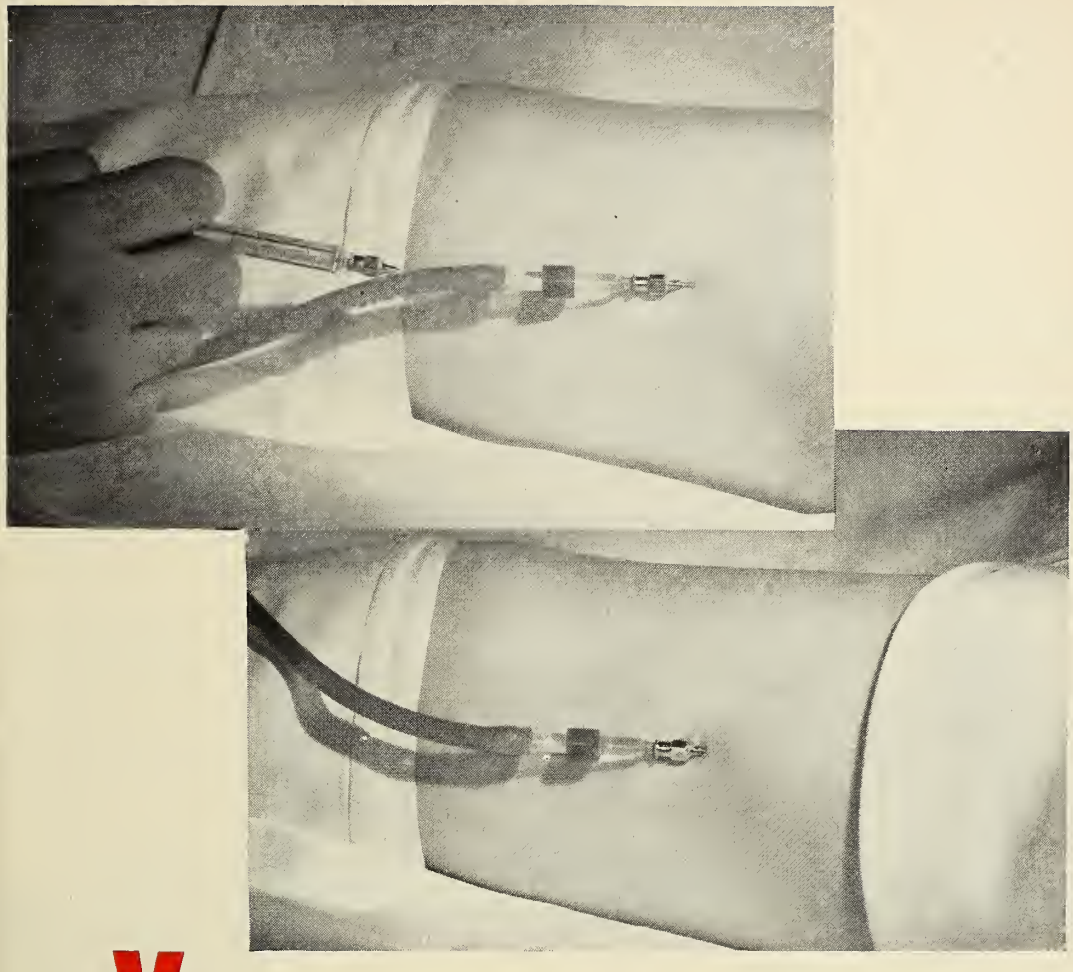
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5715 Michigan Avenue

FOOT AND MOUTH DISEASE LABORATORY

Secretary of Agriculture Charles Brannan has nounced selection of Plum Island, 1½ miles off north tip of Long Island and 10 miles from Connecticut ma land, as site for research laboratory for foot-and-mo and other animal diseases. Congress has appropria $10 million for the project.



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FOR
GRADUATES IN MEDICINE

The Michigan State Medical Society, in co-operation with the University of Michigan Medical School, Wayne University College of Medicine, and the Michigan Department of Health, announces the *extramural* semi-annual postgraduate program for the fall of 1952:

Place	*Date*
Alpena	Thursday, October 23
Battle Creek	Tuesday, October 7
Bay City	Wednesday, October 22
Flint	Tuesday, November 25
Jackson	Tuesday, November 18
Lansing	Tuesday, October 28
Midland	Friday, November 14
Mt. Clemens	Wednesday, October 1 Wednesday, November 5
Muskegon	Wednesday, October 8
Traverse City	Thursday, November 6
Upper Peninsula	
Sault Ste. Marie	Monday, November 10
Marquette	Tuesday, November 11
Ironwood	Wednesday, November 12
Escanaba	Monday, November 10
Houghton	Tuesday, November 11
Menominee	Wednesday, November 12
Iron Mountain	Thursday, November 13

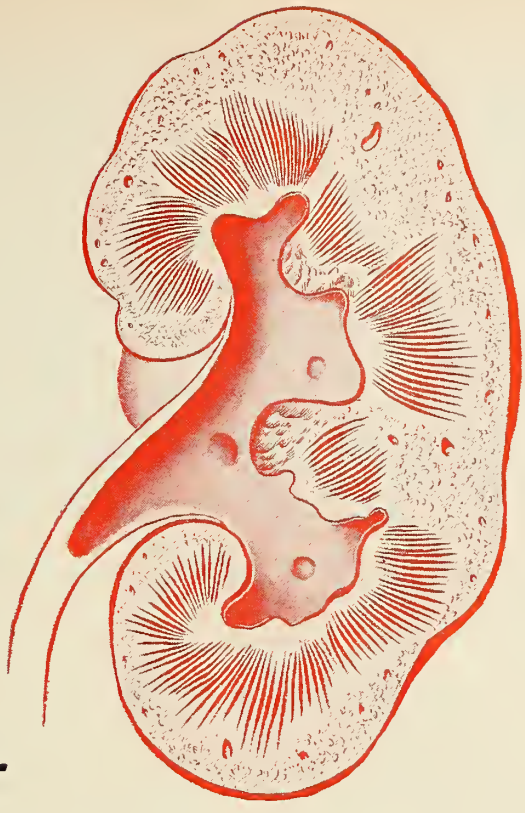
The following *intramural* courses will be given at the University Hospital, Ann Arbor:

Basic Sciences	September 29, 1952-June 7, 1953
Clinical Internal Medicine	Thursdays. October 2-Dec. 18, 1952; January 8-April 16, 1953. 1:30-5:00 P.M.
Clinical Exercises for Practitioners	Wednesdays. October 1-December 17, 1952. 10:00 A.M.-5:00 P.M.
Pediatrics	October 8-11, 1952
Cancer	February 2 and 3, 1953
Obstetrics	January 21-24, 1953
Gynecology	February 25-28, 1953

Further information may be obtained by writing to H. H. Cummings, M.D., Chairman, Department of Postgraduate Medicine, Room 2040, University Hospital, Ann Arbor, Michigan.

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GAMMA GLOBULIN

Until such time as there is conclusive evidence that gamma globulin is an effective prophylactic in the prevention of poliomyelitis, the gamma globulin distributed by the Michigan Department of Health is to be used in the prevention of measles.

The investigation carried out in Provo, Utah, in 1951 involving the administration of gamma globulin to approximately 2,900 children was an experiment. Unfortunately, this soundly devised experiment for the evaluation of prophylactic potency in the control of poliomyelitis did not provide conclusive evidence. The Michigan Department of Health, therefore, does not encourage the use of gamma globulin in the prevention of poliomyelitis.

The Michigan Department of Health produces and distributes a number of biologic products to the citizens of Michigan through their local health departments and family physicians. All of the products so produced and distributed have a specific use and are available because they are of proved merit. Research and clinical trial has provided us the necessary knowledge to verify their validity for the purpose for which they are produced and distributed. Gamma globulin is one of these products distributed by the Michigan Department of Health for the specific purpose of prevention of measles. This policy and purpose has not changed.

The "Certificate of Death" has been revised to include a statutory amendment provided by Act 65, P. A. 1952 which was given immediate effect. Item 18 on the death certificate now reads "Informant's name."

The special case-finding program in venereal disease and tuberculosis carried on in Detroit from May 1 to July 15 recorded a final total of 41,097 blood tests and 29,720 chest x-rays.

Assistance in handling recalcitrant tuberculosis patients is being made available by the Department. A staff member is being assigned to work with four classes of patients: (1) Persons suspected of having active pulmonary tuberculosis and refusing to submit to examination for a clinical evaluation of the disease; (2) Persons known to have active pulmonary tuberculosis and refusing to be hospitalized in an approved sanatorium; (3) Persons under treatment or observation in an approved sanatorium and who leave without a proper medical discharge and against medical advice and (4) Persons whose treatment is completed but who refuse to cooperate in the post-sanatorium follow-up program. Requests for this service should be made to the local health department or where there is none, to the Michigan Department of Health.

NEW SIGN—HDA

A new sign will make its appearance along Michigan Highways this fall, a compact, green and gold sign carrying a bold "HDA." It will mark "Health Department Approved" resorts, replacing the black and white "Sanitation Approved" sign in use for many years.

Presence of the sign will mean that the resort has been inspected by either a local or a state health department sanitarian and that it meets local and state health department standards for approved resorts. The traveller may count on a safe water supply, satisfactory sewage disposal, regular garbage disposal, good building construction, proper ventilation, adequate lighting, proper heating equipment, cleanliness, sanitary sources storage, preparation and handling of food and use of pasteurized milk and milk products. If there is a bathing beach, it will be free from dangerous pollution or undue safety hazards. Noxious weeds such as poison ivy and poison oak will have been eliminated or kept under control. Guests at the resort will be required to register and the registers will be kept for not less than three years.

The Department is beginning an intensive campaign of educating highway travellers to stop at HDA resorts.

A new type of pre-service training in public health was given in Michigan this summer. Four University of Michigan medical students took their externships in public health medicine under a program sponsored by the Department. One man worked in the Department on health problems of migrant labor, two were in the Washtenaw County Health Department and one was in the Grand Rapids Health Department.

The State's water fluoridation program makes steady progress. Lake Odessa became the 25th community to fluoridate its supply. Michigan is one of the top-ranking states in percentage of population drinking fluoridated water. It leads, also, in the topical application of fluoride. It is the only state using dental and dental hygiene students, under supervision, in giving this protective service to children.

Bronchitis, pneumonitis, and atypical or virus pneumonia are the conditions most commonly confused with lung cancer.

* * *

Doctors should be alert to the fact that a small silent shadow on an x-ray film of the lung may represent altered density caused by an early cancer.

* * *

Most silent cancers of the lung are not within range of the bronchoscope.

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In Memoriam

RUSSELL G. EDGAR, M.D., of Detroit, died July 9, 1952 at the age of sixty-one.

For the past thirty-four years Dr. Edgar had practiced medicine in Detroit. Previous to that, he had practiced in Clarkston, following his graduation from the Detroit College of Medicine in 1914.

He was a member of the staff of Delray General Hospital for many years.

He is survived by his wife, Lena; a daughter, Mrs. Helen Watts; a son, Robert H. Edgar; a brother, Horace; a sister, Miss Olive Edgar; and one grandson.

JOSEPH P. GILDING, M.D., of Vicksburg, died August 2, 1952 at the age of forty-five.

Dr. Gilding had practiced medicine in Vicksburg following his graduation from the University of Michigan Medical School in 1931.

During World War II he served in the Army Medical Corps.

Dr. Gilding is survived by his wife, Gladys; two daughters, Mary and Margo; and a son, Peter.

SIDNEY L. LaFEVER, M.D., of Ann Arbor, died July 26, 1952 at the age of fifty-three.

For more than twenty-five years Dr. LaFever had served the community of Ann Arbor as an obstetrician and gynecologist. He was graduated from the University of Michigan medical school in 1924, and interned for two years at the Elizabeth Steele Magee Hospital in Pittsburgh, Pennsylvania.

He had served as chief of staff of St. Joseph's Mercy Hospital in 1949 and 1950. Dr. LaFever was a member of the American College of Surgeons.

He is survived by his wife, Florence and a son, Richard. He also leaves a sister, Mrs. Marion Bronson of Watkins Glen, N. Y.; and a brother, Lester LaFever of Corning, N. Y.

FRANK D. LINN, M.D., of Albion, died July 19, 1952 at the age of fifty-two.

Since 1947, Dr. Linn had served the community of Albion as an otolaryngologist. Previous to that, he had practiced in Memphis, Tennessee.

He was graduated from the University of Michigan medical school in 1924 and interned at Harper Hospital, Detroit.

During World War II he served in the Navy medical corps and spent four years in the Pacific Theater. At one time he commanded an evacuation hospital at Guam.

Dr. Linn died at Council Bluffs, Iowa, where he had gone to attend the wedding of a friend.

He is survived by his wife, Bonar; a son, Frank Linn, Jr., and a brother, Max Linn.

FRED C. MUSSER, M.D., a former Detroit practitioner, died July 1, 1952 in Hollywood, California, at the age of sixty-four.

Dr. Musser was graduated from the Detroit College of Medicine in 1915 and interned at Providence Hospital, Detroit. He was on the staff of Woman's, Harper, Florence Crittenton, and Providence Hospitals.

After suffering a coronary attack in 1943, he moved to California where he limited his practice to cardiology.

He is survived by a daughter, Marilyn, and a son, Freddie Mercer, a motion picture actor.

CHARLES T. PANKHURST, M.D., a retired Ionia otolaryngoloist, died August 4, 1952 at the age of seventy-four.

Dr. Pankhurst received his medical degree from Western Reserve University School of Medicine in 1904. He was licensed to practice medicine in Michigan in 1912 and first served the community of North Star for ten years before coming to Ionia where he practiced for twenty-seven years.

He was a former president of the Ionia-Montcalm County Medical Society.

OTTO T. TOEPEL, M.D., of Detroit, died July 19, 1952 at the age of eighty-one.

Dr. Toepel had practiced medicine in Detroit for more than half a century. He was an Emeritus member of the Michigan State Medical Society. A native Detroiter, Dr. Toepel was graduated from the Detroit College of Medicine in 1893.

He served a part of a term as Wayne County coroner in 1904. Dr. Toepel is survived by his wife, Emily.

COLIN C. VARDON, M.D., of Detroit, died July 23, 1952 at the age of sixty-six. Since 1911 Dr. Vardon had practiced surgery in Detroit. He was a senior surgeon of the Highland Park General Hospital staff.

Dr. Vardon died in San Francisco, California, while on a vacation trip.

He was graduated from the Detroit College of Medicine in 1911. Dr. Vardon was a Life Member of the American College of Surgeons and a Fellow of the International College of Surgeons.

He is survived by his wife, Edith, and two sons, Colin C., Jr., and Robert. He also leaves a sister and two brothers. They are Ann Vardon, Edward M. Vardon M.D., and William S. Vardon.

An enlarged node that lasts three weeks should b regarded as a danger signal, demanding complete in vestigation.

* * *

While the early nodes of lymphosarcoma tend to b rounded and firm, they may be soft, as early Hodgkin' nodes often are, and even an apparent or real fluctuatio would not be sufficient evidence on which to rule out malignant lymphoma.

* * *

There is nothing pathognomonic about the bloo count in malignant lymphoma.

JMSM

Correspondence

Wilfrid Haughey, M.D.
610 Post Bldg.
Battle Creek, Michigan

Dear Dr. Haughey:

The attached copy of my letter addressed to John W. Castellucci, is self explanatory. Surely the tremendous success of the Michigan Medical Service must be attributed in part, not only to the Physician Relations program but to you as editor of the JOURNAL.

With greatest personal regards, I am

Sincerely,

LEWIS G. HERSEY
Executive Director
The Medical Service Bureau
Utah State Medical Association

July 29, 1952
John W. Castellucci
Assistant to the Director
Michigan Medical Service
Washington Boulevard Bldg.
Detroit, Michigan.

Dear John:

It was with considerable interest that I read the article entitled "You Built It," in the June issue of THE JOURNAL of the MICHIGAN STATE MEDICAL SOCIETY. Certainly you and your associates may take unlimited pride in the splendid work you have done in Physician Relations.

In addition, surely a word of commendation is in order for the exceptionally fine recognition afforded such publicity in the JOURNAL.

With greatest personal regards, I am

Sincerely,

LEWIS G. HERSEY
Executive Director
The Medical Service Bureau
Utah State Medical Association

Mr. William J. Burns, Executive Secretary
Michigan State Medical Society
224 West Allegan Street
Lansing, Michigan.

Gentlemen:

There is a fine young doctor in your midst who in my opinion reflects the highest credit on his profession. I refer to Dan W. Everett, M.D., Edwardsburg, Michigan.

On July 3, 1952, I began an automobile trip with my family from Detroit, Michigan, to my home in Chicago. I became ill in Ypsilanti and by the time we reached Edwardsburg I was in a very bad way. We inquired of the state highway police if there were a doctor in the vicinity and they directed us to Dr. Everett. When we arrived at his office it was pretty late, about 10:30 P.M., and he was closing up. Nevertheless, without hesitation, Dr. Everett came out to the car and examined me. He expressed deep concern as to whether or not I would be able to make it to Chicago. He concluded it would be risky for me to continue the trip without medical attention. Casting aside all personal consideration for himself and at that hour of the night, he took his car and drove ahead of us 10 miles to the Pawating Hospital at Niles where I received excellent treatment under his supervision. For this deed of mercy and sacrifice I am deeply grateful for these are traits rarely found in the



Immediately after the patient's arrival an admitting physician takes a complete medical history.

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doctors with whom I have had experience. I know some who positively will not come out at night to tend the sick unless the patient is known to them. By contrast, Dr. Everett did everything he could for me and he had never seen me before and probably never will again.

Dr. Everett's display of human kindness and dedication to give succor to the sick does not end here. When I asked him to tell me his fee he wrote it down and told me I could mail the money to him. I told him that I was willing and able to pay immediately but he refused to take the money stating that I should keep it, that I might need it if additional medical care became necessary. I finally prevailed upon him to let me pay but I really had to beg him to take it and that is no exaggeration.

There is no way to measure the hope and comfort and confidence such a doctor inspires in a patient. To me Dr. Everett symbolizes everything that is decent and noble and commendable. I sincerely hope you consider him worthy of commendation also.

Respectfully yours,
MRS. LOLITA J. DRINKARD (signed)
5007 Prairie Avenue
Chicago, Illinois
July 24, 1952

EMERGENCY MEDICAL ATTENTION

We continually hear of patients being unable to get emergency medical attention. I have, as yet, been unable to find in our community or elsewhere any such cases. It is time that we speak up and ask the accusers to point out where and when it is that people don't get medical attention. They will be unable to show any such cases. Occasionally, in our community, such statements appear in the newspayers. Prompt investigation has always revealed the untruth of the statements. Our newspapers have willingly printed corrections in every case. It is time that doctors everywhere begin to speak up.—W. ROBERT MALONY, M.D., *Illinois Medical Journal*, May, 1952.

ULTRASONICS IN CHRONIC RHEUMATIC DISEASE

(Continued from Page 1215)

4. Demmel, F.: Experiences with ultrasonic therapy Deutsche med. Rundschau, No. 7 (July) 1948.
5. Fuchs, H. K., and Buchtala, V.: Results of ultrasonic therapy and experimental investigations. Deutsche med. Wchnschr., No. 9 (Mar.) 1949.
6. Hintzelmann, U.: Ultrasonic therapy in rheumatic disease. Deutsche med. Wchnschr., No. 5-26 (July) 1947.
7. Investigators of the Mayo Clinic and Mayo Foundation: Present status of use of ultrasonic energy in physical medicine. J.A.M.A., (Feb. 23) 1952.



. NEWS MEDICAL

MICHIGAN AUTHORS

Charles E. Frohman, Ph.D. and **V. Everett Kinsey, Ph. D.**, of Detroit, are the authors of an article, "Studies on the Crystalline Lens," published in the *Archives of Ophthalmology,* July, 1952.

Reed O. Dingman, D.D.S., M.D., of Ann Arbor, is the author of an article "Meniscectomy in Treating Lesions of the Temporomandibular Joint," published in the *Journal of Oral Surgery,* April, 1952; abstract in *Digest of Ophthalmology and Otolaryngology,* July, 1952.

Kenneth B. Babcock, M.D., of Detroit, is the author of an article, "The Excessive Use of Blue Cross Benefits," published in *Hospitals,* July, 1952.

E. H. Steffensen, M.D., H. B. Ivy, M.D. and **F. O. Nagle, M.D.**, of Detroit, are the authors of a paper, "Topical Compound F in the Treatment of Anterior Sigmat Eye Disease," in the *American Journal of Ophthalmology,* July, 1952.

H. Saul Sugar, M.D., of Detroit, is the author of an article, "Evaluation of Results in Correction of Horizontal Concomitant Strabismus," in the *American Journal of Ophthalmology,* July, 1952.

Maurice Croll, M.D., and **Leo Croll, M.D.**, published a paper "Ocular Manifestation of Trichinosis," in the *American Journal of Ophthalmology,* July, 1952.

Mark A. Hayes, M.D., Ph.D., and **Frederick A. Coller, M.S., M.D., F.A.C.S.**, of Ann Arbor, are the authors of a paper, "The Neuroendocrine Control of Water and Electrolyte Excretion during Surgical Anesthesia," published in *Surgery, Gynecology and Obstetrics,* August, 1952.

Eugene A. Osius, M.D., of Detroit, is the author of an article, "Acute Massive Venous Occlusion," published in *Archives of Surgery,* July, 1952.

A. B. McGraw, M.D., R. R. Margulis, M.D., and **. E. Brush, M.D.**, of Detroit, are the authors of an article, "Twofold Effect of Corticotropin (ACTH) on Blood Clotting and Its Implications in Surgery," published in *Archives of Surgery,* July, 1952.

Leonard E. Himler, M.D., of Ann Arbor, is the author of an article, "Incidence and Types of Human Relations Problems," published in *Industrial Medicine and Surgery,* August, 1952.

William J. Fulton, M.D., of Detroit, is the author of an article, "How Human Relations Problems are Dealt with by Medical Directors, Physicians and Nurses," published in *Industrial Medicine and Surgery,* August, 1952.

S. Behrman, M.D., of Ann Arbor, is the author of an article, "Genesis of Fetal Abnormalities," published GP journal of The American Academy of General Practice, August, 1952.

George L. Waldbott, M.D., of Detroit is the author of an article, "Contact Dermatitis of the Hands," published in GP journal of The American Academy of General Practice, August, 1952.

Lyons N. Howland, of Ann Arbor, is the author of an article, "The Techniques and Importance of Interviewing," published in *Industrial Medicine and Surgery,* August, 1952.

* * *

Volume I, Number 1, of a new monthly journal entitled *Obstetrics and Gynecology,* sponsored by the American Academy of Obstetrics and Gynecology, will appear in January, 1953. It is believed to be the first new monthly periodical exclusively devoted to this field to be launched in over thirty years, according to an announcement by Dr. Carl P. Huber, Academy President. The new journal will publish original articles, reviews, clinical notes, editorials, and book reviews covering the entire range of clinical obstetrics and gynecology. Subscription $12.00 per year.

The Academy has appointed Dr. Ralph A. Reis of Chicago, Editor of *Obstetrics and Gynecology* and the following Board of Associate Editors: F. Bayard Carter, M.D., R. Gordon Douglas, M.D., Ludwig A. Emge, M.D., Arthur T. Hertig, M.D., S. Leon Israel, M.D., William F. Mengert, M.D., Norman F. Miller, M.D., and Herbert E. Schmitz, M.D.

* * *

Hill-Burton Hospital Construction in Michigan, to August 1, 1952, includes the following:

Completed and in Operation: Twenty-two projects at a total cost of $19,187,485, including federal contribution of $6,935,312 and supplying 1,351 additional beds.

Under Construction: Fifteen projects at a total cost of $15,345,986, including federal contribution of $6,119,113 and designed to supply 798 additional beds.

Approved, But Not Yet Under Construction: Two projects at total cost of $561,955, including $312,723 federal contribution and designed to supply 41 additional beds.

* * *

Food and Drug Administration, acting through the Federal Security Administrator, has issued in final form a modified series of regulations bringing federal prescription requirements into conformity with the new Durham-Humphrey Act (P.L. 215, 82nd Congress). The new regulations: *1.* Provide labeling guide to manufacturers on directions for use of drugs. *2.* Continue labeling exemptions for physicians. *3.* Tighten up rules to make certain that prescription drugs are dispensed only by or on the prescription of a physician or other licensed practitioner. *4.* Exempt certain habit-forming

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drugs from the prescription-only restrictions when used in non-hazardous combinations.

The new reglations are an amended version of proposed regulations published in February. However, the new ones do not attempt to rule on certain points in dispute since February. Specifically, the final regulations make no mention of prohibiting sale by mail of prescription drugs, do not attempt to define toxicity and do not apply "method of use" as a criterion for prescription-only designation (the *proposed* regulations listed all injection drugs except insulin as prescription-only).

FDA is reserving the right to rule on these controversial points in the future, but a spokesman said the agency did not wish to delay longer the official publication of regulations on which he said there is substantial agreement among the pharmaceutical industry and the medical profession.

The new regulations appear in the Federal Register for July 25 (Vol. 17, No. 145). Copies may be obtained from Food and Drug Administration, Washington 25, D. C.

Food and Drug Administration has ruled that, if the standards set by Public Health Service are met, fluoridated water supplies are outside FDA's jurisdiction and, under most conditions, foods prepared with such water "will not be regarded as actionable . . . because of the fluorine content of the water."

* * *

National Science Foundation has begun collecting records of all federal agencies offering grants or contracts to educational and non-profit institutions for scientific research. It hopes to have a complete report on all funds ready by the first of next year. Direct research of the various agencies will not be included.

* * *

The Keogh-Reed bills, which would establish a voluntary pension plan for the self-employed, including physicians, have been revised considerably, and Frank G. Dickinson informs us that there is a possibility that the new bills (H.R. 8390 and H.R. 8391, introduced on June 27) will be considered if Congress is in session at any time during the remainder of 1952. Otherwise the bills will be re-introduced in the next Congress.

Dr. Dickinson listed these new features of the revised (identical) bills:

(1) A lifetime limit of $150,000 on the total amount which an eligible taxpayer could exclude from taxable income for the purpose of saving for his old age; (2) eligible taxpayers now over age 55 could exclude more than the limits of $7,500 or 10 per cent of earned income, whichever is the lesser; (3) only the self-employed and persons not covered by private or public employer-employee pension plans are eligible; (4) the amounts excluded from current taxable income could be invested either in a restricted trust fund or a restricted retirement annuity issued by an insurance company; (5) a carry-over of unused exclusions for a period of not more than five years; (6) no withdrawals until age 65 (changed from age 60) unless totally disabled for more than three months.

Congressmen Keogh and Reed now believe that this

ipartisan bill could be passed after January 1, 1953, enough sustained effort is made by national organizaons representing the self-employed.

* * *

A new program has been set up by the American Medical Association to acquaint physicians newly-disharged from the armed forces with existing opportunities private practice, industry, hospitals and medical schools roughout the country. Inaugurated by the Council on ational Emergency Medical Service, the plan incidentlly will also provide replacements for physicians classified riority I under the "Doctor Draft Law" who are now eferred from active military service because of essenality.

The Council will contact army, navy and air force hysicians before they are discharged to find out if they ave any post-service plans. If the doctor hasn't made ny plans, he may indicate to the Council where he ants to locate and in what field of medicine he is nterested. This information will be sent to state medical ocieties and to state medical advisory committees to the elective Service System. Correspondence with individual hysicians on these lists will be handled by either the ate advisory committees or the medical societies.

* * *

The International College of Surgeons (United States hapter) Annual Assembly was held at the Conrad ilton Hotel, Chicago, September 2, 3, 4 and 5, 1952. ne of the featured speakers was the Right Honorable Lord Thomas Horder, physician to Queen Elizabeth, Chairman of the Fellowship for Freedom in Medicine, and Member of the Council of the British Medical Association. Dr. Horder's topic at the Convocation was "Freedom in Medicine." Over 700 new Fellows were received into the College at this ceremony to be held at the Civic Opera House, September 5.

The scientific sessions and the exhibits were held at the Conrad Hilton Hotel where the annual banquet was held on September 4 with another outstanding British surgeon, Mr. Arthur Dixon Wright, F.R.C.S., Member of the Council of the Royal College of Surgeons, as the principal speaker.

Henry W. Meyerding, M.D., Rochester, Minnesota, is President and Arnold S. Jackson, M.D., Madison, Wisconsin, is Secretary, the United States Chapter, International College of Surgeons.

* * *

H. W. Brenneman, Public Relations Counsel of the Michigan State Medical Society, was chairman of the opening meeting of the American Medical Association's Medical Public Relations Institute held in Chicago, September 4 and 5. The first meeting was dedicated to "Practical Ways to Increase Physician Participation in Society Activities" and "Putting PR to Work."

Questionnaires will be sent out this month by the AMA's Committee on Research to determine what medical research projects currently are in progress throughout the country. The survey has a threefold purpose: To

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3. *Letters of Introduction* to foreign medical associations and their members, facilitating professional contacts when you travel abroad.
4. *A share* in representing the interests of the practicing physician before other international groups such as UNESCO and WHO.
5. *The satisfaction* of sharing the advantages of American medical progress with other lands, thus repaying a debt for the inspiration we have drawn from many countries through the generations.

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establish an up-to-date file of medical research projects; evaluate the premise that certain fields of medical research are suffering from lack of financial support, and consider the actual contribution of individual scientists in terms of free time and personal expenditure of funds. A random sample of 15,000 physicians from all parts of the United States and selected personnel from medical schools, public health services and pharmaceutical firms will be asked to participate in the survey.

* * *

The Committee on Indigent Care of the AMA's Council on Medical Service has outlined the following criteria for developing indigent medical care plans. The Committee believes that indigent medical care plans should provide all the services which normally are available locally to other citizens, and should make equal services available to all indigent persons—the blind, old age pensioners, dependent children. Also, the Committee feels that such a plan should provide for medical supervision and, wherever possible, offer a free choice of physician for both home and office care. The plan should use existing facilities, avoid duplication and provide for local administration by a single agency of the medical program for all groups concerned.

The Committee believes that medical care for the indigent is a local problem requiring the wholehearted co-operation and participation of local physicians. Such plans should be administered locally regardless of the source of funds.

The sum of $671,834 was turned over by the American Medical Education Foundation to the National Fund fo Medical Education for distribution to the 79 medica schools in the United States. This represents the amoun collected from physicians during the first six months o 1952. This money added to the amount collected fror industry by the National Fund for Medical Educatio was distributed July 31 in the forms of grants amountin to $15,000 to each of the 72 four-year schools an $7,500 to each of the seven two-year schools.

* * *

The American Medical Association has deferred actio on the establishment of any new specialty boards invol ing the certification of persons who are not doctors medicine until after the Council on Medical Educatic and Hospitals has completed its study of all allied sc entific fields. This report will include studies of vario professional non-physician groups whose work is close related to the practice of medicine, such as clinical cher istry and clinical psychology.

* * *

A new series of radio transcriptions entitled "T Heart of America" will be released September 15 by t AMA's Bureau of Health Education. Dramatizing va ous aspects of the heart and its diseases, the 13 progra in the series are summarized by outstanding cardiologi and related experts. Subjects include: research in he disease; heart murmur; rheumatism and rheumatic he disease; the congenital heart disease program; the he

nd athletics; coronary disease; overweight and the eart; arterial disease; high blood pressure and the heart; urgery for heart valve and arterial diseases; the heart in elation to stresses and strains; rehabilitation; protecting he good heart from injury, and how to live with a damged heart. The series was produced in co-operation with ne American Heart Association.

* * *

Director Edwin L. Crosby, M.D., former superinendent of Johns Hopkins Hospital, Baltimore, opened he new Joint Commission on Accreditation of Hospitals ffice September 1 at 660 Rush Street, Chicago. The Commission, with representatives from the American Hospital Association, the American College of Surgeons, he American College of Physicians, the Canadian Medial Association and the American Medical Association, vill assume responsibility for the hospital standardization rogram formerly carried out by the American College of urgeons. The Commission's program will get under way arly this fall.

* * *

The American Fracture Association announces its hirteenth annual meeting at the Hotel Sherman, Chiago, on October 6-9, 1952, under the chairmanship of Ienry W. Meyerding, M.D., Rochester, Minn. For copy f program, write Secretary-Treasurer H. W. Wellnerling, M.D., 610 Griesheim Bldg., Bloomington, Illnois.

* * *

E. C. Long, M.D., Detroit, President of the Michigan .cademy of General Practice, has been authorized to evelop a plan for the formulation of a House of Delegates of the MAGP. The Michigan Academy and the Wayne County Academy of General Practice are sponsoring a scientific program at the Kellogg Center, East Lansing, on Monday and Tuesday, November 17 and 18.

* * *

The American Medical Education Foundation announces that seventy-nine medical schools in the United States were awarded Class "A" grants on July 31, totalling $1,132,500. A Class A grant amounts to $15,000 for each four-year school and $7,500 for each two-year school.

* * *

"Why the Private Practice of Medicine Furnished in This Country Is the Finest Medical Care" is the subject of the 1953 (Seventh Annual) National Essay Contest for high school students sponsored by the Association of American Physicians and Surgeons. AAPS will award six national prizes: the first $1,000; the second $500; the third $100; fourth, fifth and sixth, $25 each. Contest starts January 1 and essays must be submitted on or before March 1, 1953. For information, write AAPS, 360 N. Michigan Avenue, Chicago 1, Illinois.

* * *

"Health needs and health care in two selected Michigan communities" covering the Michigan communities of Pellston and of Tecumseh has just been published as Special Bulletin No. 377 of Michigan State College. Copies may be obtained by writing Charles R. Hoffer and Clarence Jane, Department of Sociology and Anthropology and Social Research Service, Michigan State College, East Lansing.



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Michigan's declining tuberculosis mortality and continuing high morbidity are typical of the current trend throughout the United States, as well as in other countries of the world where records are available. Evidently, the treatment of tuberculosis is proving more effective than efforts for preventing the disease.

Referring to eradication as the objective in the effort against tuberculosis, David A. Cooper, M.D., president of the American Trudeau Society, writes: "While unknown cases are living in the community, the treatment of known cases is a weak gesture." Michigan's share of the nation's 150,000 unknown active cases of tuberculosis is about 6,000.

MICHIGAN TUBERCULOSIS ASSOCIATION

Wayne University College of Medicine has just received a special research grant in organic chemistry and natural products from Schenley Laboratories, Inc. The grant is for $4,500.

* * *

The graduate fortnight (25th) of the New York Academy of Medicine will be held at 2 East 103rd Street, New York City, October 6-17, 1952. This year's subject is "Hormones in Health and Disease." For program and application blank, write the Committee on Medical Education, 2 East 103rd Street, New York, New York.

Journal Covers and content for the next fifteen month in accordance with action of the MSMS Council wil be dedicated to the following subjects:

1952	October	Diabetes Detection
	November	Michigan Health Council
	December	Michigan Clinical Institute
1953	January	Heart and rheumatic fever
	February	Medico-legal jurisprudence
	March	Cancer
	April	Beaumont Memorial
	May	Michigan Foremost Family Physician and Geriatrics
	June	Michigan Medical Service
	July	Annual Session
	August	Roster Number
	September	Arthritis and rheumatism
	October	Diabetes Detection
	November	Michigan Health Council
	December	Michigan Clinical Institute.

* * *

Jack Rom, M.D., Detroit, is President of the Michiga Allergy Society for the year 1952-53. Donald S. Smitl M.D., Pontiac, is Vice President and Frank F. A. Rav ling, M.D., Toledo, is Secretary-Treasurer.

The Executive Committee is composed of Drs. Ron Smith, Rawling and Homer A. Howes, Sidney Frie laender, and Joseph H. Shaffer, all of Detroit.

* * *

The Medical Advisors of the Clara Elizabeth Fur for Maternal Health of Flint, Michigan, present for th Genesee County Medical Society, obstetricians and pec atricians of Michigan, The Third Annual Fund Le



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es. These will be given on October 8, 1952, 1:30 to)0 P.M. at Hurley Hospital, Flint.

Speakers and topics are as follows:

airman, ERNEST WATSON, M.D., Associate Professor of Pediatrics, University Hospital, Ann Arbor, Michigan.

id-Pelvic Contractions" — WILLIAM F. MENGERT, M.D., Professor and Chairman of the Department of Obstetrics and Gynecology, Southwestern Medical School of the University of Texas, Dallas, and Chairman, Department of Obstetrics and Gynecology, Parkland Hospital, Dallas.

aternal and Neonatal Care"—JOHN PARKS, M.D., Professor of Obstetrics and Gynecology, George Washington University School of Medicine, Washington, D. C.

opic to be announced)—LOUIS K. DIAMOND, M.D., Associate Professor of Pediatrics, Harvard Medical School, Boston, and Senior Physician, Children's Hospital, Boston.

* * *

). Hale Brake, Treasurer of the State of Michigan, recently made an Honorary Member of the Ionia-ntcalm County Medical Society. In the letter of reciation to Mr. Brake, the Ionia-Montcalm Medical iety stated: "We hold in high regard the integrity, esty and efficiency that you have demonstrated in performance of your public office."

ongratulations, State Treasurer Brake!

The Processing Department of the Michigan State Medical Society is not often heard from—but it is a very busy place in the new "home" of the Michigan State Medical Society at 606 Townsend, Lansing.

For example, a total of 174,373 pieces of mail were processed through the MSMS addressograph from January 1 to July 24, 1952.

* * *

Hoover Assails Give-Away Programs.—Herbert Hoover was given a big hand when he mentioned socialized medicine in connection with the government's give-away programs before the Republican national convention in Chicago.

"Behind this plush curtain of tax and spend, three sinister spooks or ghosts are mixing poison for the American people," he said. "They are the shades of Mussolini, with his bureaucratic fascism; of Karl Marx, and his socialism, and of Lord Keynes, with his perpetual government spending, deficits, and inflation. . . .

"If you want to see pure fascism mixed with give-away programs, take a look into the Brannan plan.

"If you want to see pure socialism mixed with give-away programs, take a look at socialized medicine and socialized electrical power.

"These things do not make for free men."

* * *

"The more responsibilities on a man's shoulders, the less room for chips."—Scandal Sheet.

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DETROIT INSTITUTE OF CANCER RESEARCH

Fifth Annual Scientific Meeting

Scientific and clinical sessions will be held in the auditorium of the Engineering Society of Detroit, Horace H. Rackham Educational Memorial, 100 Farnsworth Avenue, Detroit, unless otherwise indicated.

Monday, October 20

Morning Session—10:00 A.M.

A Commentary to the Problem of Differentiation
PAUL WEISS, Ph.D.
The University of Chicago

Biochemical Mechanisms in Insect Growth and Metamorphosis
CARROLL M. WILLIAMS, Ph.D., M.D.
Harvard University

Luncheon—12:15 P.M.

Luncheon reservations must be made in advance by writing to the Detroit Institute of Cancer Research, 4811 John R Street, Detroit 1, Michigan.

Afternoon Session—2:00 P.M.

The Biological Synthesis of Cholesterol
KONRAD BLOCH, Ph.D.
The University of Chicago

On the Nature of Biosynthetics Mechanisms of Protein Synthesis
C. B. ANFINSEN, JR., Ph.D.
National Heart Institute

Esterases of Animal Tissues
G. GOMORI, M.D., Ph.D.
The University of Chicago

Evening Entertainment—8:00 P.M.

Guests are cordially invited to an informal smoker in the auditorium of the Detroit Cancer Center, 4811 John R Street.

Tuesday, October 21

Morning Session—10:00 A.M.

The Problem of Autonomy and Dependence of Tumor Cells
JACOB FURTH, M.D.
Oak Ridge National Laboratory

The Considered Use of Antimetabolites
D. W. WOOLLEY, Ph.D.
The Rockefeller Institute for Medical Research

Lunch—12:15 P.M.

Afternoon Session—2:00 P.M.

Studies on the Basic Mechanism of the Effects of Radiation on Individual Cells
ALEXANDER HOLLAENDER, Ph.D.
Oak Ridge National Laboratory

Genetics and its Implications for Human Disease
LAURENCE H. SNYDER, Sc.D.
The University of Oklahoma

Wednesday, October 22

Morning Program—9:00 A.M. to 12:00

Open House at the Detroit Cancer Center

Lunch—12:15 P.M.

Afternoon Session—2:00 P.M.

The clinical program is sponsored by the American Cancer Society, Southeastern Michigan Division.

The Localization and Treatment of Gliomas of the Brain
LOYAL DAVIS, M.D., Ph.D.
Northwestern University Medical School

An Appraisal of Radioisotopes in Cancer Therapy
SHIELDS WARREN, M.D.
New England Deaconess Hospital

The Problem of Pigmented Moles and Malignant Melanoma
GEORGE T. PACK, M.D.
Pack Medical Group

A Review of Our Most Recent Experience in the Chemotherapy of Cancer
SIDNEY FARBER, M.D.
Boston Children's Hospital

* * *

The UAW (CIO) listed its net worth at $12,039,29 Friday [August 22], a gain of more than 50 per cent o $4,000,000 in the past year.

The accounting was contained in the union's annua report for the year ended May 31. It was submitted b UAW Secretary-Treasurer Emil Mazey.

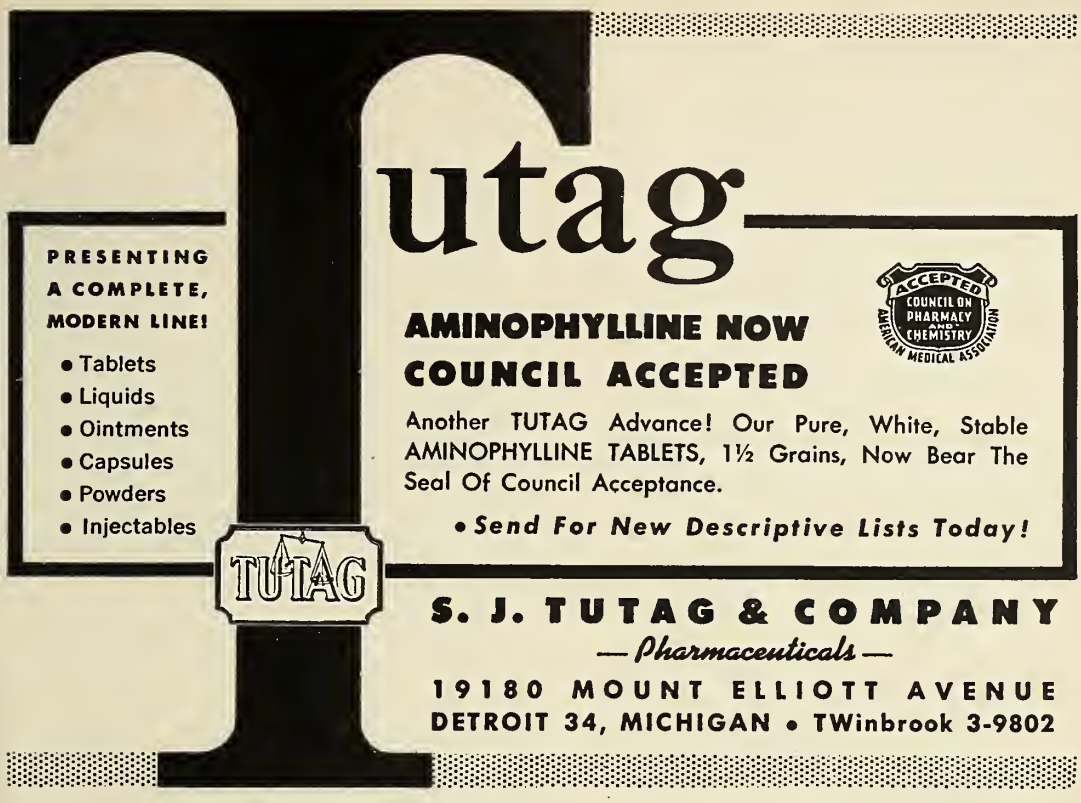
Slightly more than half of the net worth, or $6,088, 404 is in the union's strike fund, the Mazey report said

It said the fund increased $1,534,961 during the yea despite strike contributions of $1,796,255 made to 11 local unions in the 12-month period.

The union's general fund collected $13,020,775 i per capita taxes and other receipts and spent $10,627, 267.

Among the receipts was $255.51, which represents ir terest on stocks the UAW holds in corporations. Pu chase of the stock entitles the union to entry in stoc holders' meetings and the corporations' financial report

Mazey said the improved financial condition resulte mainly from the $1 increase in dues voted at the la UAW convention in April, 1950. Members now pa



2.50 a month, of which the international union receives 95 cents.

Membership in the union was listed as 1,180,284 on ay 31, a gain of 134,595, Mazey said.—*Detroit Free ess,* August 23, 1952.

* * *

New Book on Health Resources in United States.—ie Brookings Institution in Washington has just announced publication of a new book, *Health Resources in e United States,* which gives a factual account of the rsonnel, facilities, and services available to serve the tion's health. It was written under the direction of orge W. Bachman, who has had 30 years' experience the medical sciences and public health.

Three years of research, involving the review of hunreds of documents, went into the manuscript. More an 700 private and public agencies contributed maials for analysis.

* * *

British Doctors Get Pay Hike.—The 20,000 doctors der Britain's socialized medicine set-up finally received ir pay increase, which will cost taxpayers nearly 00,000,000 between now and next March. The raise, roactive to the start of the socialized medical service 1948, represents an average payment to each doctor nearly $5,000.

The raise came after the doctors threatened to leave scheme high and dry last year.

Doctors at present earn $1.70 a year for every pant on their books, and they can have 4,000 patients. The average, however, is 2,300. The increase will mean about $1,500 more yearly.

* * *

The Committee for the Nation's Health has circularized to physicians a brochure listing leaflets, pamphlets and bulletins which it claims will "help to win the fight to take the price tag off good health for everyone."

For the information of the medical profession, generally, here is the list of officers and members of the board of directors.

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Secretary: Walton Hamilton.

Treasurer: Morris Llewellyn Cooke.

Honorary Vice-Chairmen: William Green, Bishop Francis J. McConnell, Philip Murray, Bishop G. Bromley Oxnam, Mrs. Franklin D. Roosevelt, Gerard Swope, Walter Wanger.

Chairman, Executive Committee: Michael M. Davis.

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* * *

Your Reference Committee on Medical Educati and Hospitals commends the excellent report of D Elmer L. Henderson, President of the American Me cal Education Foundation. Your Reference Committ believes that the American Medical Education Founc tion deserves and should have the unqualified suppc of all members of the American Medical Associatic Many of the constituent state medical societies ha set up committees for the collection of funds from th members in addition to making a substantial contrit tion to the Foundation from their own funds. Yo Reference Committee urges that similar committees formed in the state societies where this has not be done. The large sums collected by some state and cour medical societies is an indication of what can be complished when the importance of this laudable u dertaking is brought to the attention of each in vidual member of the Association. Your Referer Committee believes that those who adhere to the ba concepts of democracy should support the tenets democracy not only with words but with deeds.—Rep of AMA Reference Committee on Medical Educat and Hospitals, adopted by AMA House of Delegates June 11, 1952.

* * *

New hospital projects authorized by the Division Civilian Health Requirements, Federal Security Agen for construction under the controlled materials pl during June, 1952, included an addition of 42 beds Mercy Hospital, Muskegon, at an estimated cost $1,621,000 and an addition to the laundry of Penn Hospital, Hastings, at an estimated cost of $315,000.

* * *

The President's Commission on the Health Needs the Nation has been holding hearings on voluntary-c pulsory insurance. These included meetings in Ph delphia, Houston, Raleigh, Minneapolis, St. Louis, Cle land, San Francisco and Detroit. The last named m ing was held September 23.

* * *

A new GI bill for veterans who served in the arr forces since the start of the Korean conflict on June 1950 provides five benefits, to assist veterans in t return to civilian life. Included are education and tr ing; guaranteed or insured loans for homes, farms businesses; unemployment compensation; mustering pay, and job-finding help. For detailed informat write Veterans Administration Information Ser Washington 25, D. C.

* * *

The American Goiter Association offers the Meter Prize Award of $300 and two honorable n tions for the best essay submitted concerning orig work on problems related to the thyroid gland. Award will be made at the Annual Meeting of the

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ciation in Chicago, May 7-8-9, 1953. For informan, write George C. Shivers, M.D., Corresponding cretary, Colorado Springs, Colorado.

* * *

"Can we conquer polio now?" is the title of an article Wm. A. Lydgate, published in *Today's Woman,* Aust, 1952. Among the conclusions are that "polio is ead by human filth and carelessness, not by rats or ce, or by droplets in the sneeze of a polio patient, crowded schools or swimming pools."

* * *

H.R. 7800.—Before its adjournment on July 7 Conss left this controversial old age pension bill a coned jumbled wreck on the legislative shores, accordto George F. Lull, M.D., Secretary of the AMA. e House adopted the controversial Section 3 which vided for the establishment of Administrative manery to determine permanent and total disability ong potential beneficiaries under the Old Age and vivors Insurance provisions of the Social Security . The Senate eliminated this Section. Then the nference Committee came up with a most confusing mpromise: provision is made that no application shall accepted prior to July 1, 1953. However the final ence of the Section provides that all of the provisions uded therein shall cease to be in effect as of June 1953. The net result of this anomalous working is provide for an expiration date of the section on the preceding the acceptable date for receiving applions.

is clear that further legislative action must be taken before such provisions can be adopted into permanent law. Under the present Act, Congress has merely written a memorandum to itself suggesting that hearings be held on this matter early in 1953!

* * *

"Ten Ways to Ruin a Practice" is the title of a searching editorial published in the *Detroit Medical News* of May 26 and written by Wm. S. Reveno, M.D., Detroit. Here are a few of the listed practices "that can ruin any practice":

1. Disappearing whenever the mood strikes us and otherwise making ourselves as unavailable as possible.
2. Making no pretense about keeping appointments and keeping patients waiting in the belief that they will thus appreciate us more.
3. Prescribing by ear and without regard to cost, not taking the time to diagnose or to plan treatment beforehand.
4. Being as impersonal as possible and brushing patients off quickly so they can't ask questions.
5. Sparing no one's feelings in discussing prognosis —giving it to 'em straight and walking off.
6. Failing to plan for patients who are hospitalized, and having no regard for the length of stay or its cost.
7. Labelling the problem patient a neurotic and punishing him if he fails to respond to treatment.
8. Blowing our tops often to impress the patient with our maturity.
9. Keeping no records but relying solely on memory.
10. Charging all the traffic will bear.

THE DOCTOR'S LIBRARY

Acknowledgment of all books received will be made in this column, and this will be deemed by us as full compensation to those sending them. A selection will be made for review, as expedient.

THE STORY OF THE ADAPTATION SYNDROME (Told in the Form of Informal, Illustrated Lectures). By Hans Selye, M.D., Ph.D. (Prague), D.Sc. (McGill), F.R.S. (Canada), Professor and Director of the Institute de Medicine et de Chirurgie experimentales Universite de Montreal. Complimentary Copy. Montreal, Canada: Acta, Inc., Medical Publishers, 1952. Price $4.50.

The author has compiled another collection of his findings—the result of research and experimentation. He presents this material in the form of seven lectures. These lectures are another attempt to explain and elucidate the author's theories regarding his concepts on the general adaptation syndrome reaction to stress. He presents his methods of animal experimentation to show the importance of the endocrine glands in this adaptation mechanism. He discusses the diseases of adaptation, the clinical uses of adaptative hormones and the animal effects of hormonal overdosage. The seventh chapter is devoted to a general summary and outlook in which the author presents his own views.

"The author admits that there are many investigators who disagree with some of his concepts, and there are divergent points of view and schools of thought which advocate different possibilities of interpretation." These are admissions that the author has included in this volume. The reader may draw his own conclusions regarding the value of these concepts. To get an over-all view of this subject in an easily read volume, this book meets its requirements.

G.K.S.

SURGERY AND THE ENDOCRINE SYSTEM—Physiologic Response to Surgical Trauma-Operative Management of Endocrine Dysfunction. By James D Hardy, M.D., F.A.C.S., Assistant Professor of Surgery University of Tennessee Medical College. Illustrated Philadelphia: W. B. Saunders Co., 1952. Price $5.00

Dr. Hardy states he hopes to accomplish two objectives in writing this monograph. First he wishes to outline the mechanism by which the patient survives injury and to clarify the way in which the pertinent newe advances in physiology affect surgical care. Secondly h wishes to present facts and procedures related to th surgical management of disease of the endocrine glands Material of much practical value will be found in chap ters seven to eleven. In these chapters the author review the surgical problem related to the thyroid, parathyroid pancreas, adrenals, pituitary, thymus, ovaries and teste However, no attempt is made to portray operative tech nique in detail. The bibliographies at the end of eac chapter are excellent. This book is recommended to th busy general surgeon.

JW

BACITRACIN—A Review and Digest of the Literatu Up to and Including January, 1952. New York: R search Division S. B. Penick & Co., 1952.

This book makes available to the pharmaceutical indu try and the medical profession a review of the data whi has accumulated on the clinical usefulness of bacitrac and to direct attention to the wide potential of this dr based upon its known synergistic action with other an biotics. Bacitracin may be administered parenterally a when employed under proper hospital supervision is life-saving drug.

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'AN TO MAN. By Bernard N. Ward, C.P.A. Illustrations and Jacket by Rodolphe LaRiviere. Caldwell, Idaho: The Caxton Printers, Ltd., 1952. Price $4.00.

The author, Mr. Ward, is a Certified Public Accountıt in Bay City, whom the editor met when addressing e Lions Club. The book was in process at that time, d we have anticipated reviewing it for about four onths. The book is well bound, well printed volume, t in large, easily readable type. We confess we were willing to lay the book down until it was finished, which : cannot say for many volumes. The author pictures the come tax problem from the payer's standpoint, from e CPA's standpoint, and also from the standpoint of e collector. He refers back to the time before the ıendment to the Constitution which allowed an income x. He reminds the reader of the promises that the tax ıuld be assessed only on a comparatively few well-able-pay persons, but now it has expanded as such things ve a tendency to do until it covers practically every ırking person, and the tax instead of being nominal ɔmised never to exceed one per cent, is now in the ighborhood of 30 per cent of income.

Mr. Ward describes the uncertainty and sometimes possibility of the taxpayer learning how much his tax ually is, and that sometimes not until years later. He tures the embarrassments, the unrelenting searching facts and figures, the actual witch hunt of governnt in trying to find some more to tax. He has seen : problem from both sides in his official capacity. He calls attention to the fact that all of us are concerned with how much we have to pay, but almost never know what becomes of the tax money, how it is spent, or wasted. Government builds more bureaucracies to collect the tax. The administration of the program is wasteful, inefficient, and employs an army of nonproducing persons who are parasites on the public, as is every nonproducer.

Mr. Ward advocates repeal of the income tax laws, and repealing of the amendment. He has a proposal that sounds good. It would eliminate hundreds of thousands of federal employes, and therefore would not have to produce anywhere near so much revenue. Every income taxpayer should read this book, and form his own opinion.

VOCATIONAL SERVICES FOR PSYCHIATRIC CLINIC PATIENTS. By Thomas A. C. Rennie, M.D., Cornell University Medical College and The New York Hospital and Mary F. Bozeman Rehabilitation Project National Association for Mental Health. Published for the Commonwealth Fund. Cambridge, Massachusetts: Harvard University Press, 1952. Price $1.25.

This booklet is a statistical report which was begun by the National Association for Mental Health in the study of vocational needs of psychiatrically handicapped patients and published in 1950. To further these studies there was an extension of the enquiries to a group of psychiatric patients who had only received treatments in

Out Patient Clinics. The clinics selected were from several New York hospitals and the Jackson, Michigan, Mental Hygiene Clinic in conjunction with various vocational agencies.

This study is an exploration of the extent to which patients presented vocational problems and of the ways in which clinics and vocational agencies can work together. An attempt has been made to show how these agencies can function more fully together. It also points out the need for research aid the accumulation of further research.

G.K.S.

NEW AND NON-OFFICIAL REMEDIES 1952, containing descriptions of the articles which stand accepted by The Council on Pharmacy and Chemistry of the American Medical Association on January 1, 1952. Issued under the direction and supervision of The Council on Pharmacy and Chemistry, American Medical Association. Philadelphia: J. B. Lippincott Company, 1952. Price $3.00.

New and Non-Official Remedies is a book published annually for many years by the American Medical Association, containing descriptions of the articles accepted by The Council on Pharmacy and Chemistry of the Association as of January 1 of each year. The books are gradually increasing in size and in volume, being a ready reference for the practitioner who desires to be sure his remedies are properly tested and proven.

DYNAMIC PSYCHIATRY. Transvestism-Desire for Crippled Women. Volume Two. Louis S. London, M.D. New York: Corinthian Publications, Inc., 1952.

This is the second volume of what appears to be the author's presentation of "dynamic psychiatry." The entire small volume is devoted to the dynamics of one patient who presented three component deviations in transvestism—dressed as a woman, practiced shoe fetishism, and had a pathological interest in crippled and deformed women. The second part of this small volume is devoted to fifty drawings of his "fantasy life." The first part is a short chapter on anthropological and historical writings on this subject.

Unfortunately, this book appears to lack anything more than a superficial exposition on this one form of sexual deviation. The adolescent style of drawings are redundant, and one can question the conclusions drawn by the author regarding his case report.

G.K.S.

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Coronary Thrombosis: In a "Medical Memo" by Roger Sterling in *Stag*, August number, the following statistic is mentioned: "Ninety-six per cent of coronary thrombosis victims under forty are male. Of these, the majority are the muscular type of men."

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JMS

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1. Michael, N.: Ohio State M. J. *48*:42, 1952.
2. Carter, S., in Conn, H. F.: Current Therapy 1952, Philadelphia, W. B. Saunders Company, p. 610.
3. Lennox, W. G., in Cecil, R. L., and Loeb, R. F.: A Textbook of Medicine, ed. 8, Philadelphia, W. B. Saunders Company, 1951, p. 1379.
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5. Christian, H. A.. The Principles and Practice of Medicine, ed. 16, New York, D. Appleton-Century Company, 1947, p. 1370.

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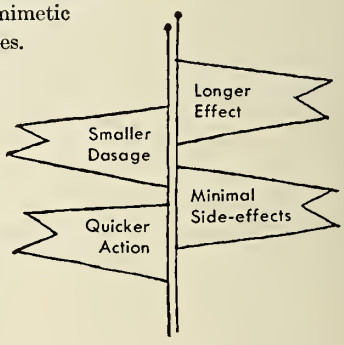


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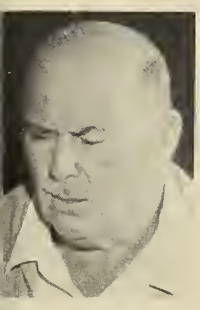
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THE JOURNAL
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)LUME 51 OCTOBER, 1952 NUMBER 10

Contributors to This Issue



Paul de Kruif



Wm. M. Le Fevre, M.D.



Bruce C. Lockwood, M.D.

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THE JOURNAL
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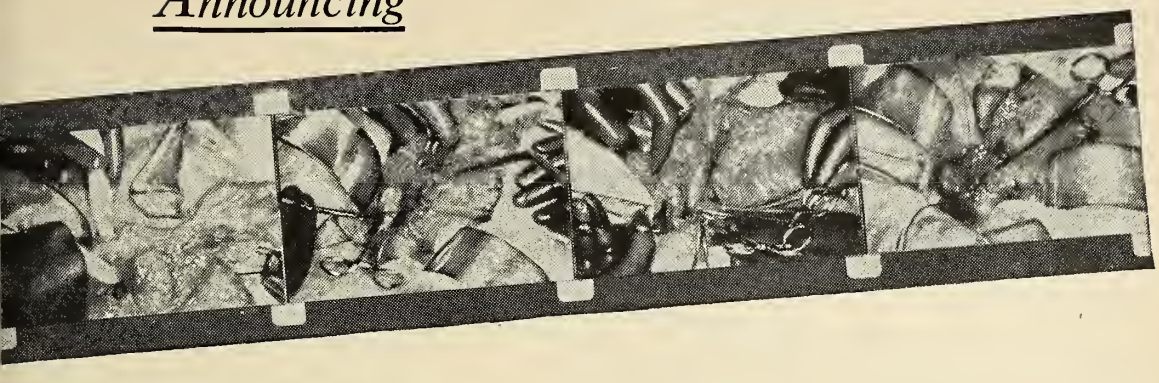
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Bacterial resistance	Tubercle bacilli with increased resistance to Nydrazid have been isolated from patients. Resistant organisms can also be cultured in vitro, but this phenomenon is virtually eliminated when cultures are exposed to streptomycin and Nydrazid simultaneously.	The clinical implications of bacterial resistance are not completely known. Patients harboring resistant organisms may continue to improve under treatment. The question of delaying the emergence of resistant bacilli by combined therapy must await further study.
Toxicity	Toxic reactions to Nydrazid are chiefly due to stimulation of the central nervous system. They are negligible in the therapeutic dose range, except in patients with convulsive tendencies.	It appears probable that central nervous reactions to Nydrazid can be controlled by barbiturates. But with continued use of the drug, it is not known what sensitivity reactions may occur.

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INTERNAL REVENUE RULES M.D.S MAY DEDUCT PAYMENTS FOR PROFESSIONAL ASSISTANCE

U. S. Bureau of Internal Revenue has ruled that physicians may deduct from their taxable income the payments they make for "professional assistance" in conducting their practice. Such deductions may be made, the Bureau states in its Bulletin of September 1, 1952, as an ordinary and necessary expense of carrying on a trade or business. The Bureau did not define "professional assistance."

On the question of payments made by a physician, on a split fee basis, to another physician who refers patients to him, the Bureau states that such payments as deductible business expense must be determined "in the light of all the circumstances in each case." It adds:

"However, as a general rule, such payments are deductible for Federal income tax purposes provided they are normal, usual, and customary in the profession and in the community; are appropriate and helpful in obtaining business; and do not frustrate sharply defined national or state policies evidenced by a governmental declaration proscribing particular types of conduct."

A Bureau spokesman explained that the decision sets forth the pattern the Bureau is to follow in the future when ruling on such cases. The ruling cited the U. S. Supreme Court decision in the Thomas B. Lilly case which permitted tax deductions of rebates paid by an optical company to physicians prescribing eyeglasses sold by the firm. The Bureau Bulletin (No. 18) is available at Government Printing Office, Washington 25, D. C., at 15 cents a copy.

MICHIGAN CLINICAL INSTITUTE

March 11-12-13, 1953

The "block system"—so successful at the 1952 MCI—will be continued at the Institute in Detroit next March.

Wednesday morning "block" subjects will cover *Surgery.*

Wednesday afternoon's topics will be devoted to *Obstetrics, Gynecology* and *Pediatrics.*

Cancer Control will be the subject of four lectures on Thursday morning, March 12.

Surgery of Trauma will be featured on Thursday afternoon.

Friday, March 13, will feature *Heart and Rheumatic Fever* in the morning.

Internal Medicine will be the topic of subjects featured Friday afternoon, March 13.

Among the speakers who already have accepted invitations to appear on the 1953 Michigan Clinical Institute program are:

H. W. Dargeon, M.D., New York City; R. S. Dinsmore, M.D., Cleveland; J. R. Driver, M.D., Cleveland; M. H. Griswold, M.D., Hartford, Conn.; R. W. Houde, M.D., New York City; H. B. Houser, M.C., Warren Air Force Base, Wyoming; E. M. Kline, M.D., Cleveland; W. B. Kountz, M.D., St. Louis, Mo.; D. J. Barnes, M.D., Detroit; G. S. Bates, M.D., Detroit; L. E. Bauer, M.D., Detroit; A. I. Braudo, M.D., Ann Arbor; W. N. Davey, M.D., Ann Arbor; F. D. Dodrill, M.D., Detroit; R. A. Gerisch, M.D., Detroit; H. K. Hellems, M.D., Detroit; W. S. Reveno, M.D., Detroit; and C. N. Swanson, M.D., Detroit.

The complete program of the 1953 MCI will be published in the December, 1952, number of JMSMS.

J. Milton Robb, M.D., of Detroit, is General Chairman of Arrangements for the 1953 Institute.

SOCIALIZED MEDICINE THROUGH THE BACK DOOR

The last ILO Conference, held in June, 1952, gives evidence that the drive for socialized medicine has shifted from the domestic scene to the international scene—that it may walk through the back door under the guise of an international treaty.

ILO means International Labor Organization, an affiliated agency of the United Nations.

Ratification of the ILO's newest Convention (Treaty) on Minimum Standards of Social Security by a two-thirds vote by only the Senate would establish "socialized medicine" irrespective of the wishes of the majority of the members of Congress and the public to the contrary. The medical care section of the convention stipulates as part that a country ratifying must provide a system of compulsory health insurance. Lacking this, it has two alternatives: (1) private, voluntary health insurance administered by public authorities under established regulation, or (2) private voluntary health insurance administered by insurance companies under government supervision.

The same forces which unsuccessfully attempted to socialize the medical profession through legislation in our State Legislature and in the Federal Congress are finding it much easier to work through the United Nations and the ILO. Through the wholesale approval of treaties, convention, and executive agreements, our international representatives have placed not only American medicine in

(Continued on Page 1258)

WHEN DRUG THERAPY

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The administration of many drugs can sharply increase the patient's requirements for various essential nutrients. The presence and action of certain drugs in the organism may alter normal utilization of nutrients to purposes of detoxication of these drugs.

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CHLORINE	900 mg.	MANGANESE	0.4 mg.	BIOTIN	0.03 mg.	*RIBOFLAVIN	2.0 mg.
COBALT	0.006 mg.	*PHOSPHORUS	940 mg.	CHOLINE	200 mg.	*THIAMINE	1.2 mg.
*COPPER	0.7 mg.	POTASSIUM	1300 mg.	FOLIC ACID	0.05 mg.	*VITAMIN A	3200 I.U.
FLUORINE	3.0 mg.	SODIUM	560 mg.	*NIACIN	6.7 mg.	VITAMIN B_{12}	0.005 mg.
*IODINE	0.7 mg.	ZINC	2.6 mg.	PANTOTHENIC ACID	3.0 mg.	*VITAMIN D	420 I.U.
*IRON	12 mg.						

*PROTEIN (biologically complete) 32 Gm.
*CARBOHYDRATE 65 Gm.
*FAT 30 Gm.

*Nutrients for which daily dietary allowances are recommended by the National Research Council.

SOCIALIZED MEDICINE

(Continued from Page 1256)

our national sovereignty in our Constitution in jeopardy.

Doctor, get acquainted with the ILO, its history, purpose, and plans—and then wage the same vigorous campaign against socialism by treaty that you are now conducting against socialism made-in-America.

"Must" reading for every physician are the articles which have been appearing in JAMA on the ILO, such as the excellent editorial "Socialized Medicine—the ILO Way" which appears in the August 23 number of JAMA.

HIGHLIGHTS OF EXECUTIVE COMMITTEE OF THE COUNCIL

August 13, 1952

- Sixty-one items were presented to the Executive Committee of The Council on August 13. Chief in importance were:
- Financial reports were presented, studied and approved. Bills payable were presented and payment was authorized.
- The Michigan State Board of Registration in Medicine advised that it had appointed a Liaison Committee to the Michigan State Medical Society composed of E. W. Schnoor, M.D., Grand Rapids; E. C. Swanson, M.D., Vassar, and O. D. Stryker, M.D., Mt. Clemens. (The MSMS representatives to the Liaison Committee with the State Board are: W. B. Harm, M.D., Detroit; L. Fernald Foster, M.D., Bay City; and W. S. Jones, M.D., Menominee).
 The State Board's letter also included copies of the Board's new Rules and Regulations applicable to the amendments made to the Medical Practice Act by the 1952 Legislature.
- Committee reports—the following were given consideration: (a) Committee to Survey Hospital Facilities at the State Prison of Southern Michigan at Jackson, meeting of July 15 (interim report); (b) Beaumont Memorial Working Committee, meeting of July 30; (c) Public Relations Committee, meeting of August 3; (d) Committee on Arbitration (re Uniform Fee Schedule for Governmental Agencies), meeting of August 8.
- Beaumont Memorial Restoration. The suggestions of President Otto O. Beck, M.D.: (a) to draw up a lease so that MSMS has sole control of the building during the period it is being restored as a monument or shrine to William Beaumont, M.D.; (b) that copies of the MSMS offer and the acceptance by the Mackinac Island State Park Commission be forwarded to the Governor and to the State Administrative Board for their files; (c) that a written understanding be made as to the place the MSMS will hold after it relinquishes the building and turns the completed project over to the State so that future Park Commissions may know and follow the terms of the agreement; (d) that full credit be given to Mr. W. F. Doyle, Chairman of the Park Commission, for the impetus he gave to the restoration movement and that his work be prominently presented in a history of the Beaumont Memorial Restoration for dissemination to the public and for preservation in the Memorial itself on Mackinac Island; and (e) that the Park Commission be requested to zone the area to protect the quality of the neighborhood in which the Beaumont Memorial is located.

 Dr. Beck also reported that contributions to the Beaumont Memorial to August 10, totaled $20,689.30, including gifts of 1,359 individual doctors of medicine with an average contribution of $11.60; to date 25.6 per cent of MSMS members have contributed.

 President Beck also announced that a special emblem or badge will be pinned on all doctors of medicine who have contributed to the Beaumont Memorial Fund when they register at the MSMS Annual Session in Detroit.
- Chairman William Bromme, M.D., appointed Consultative Committee to the Beaumont Memorial Restoration: Otto O. Beck, M.D., Chairman, Birmingham; F. A. Coller, M.D., Ann Arbor; Prentiss M. Brown, St. Ignace; L. Hirschman, M.D., Traverse City; Professor Emil Lorch, Ann Arbor; H. J. Loynd, Detroit; and A. H. Whittaker, M.D., Detroit. The appointments were confirmed by the Executive Committee of The Council.
- President's Commission on Health Needs of the Nation, Regional Hearing in Detroit on September 23 under chairmanship of Walter Reuther, member of the Commission. The Executive Committee of The Council instructed the Secretary to request the privilege of an oral presentation by an MSMS representative at the Regional Public Hearing in Detroit; it also requested C. E. Umphrey, M.D., Detroit, to coordinate the health and medical groups so that an adequate presentation is made at this hearing of September 23.
- Michigan Insurance Commissioner Joseph Navarre and Deputy Commissioner H. Thompson were present and discussed voluntary hospital and medical care programs.
- The monthly report of Rheumatic Fever Coordinator Leon DeVel, M.D., was presented and accepted.
- Requests of Medical Economics, the magazine for statement re the future of prepaid medical care plans was referred for report to the MSMS representatives on Michigan Medical Service Board and also to the Liaison Committee with Michigan Medical Service.

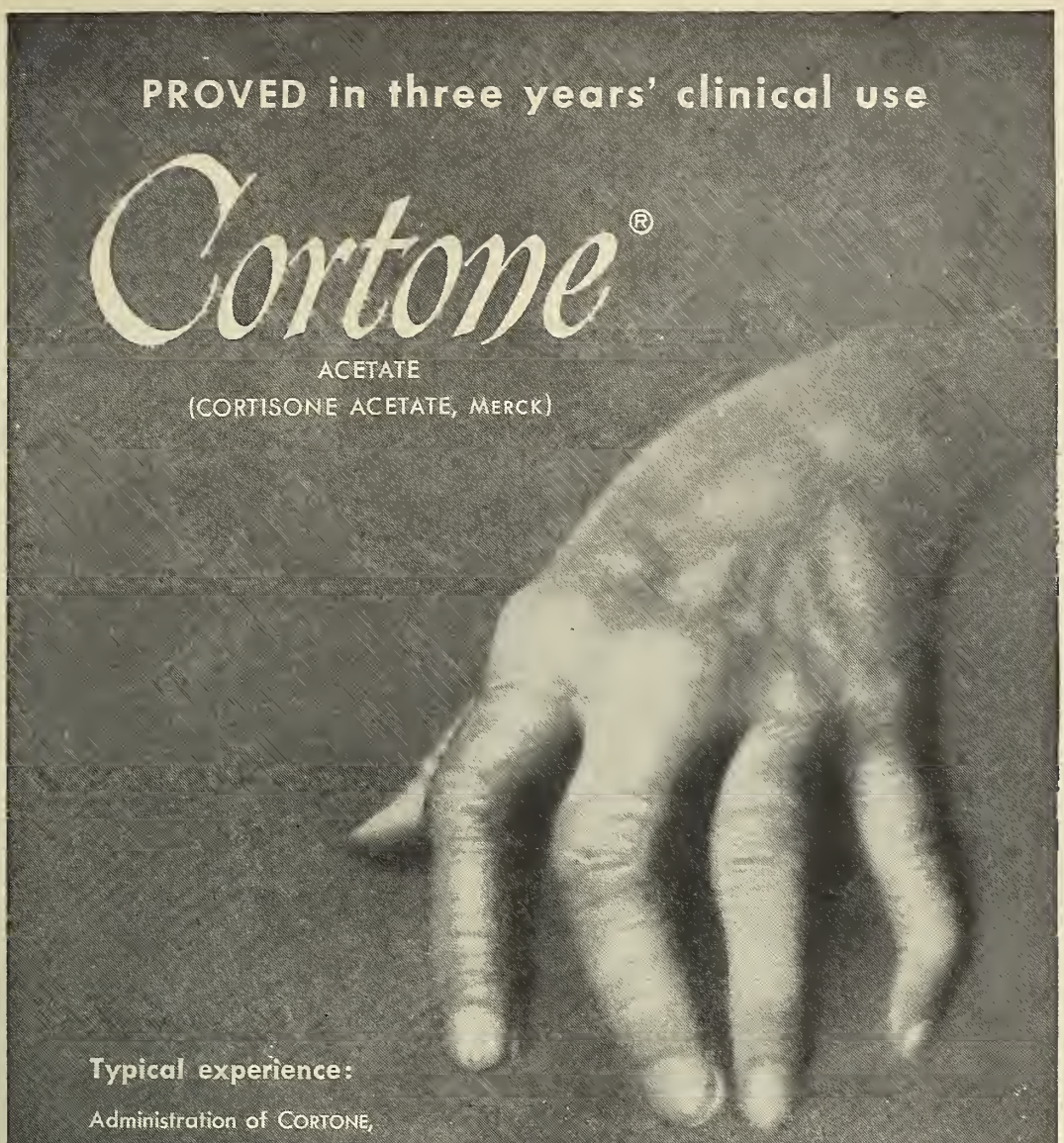
(Continued on Page 1260)

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Ward, E., Slocumb, C. H., Polley, H. F., Lowman, E. W., and Hench, P. S.,
Proc. Staff Meet. Mayo Clin. **26**: 361, Sept. 26, 1951.

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HIGHLIGHTS OF THE COUNCIL

(Continued from Page 1258)

- The MSMS County Secretaries Conference of 1953 was set for Lansing on Wednesday, February 25, 1953.
- Michigan Clinical Institute of 1953, Detroit. Discussion Conference Leaders were chosen: W. H. Huron, M.D., Iron Mountain, for March 11; F. A. Coller, M.D., Ann Arbor, for March 12; E. D. Spalding, M.D., Detroit, for March 13.

 A special meeting for residents, interns and senior medical students, during the 1953 MCI was authorized—the arrangement of one period of particular interest to these young men and women to be recommended to the Committee on Arrangements.
- (a) Report of S. E. Gould, M.D., Eloise, on Brucellosis Conference in St. Paul was accepted with thanks and referred to Editor Haughey for possible publication in JMSMS.
 (b) Report of A. H. Whittaker, M.D., Detroit, on President's Conference on Industrial Safety was received with thanks.
- Michigan Industrial Health Day was scheduled for Tuesday, March 10, 1953, at the Sheraton-Cadillac Hotel, Detroit, with a testimonial banquet in the evening to honor the President of the Industrial Medical Association, E. A. Irvin, M.D., Detroit.
- A. Hazen Price, M.D., was nominated to succeed himself on the State Advisory Committee for Practical Nurse Education, a committee of the Michigan Department of Public Instruction.
- The monthly report of the Public Relations Counsel included (a) information on a WWJ dramatic radio program to "Beaumont" scheduled during MSMS Annual Session in Detroit; (b) Annual Session luncheons, radio and TV speakers; (c) MSMS Public Relations Conference scheduled for Detroit, February 1, 1953—tentative program presented; (d) Plans for Exhibit at State Fair approved.
- Nominated to represent MSMS at the Michigan Welfare League convention in Detroit, November 10-12 were R. J. Hubbell, M.D., Kalamazoo; L. W. Hull, M.D., Detroit; O. D. Stryker, M.D., Mt. Clemens, and H. B. Zemmer, M.D., Lapeer.

MSMS PLACEMENT BUREAU—AT YOUR SERVICE

For those readers who may not be familiar with the Placement Service activities of the Michigan State Medical Society, we invite attention to the fact the State Medical Society maintains a listing of doctors of medicine seeking locations in which to practice, that is, interns and residents who are about to enter private practice, medical practitioners in larger cities who many times wish to locate in a smaller community, and M.D.s from other states who indicate a desire to transfer to Michigan.

Your State Medical Society also maintains a list of Michigan communities which have indicated a need for medical services, communities which have no doctor of medicine available at all, and some communities which need additional medical service.

This service operates by providing, upon request, a list of communities seeking medical service to those physicians who indicate a desire to locate in Michigan; and, supply a list of physicians desiring Michigan locations in those communities who may request same. Contact between the physician and the community is made directly by the interested parties.

Locum tenens: The MSMS office also receives requests for locum tenens and since it is felt that more requests might be secured and additional service rendered if such a department for placement activities were added, we would appreciate notification when a locum tenens physician is desired, also, advice as to doctors of medicine who may desire to perform locum tenens activities in order that we may be of assistance to both parties in satisfying their needs.

The Placement Bureau of the Michigan State Medical Society is at YOUR service to provide better medical care in Michigan.

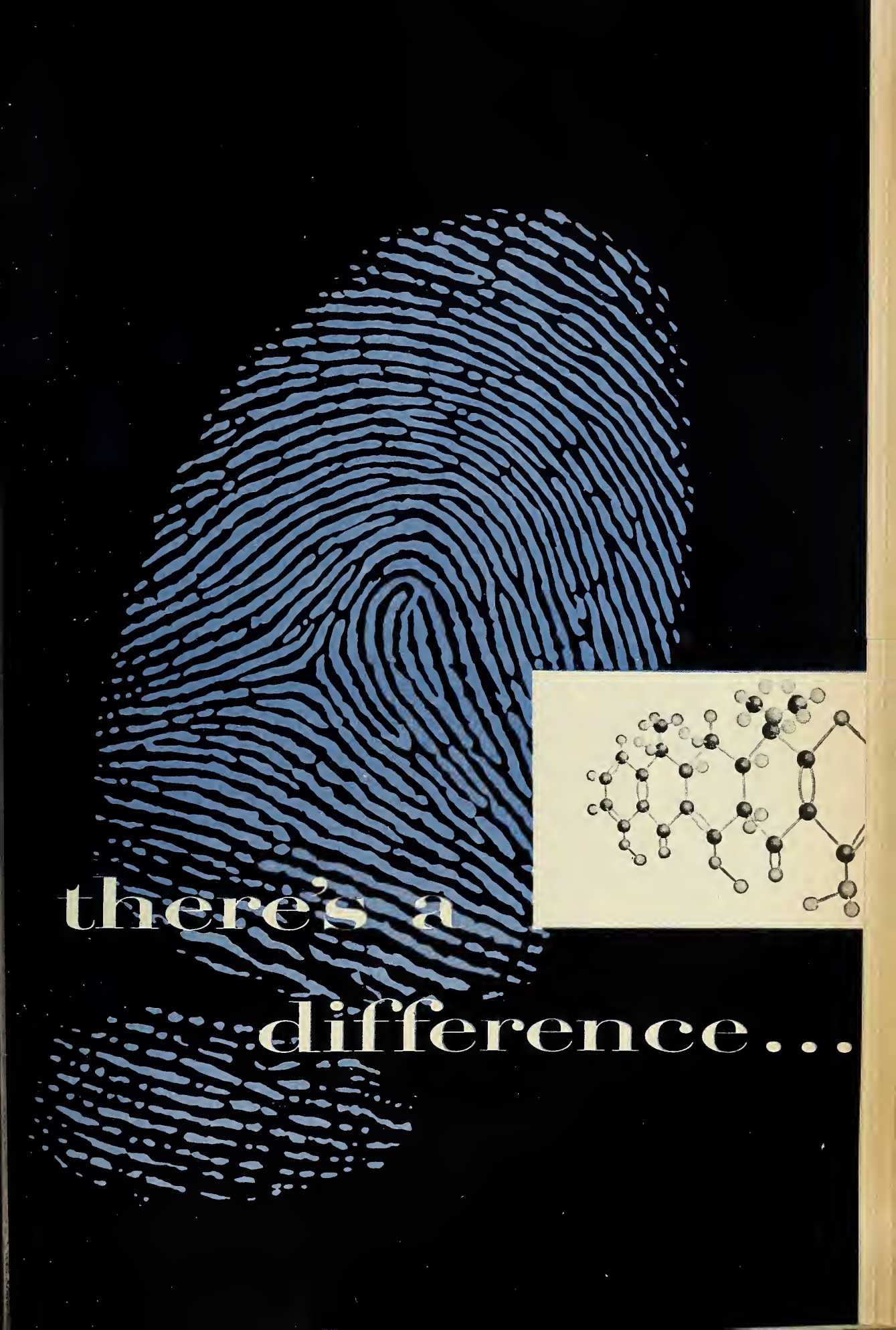
CIO RETRACTION

A $50,000 libel suit commenced against the Wisconsin CIO publications office by the head of the Kohler Co. medical staff is being withdrawn. Dr. C. C. Gascoigne said Thursday he planned to ask for dismissal of the action following the August 8 publication of a retraction in the state edition of the *Wisconsin CIO News*. Dr. Gascoigne had charged that a news article in the May 9 issue was "deliberately, maliciously and falsely" designed to lead readers to understand that Kohler Co. doctors made an incorrect diagnosis of the condition of a plant employe. "Any implication that the Kohler Co. doctors made an incorrect diagnosis or advised or administered any incorrect treatment is without foundation and fact," the retraction notice stated.—*Milwaukee Sentinel,* August 15, 1952. Editorial, Industrial Medicine and Surgery, September, 1952.

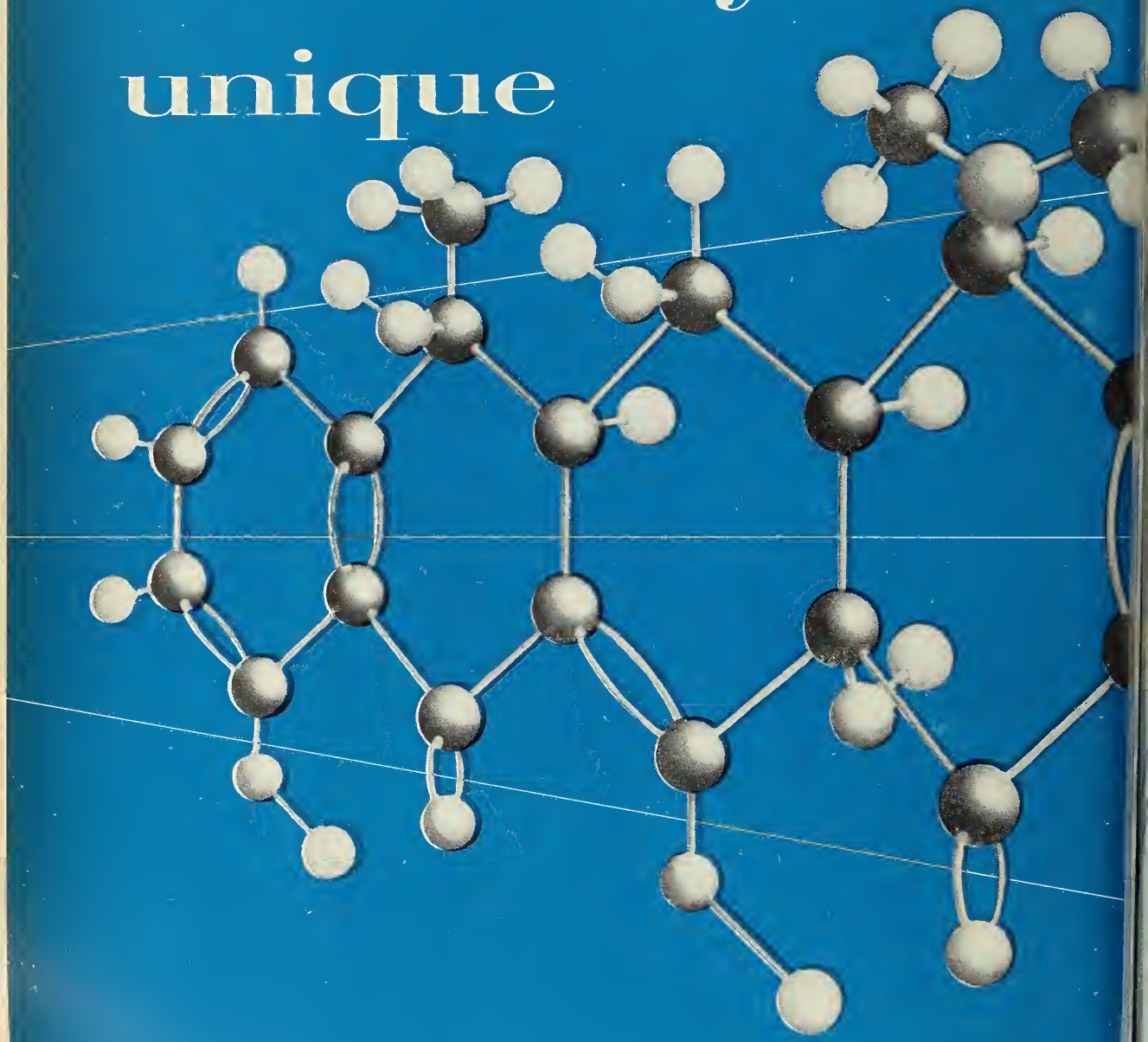
MORE MEDICAL-SOCIAL DEVELOPMENTS REPORTED AT ILO HEADQUARTERS

Two more developments of some medical interest are reported from International Labor Organization's headquarters in Geneva. An ILO survey, with special reference to the chemical industry, concluded that American physicians generally oppose frequent rotation of night workers, while European experts favor more frequent

(Continued on Page 1264)


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APPEARING REGULARLY IN THE J. A. M. A.

MEDICO-LEGAL DEVELOPMENTS

(Continued from Page 1260)

change. Americans were said to feel that rotated night workers were particularly subject to gastric disorders, possibly caused by necessity of repeated adaptation to new hours. The report was limited to discussion and fact-finding and is not proposed as the basis for a treaty. An ILO convention (treaty) becoming effective next January 21 specifies that a minimum of 30 square feet of floor area be provided for each crewman in ships of 3,000 tons or more. The agreement, drawn up in 1946 and revised in 1949, became effective upon ratification by the twenty-third country, Portugal. The convention has not been approved as a treaty by the U. S. Senate, although it was submitted by the President during the 81st Congress.

(Two reports on how ILO operates in medical and social fields appear in the *Journal of the American Medical Association* for August 23, 1952 (Vol. 149, No. 17). *Medical Care and the International Social Security Treaty* was written by Leonard J. Calhoun, Washington attorney and social security expert, who was alternate employer member for the American delegation to this year's ILO conference. The other, *The International Labor Organization—Its History, Purpose and Plans,* was prepared in the office of AMA's Committee on Legislation.)

U. S. MEDICAL BILL FOR 1951: 12½ BILLIONS

The use of student doctors in Veterans Administration hospitals was attacked and defended today at a meeting of the President's commission on health, which also heard that medical care in 1951 cost Americans about 12½ billion dollars.

Dr. Evarts A. Graham of St. Louis, a member of the commission, raised the student doctor issue when he told the meeting he believed the American Legion and other veterans organizations would protest if they realized the extent to which student doctors are used in the VA hospitals.

Dr. Joel T. Boone, chief medical director of the VA, replied immediately that the VA utilizes the services of student doctors very much as do private hospitals. Most of the students, he said, are postgraduates working under competent guidance.

Legion Commends Plan

The American Legion, Dr. Boone said, is fully aware that the VA uses student doctors and has commended their use. The Veterans of Foreign Wars, he asserted, recently considered a resolution critical of the practice, withdrew it, and then adopted a resolution that was not critical.

The report to the commission on the 12½ billion dollar medical bill of the nation in 1951 said about one-fourth of the bill was paid by the government. It estimated there are now 6,832 hospitals in the nation with 4,521,959 beds. In 1951 hospital patients numbered about 18,783,272.

A panel on medical care of veterans said that because of the difficulty in getting the necessary doctors and other trained personnel to staff hospitals the VA hospitals now probably have the maximum number of beds they can care for.

Choose Private Care

Dr. Anthony J. Rourke, president of the American Hospital association, said acceptance of prepaid hospitalization insurance has "markedly decreased" the clinical material available to hospitals with teaching programs. He said it is his impression that university services are receiving fewer teaching patients because "80 million people now covered by prepayment insurance find it possible to elect private services, rather than teaching services."

Dr. Rourke said that if the trend continues "our traditional teaching service will disappear and some other way will have to be found for training the doctors of tomorrow."

Hospitals with programs to teach and train young doctors and interns admit indigent patients for this purpose with the cost of care borne wholly or partially by the hospital.—*Chicago Tribune,* August 14, 1952.

THE HOSPITAL DOLLAR

The following is a condensation of a talk given by Mr. George Wood, administrator of Peralta Hospital, to members of the Medical Staff. Mr. Wood was asked to make his manuscript available to the Editorial Board for publication in this issue of the BULLETIN.

"This bill is terrible, and I'm not going to pay it!" The hospital cashier was having a bad time with the husband of a patient. "How can you expect a working man like me to pay $128 for three days of care? What we need is hospitals run by the government."

The man's wife had been brought into the hospital for an emergency appendectomy three days before. The bill, broken down, covered $52.50 for the room for three days, $60.00 for the surgery, $10.50 for routine laboratory, and $5.00 for drugs, etc.

The man did pay the bill finally—a little sheepishly and shamefacedly, after he was favored with a cool and friendly analysis of the charges and a comparison of them with his own economy.

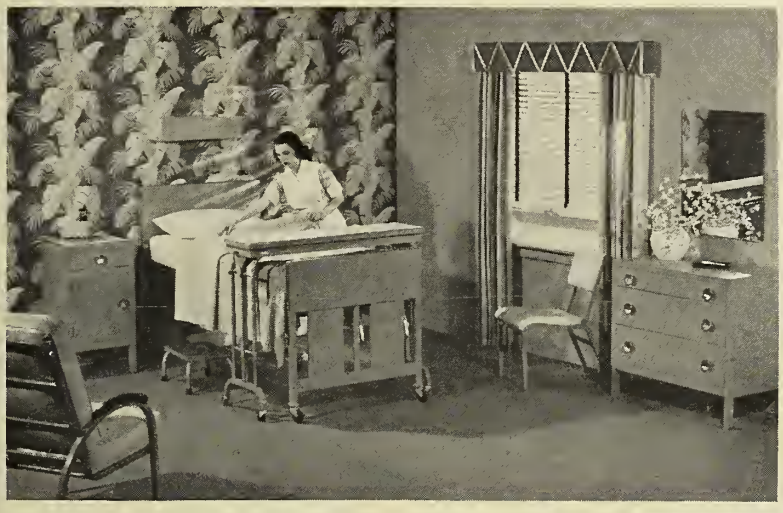
The man was a plumber. He was asked, first, if the service his wife had received was satisfactory, and he agreed that the meals were good, the linen was clean, the nurses were courteous, competent, the hospital was obviously carefully and effectively operated in every way. He had no complaint as to the prompt and competent treatment of the patient.

"What would it cost the hospital," he was asked, "if you were to provide it with plumbing service over a continuous three-day period?"

(Continued on Page 1266)

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F-885 Single Pedestal Overbed Table has extra large top, space for storage inside, may be raised or lowered as necessary.

Famous Simmons furniture efficiently fulfills the requirements of every modern hospital. The ablest designers, engineers and color stylists are employed to assure you that Simmons furniture and hospital equipment is always up to date in design and function. Most Simmons Beds are so designed that supplementary equipment such as Simmons Safety Sides and Demountable Balkan Frames may be used interchangeably. The all metal construction of patient's room furniture makes it most admirably suited for hospital use because it is sturdy, rust-proof, fire resistant and easy to keep clean. The wide variety of cheerful colors and wood grain finishes make decorating attractive rooms remarkably easy.

Whether you are remodeling one room, adding new equipment or building an entire new hospital, you will find a combination of Simmons pieces here at Randolph that will fit your needs.



Above: H-48 Safety Sides attach to brackets on bed ends. Bed is Simmons H-885-3-L-171 Vari-Hite in up position. Below: H-800-3-L-171 equipped with H-16 Balkan Frame, a complete orthopedic bed.



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THE HOSPITAL DOLLAR

(Continued from Page 1264)

"Plumber's rates are $22.00 for an eight-hour day," he replied.

"What about the two night shifts?" he was asked.

"Those would be at double time. That would be $44.00, each."

"So the cost for one day of constant attendance by one plumber would be $110.00."

"That's right. And for three days, it would be $330.00."

"And that's for wages alone. It doesn't include material. It takes more than 400 full time employes to operate Peralta Hospital—2½ employes for every patient, or 5/6ths of one person's efforts, around the clock, for your wife. In addition to this time, the hospital supplied food, linen, medication, surgical equipment, laboratory services, telephone services, dressings and techniques and skills which are at least as specialized as those of a skilled trade such as yours. In addition, the hospital assumed a tremendous responsibility for the safety of your wife."

There was a pause. "Do you still think your bill is too high?"

"For the first time," he said, "someone has taken the time to explain hospital charges to me, in language I can understand."

As gracefully as he could, the husband went out and paid his bill. He left with a good feeling.

The incident inspired some further analysis of comparative hourly costs of hospitalization compared with going rates among skilled trades. An electrician's rate per hour is $2.75, a machinist's $2.41, a teamster's $1.81, a laborer's $1.70. An analysis made of 70,516 patients admitted to Bay Area Hospitals during 1951 represented 374,027 patient days, or 8,976,648 hospital hours. Total money paid by these 70,516 patients was $10,003,042, a cost of $1.11 per hour, for all hospital services, including laboratory, surgery, et cetera.

The prevalent public misunderstanding of hospital charges is a good example of our failure in communications.—*Bulletin of the Alameda-Contra Costa Medical Association,* June, 1952.

MEDICAL MEETINGS AND CLINIC DAYS

A list of known medical meetings and clinic days, sponsored by county medical societies and other physicians' groups in Michigan, follows:

1952

Nov. 17-18	Wayne County and Michigan Academies of General Practice Kellogg Center, East Lansing
Autumn	MSMS Postgraduate Extramural Courses State-wide

1953

Jan. 16-17	Sixth Annual Michigan Rural Health Conference Kellogg Center, East Lansing
Mar. 10	MICHIGAN INDUSTRIAL HEALTH DAY..Sheraton-Cadillac Hotel, Detroit
Mar. 11-13	MICHIGAN CLINICAL INSTITUTE Sheraton-Cadillac Hotel, Detroi Complete program will be published i the December JMSMS. Plan now to at tend and secure your room reservation by writing Robert M. Buckley, Secretary Committee on Hotels, Michigan Clinica Institute, c/o Sheraton-Cadillac Hote Detroit.
April 9	Genesee County Medical Society 8t Annual Cancer Day.....Flin
May 13	Annual Clinic Day and Reunion Wayne University College of Medicin Hotel Fort Shelby, Detro

Additions to this list of meetings are invited b the Editor of JMSMS, in order to make th monthly announcement complete and accurate.

Proposed

BEAUMONT MEMORIAL



"A little from many will build the Beaumont Memorial—a monument to the generosity of Michigan's medical men."—Otto O. Beck, M.D.

Beaumont Memorial Restoration Committee:

I attach my check in the amount of: $.....

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to assist my fellow doctors of medicine of Michigan building the Beaumont Memorial on Mackinac Isla Michigan.

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Heart Beats

AMERICAN HEART ASSOCIATION TO ISSUE NEW SCIENTIFIC JOURNAL

A new bimonthly scientific journal, *Circulation Research,* the only publication devoted exclusively to reports on fundamental studies related to the heart and circulation, will be issued by the American Heart Association, beginning January, 1953, as a further step in the development of its professional education program, according to F. Janney Smith, M.D., Detroit, President of the Michigan Heart Association.

Circulation Research will be edited by Dr. Carl J. Wiggers, Professor and Director, Department of Physiology, Western Reserve University School of Medicine, Cleveland.

Circulation, which is in its third year of publication, will continue as a separate journal under the editorship of Dr. Thomas M. McMillan, Philadelphia. It will concentrate more fully on clinical problems and applied research, as distinguished from fundamental research in the cardiovascular field.

In announcing the new periodical, Dr. Irving S. Wright, President of the American Heart Association, said, "In a period of little over two years, *Circulation* as the official journal of the American Heart Association, has achieved a high position of recognition and respect among readers in the field of cardiovascular problems throughout the world. Because of the growing interest in the basic sciences and the limited space available for reports in this area, it was generally felt that the point had been reached where an entirely new publication, to be known as *Circulation Research,* should be issued. We are confident this new journal will be welcomed by the many physicians, investigators, and teachers who have long felt the need for an effective medium to integrate and disseminate new knowledge regarding fundamental problems which must first be solved before applied research can progress."

The editor of the new bimonthly, Dr. Wiggers, expressed the hope that *Circulation Research* would become "the medium for the best in various disciplines of fundamental research that may throw light on cardiovascular problems. These would include anatomic, biologic, biochemical, biophysical, morphologic, pathologic, physical, physiologic, and pharmacologic aspects, regardless of whether they emerge from laboratories of these basic disciplines or from clinical divisions." Dr. Wiggers added, "Since research acquires its full importance only after publication, the new journal will aim to narrow the gap between the completion of a discovery and its publication in the scientific literature."

In addition to original papers on fundamental research, editorials on appropriate subjects and short preliminary reports on "research in progress" will be included. For the present, the new publication will not include reviews or abstracts. Manuscripts will be considered for publication after October 1, 1952. They should be addressed to Dr. Carl J. Wiggers, Editor, *Circulation Research,* 2109 Adelbert Road, Cleveland 6, Ohio.

Circulation Research will have a format similar to that of *Circulation.* Each volume will consist of approximately 600 pages.

In order to encourage the widest possible readership, subscription rates have been set below publication cost. The American Heart Association will assume the difference in line with its policy of bringing to the medical profession knowledge of the latest scientific advances.

If you are interested in additional information regarding subscription rates to this new publication, just return the coupon below to the Michigan Heart Association.

TO: Michigan Heart Association
4421 Woodward Avenue
Detroit 1, Michigan

Please send me complete information on subscription rates to *Circulation Research.*

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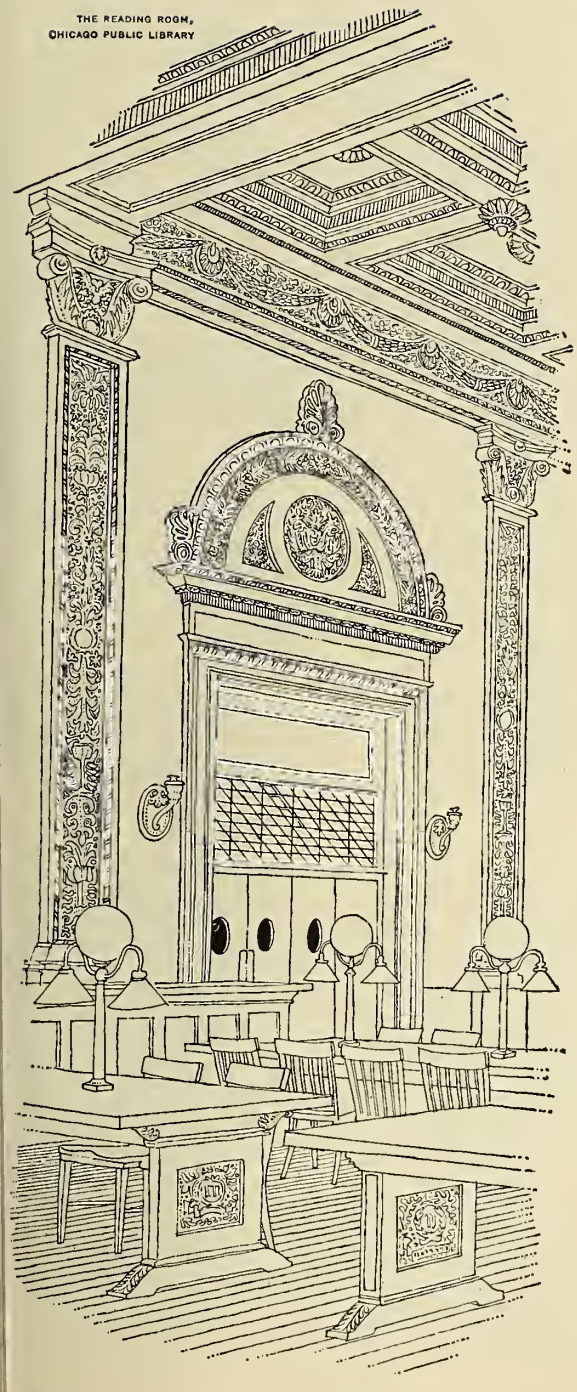
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New aureomycin minimal dosage for adults—four 250 mg. capsules daily, with milk.

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Aureomycin penetrates the ocular tissues and fluids, after passing the blood-aqueous barrier.

Aureomycin in 0.5% solution is well tolerated by the conjunctiva.

Aureomycin may be used locally in appropriate solution; or by mouth; or, in emergency, intravenously; or by a combined approach, depending upon the seriousness of the infection.

Aureomycin has proved of value in a number of ocular infections in which other remedies have failed.

Aureomycin has been reported to be effective against susceptible organisms in the following conditions commonly seen by ophthalmologists:

Blepharitis
Conjunctivitis
Dendritic Keratitis
Epidemic Keratoconjunctivitis
Episcleritis
Periorbital Infection
Acute Trachoma
Uveitis

Throughout the world, as in the United States, aureomycin is recognized as a broad-spectrum antibiotic of established effectiveness.

Capsules: 50 mg.—Bottles of 25 and 100.
250 mg.—Bottles of 16 and 100.
Ophthalmic: Vials of 25 mg. with dropper; solution prepared by adding 5 cc. of distilled water.

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Michigan's United Fund Is Democracy In Action

Medical Profession Plays Prominent Roles In Successful Pioneer Venture

"The democratic approach to health and welfare problems" . . . Thus, does a Michigan doctor summarize the accomplishments of Michigan's United Health and Welfare Fund. Speaking from first-hand experience as a working member of one of the Fund's key committees, the Admissions and Budget Committee, Richard W. Pomeroy, M.D., of Lansing, is convinced that the United Fund "idea" is a powerful and positive influence in combating "socialistic" governmental concepts and in controlling "emotional" groups in the field of community health. "If these agencies are to provide the services for which they were created—services which justify their very existence—they must be adequately financed and agency personnel must not be burdened with the responsibilities of fund-raising campaigns. The United Fund, controlled and directed by voluntary representatives of the people who contribute to the support of these agencies, is the democratic approach to the solution of this problem," he declares.

Doctors have played prominent roles in the development of the United Health and Welfare Fund from the time of its organization in 1947. Warren B. Cooksey, M.D., of Detroit, first president of the Michigan Heart Association, was elected president of the United Fund in 1950 and was re-elected to that office in 1952. L. Fernald Foster, M.D., Bay City; G. F. Frederickson, M.D., Iron Mountain; S. Rudolph Light, M.D., Kalamazoo; and Otto K. Engelke, M.D., Ann Arbor; serve on the United Fund State Board of Directors.

While Michigan's United Health and Welfare Fund has been called a new approach to the problems of financing health and welfare agencies, it is in reality an attempt to develop the well-established Community Chest idea of federation on a statewide basis. According to F. A. McCartney, its Executive Vice-President and Director, the United Fund is not primarily a fund-raising organization. Its real purpose is that of integrating the forces and activities for voluntary community services which already are in operation in most of the communities throughout the state so that worthy state and national agencies may have a method of raising funds in a united way.

Local Community Chests were organized by civic-minded leaders to bring order out of chaos and to provide dependable financial support for the many local agencies which the people themselves were developing. In a similar manner, the United Fund was created by these people to accomplish the same results for agencies of a state and national character. Participation in the Fund is on a voluntary basis. The organizations and agencies, like the personnel associated with the Fund in local drives, are members voluntarily because they believe in the "community idea."



Warren B. Cooksey, M.D., Detroit, President of the United Fund, looks over the shoulders of F. A. McCartney, Lansing, new Executive Vice President and Director, Ivan L. Wiles, Flint, Chairman of the Admissions and Budget Committee, as they review the accomplishments of the Fund during the past year.

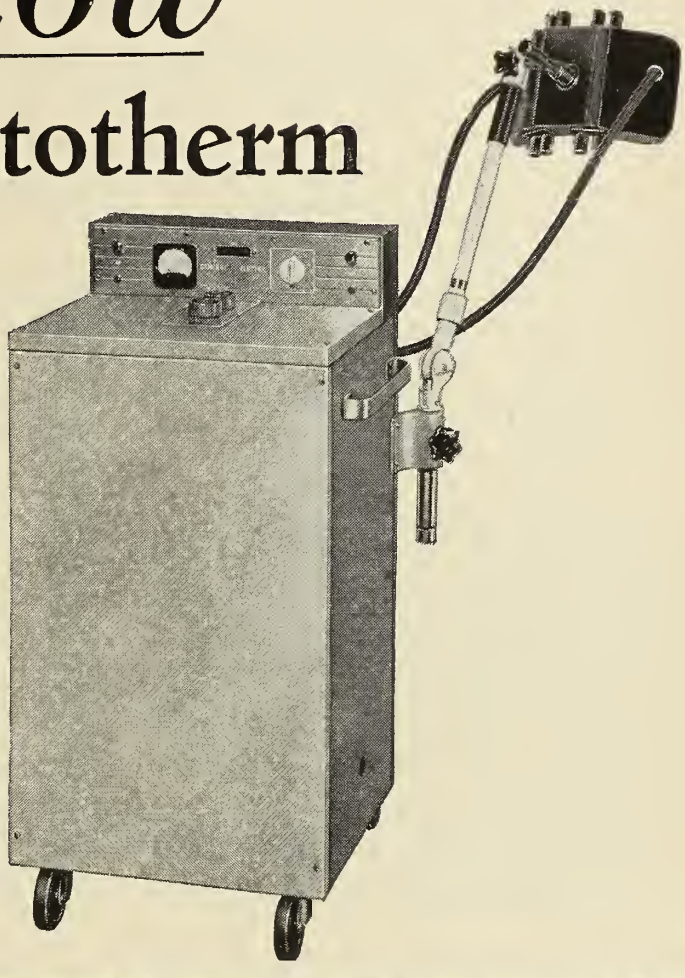
At the present time there are many counties throughout the state that lack organized Community Chests. In these areas the United Fund has assisted local civic leaders in conducting annual campaigns. It plans to continue these activities where requested. According to Mr. McCartney, the character of the Fund's operations is changing and will continue to change as communities develop their own organizations for fund raising. He believes, however, that the Fund will always be able to render valuable service in the fields of budgeting, public relations, campaigns and agency assistance.

(Continued on Page 1272)

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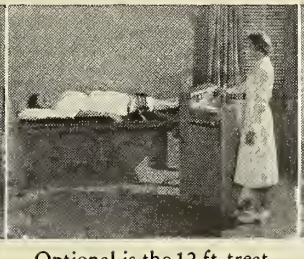
As shown in the pictures below, this handsome, trouble-free unit provides for a wide range of diathermy technics. Output has been raised to 200 watts — for most efficient utilization of induction heating methods. Unit is crystal controlled for absolute adherence to FCC-approved frequency.

Demand for the Model F is already great. To insure getting one of these great new Inductotherm units soon, call your GE x-ray representative right away. For illustrated literature, write

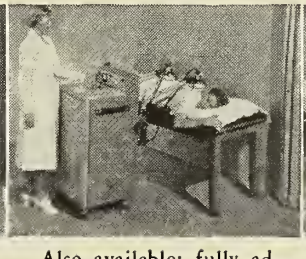
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(Continued from Page 1270)

In his President's Report for 1950-51, Dr. Cooksey described the United Fund as a "federation of state and national agencies with strong appeal." This federation, he explained, has many basic advantages over separate campaigns. Because it budgets agency needs, money is raised and allocated more nearly in proportion to need than is possible with individual campaigns. Equally important, the United Fund spreads the base for financing health and welfare agencies and thus reaches new sources of revenue.

As an example of the accomplishment of these desirable results, Dr. Cooksey cites the records of five Michigan cities (Bay City, Lansing, Port Huron, Saginaw, and Ypsilanti) in which United Campaigns are being conducted. In 1947-48 prior to United Campaigns, these cities reported a total of 79,667 contributors to their fund-raising campaigns. In 1950-51, United Campaigns in these cities recorded a total of 103,826 contributors—indicating that the base of support for financing health and welfare agencies had been expanded by more than 20 per cent.

While extending United Campaigns to new areas required considerable headquarters staff assistance at the outset, the need for guidance has diminished as communities gain campaign experience. During the five years United Fund has been in existence, administrative costs have shown a decline inversely proportional to the amount of money raised. Administrative costs for 1948, for example, were 15.6 per cent; while administrative costs for the current operation have dropped to 6.9 per cent. It is expected that this percentage ratio will continue to drop during the years ahead.

Co-operation and teamwork in attacking health problems is another of the many advantages stemming from the United Fund approach which appeals strongly to Dr. Cooksey. He mentions the Michigan State Medical Society's Rheumatic Fever Control program as an example of this teamwork. This program in its early days was financed jointly by the Michigan Heart Association, the Arthritis and Rheumatism Foundation (both member agencies of United Fund), and the Society for Crippled Children and Adults. Today it is financed by the Heart Association.

In addition to Dr. Cooksey and Dr. Pomeroy; Stanley C. Brown, M.D., Ithaca; John Cowan, M.D., Michigan State Health Department and Clarence E. Umphrey, M.D., Detroit; are members of the Admissions and Budget Committee. This Committee, composed of businessmen, lawyers, bankers and representatives of other community groups as well as these doctors, is headed by Ivan L. Wiles, General Manager, Buick Motor Division, and has the responsibility of screening requests of agencies desiring to affiliate with the Fund, of reviewing the budgets of agencies participating in the Fund, and of establishing statewide goals for annual fund-raising campaigns.

Many doctors and lay persons felt the numbers and demands of various groups were getting out of control, according to Dr. Pomeroy. The individual asked to contribute had little way of knowing about the organization—whether it was justified; whether the group co-operates with existing agencies and other organizations or overlaps in its work; whether the group is financially sound and is organized and run on an efficient basis.

"The United Fund seems to be the 'Town Hall' for these groups in ways of organization as well as public relations and finances," Dr. Pomeroy declares. "The Admissions and Budget Committee functions as a screening committee between organizations and the public attempting to assist both parties. I was particularly impressed with the business-like approach to the study of agencies and their operations during the meetings of this Committee. Not only are the services of the agency considered, but organization and efficiency in providing these services are studied also. It is not unusual for the Committee to make recommendations to an agency for the purpose of improving its organization so that it may function more effectively. This all serves to unify the work and goals of health agencies with objectives of the medical profession to better meet the needs of the community."

The widespread acceptance of the United approach to the problems of financing worthy health and welfare agencies is proof of what citizens in a free democracy can accomplish through co-operation, according to Dr. Cooksey. Since 1947 when the United Health and Welfare Fund o Michigan was organized, United campaigns hav provided opportunity for more than 80 per cen of the people of Michigan to contribute to Fun agencies in an orderly, unified way.

"This remarkable accomplishment assumes eve greater significance when one realizes that it ha been brought about by the voluntary action c hundreds of thousands of Michigan people," h explains. The Board of Directors, officers of th Fund, and committee members represent a tru cross-section of Michigan citizens. Business, in dustry, labor, agriculture, and the professions— all segments of our present-day society are unite in a common cause.

"Members of the Michigan State Medical So ciety can take real pride in the fact that th United Fund idea was pioneered in their stat Much has been accomplished in a brief space o time but there are many problems yet to be solve We, as members of the medical profession, ha a personal responsibility to continue our suppo of this program to assist in its further develo ment."

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Michigan's Stake in Medical Education

The American Medical Association launched the American Medical Education Foundation some eighteen months ago. Its purpose is to raise funds from within the medical profession to help alleviate the financial strain of our nation's medical schools.

The AMA believed the Foundation was necessary because the doctors of medicine of the United States have a stake in the education of our future M.D.'s, plus the maintenance and safeguarding of the high standards of medical education. Our medical schools were, and still are, facing serious problems because of the lack of funds to hire or retain topflight instructors on their staffs. The loss of such personnel or the inability to employ them might lessen the quality of medical education or might even cause a school to close entirely.

The AMA further realized this important fact: Unless our medical schools continued to operate as integral and independent institutions, they might be forced to accept federal subsidies. Whether this happens or not is largely dependent upon the speed with which the medical doctors of America can be made to recognize school needs and produce the necessary financial leadership. It is also hoped that this leadership would attract additional assistance from industrial sources on a volunteer basis.

Financial solvency is a must whether it is in a corporation, a medical school or your own practice. Yet our medical schools are not financially solvent.

The medical profession is urged to give its wholehearted support to the American Medical Education Foundation. This support should be volunteered by every doctor of medicine in the nation with little or no urging. However, to date, the support has been far from adequate.

Michigan is one of the more fortunate states in that it boasts two excellent medical schools. Michigan's interest in medical education is very high and its support of the Foundation should be comparable. In the past year and a half, Michigan's medical schools, however, have received unrestricted grants totaling over $75,000 to supplement their operating budgets. To date the medical profession in our state, which numbers 6,050, with 5,214 members of the Michigan State Medical Society, is represented by 111 contributions amounting to a little more than $7,000, made direct to AMEF. This is an undesirable record for a state that takes pride in being a leader in all things. (See final paragraph, this article—page 1276.)

There are several reasons why we of the profession should give our wholehearted support to the Foundation:

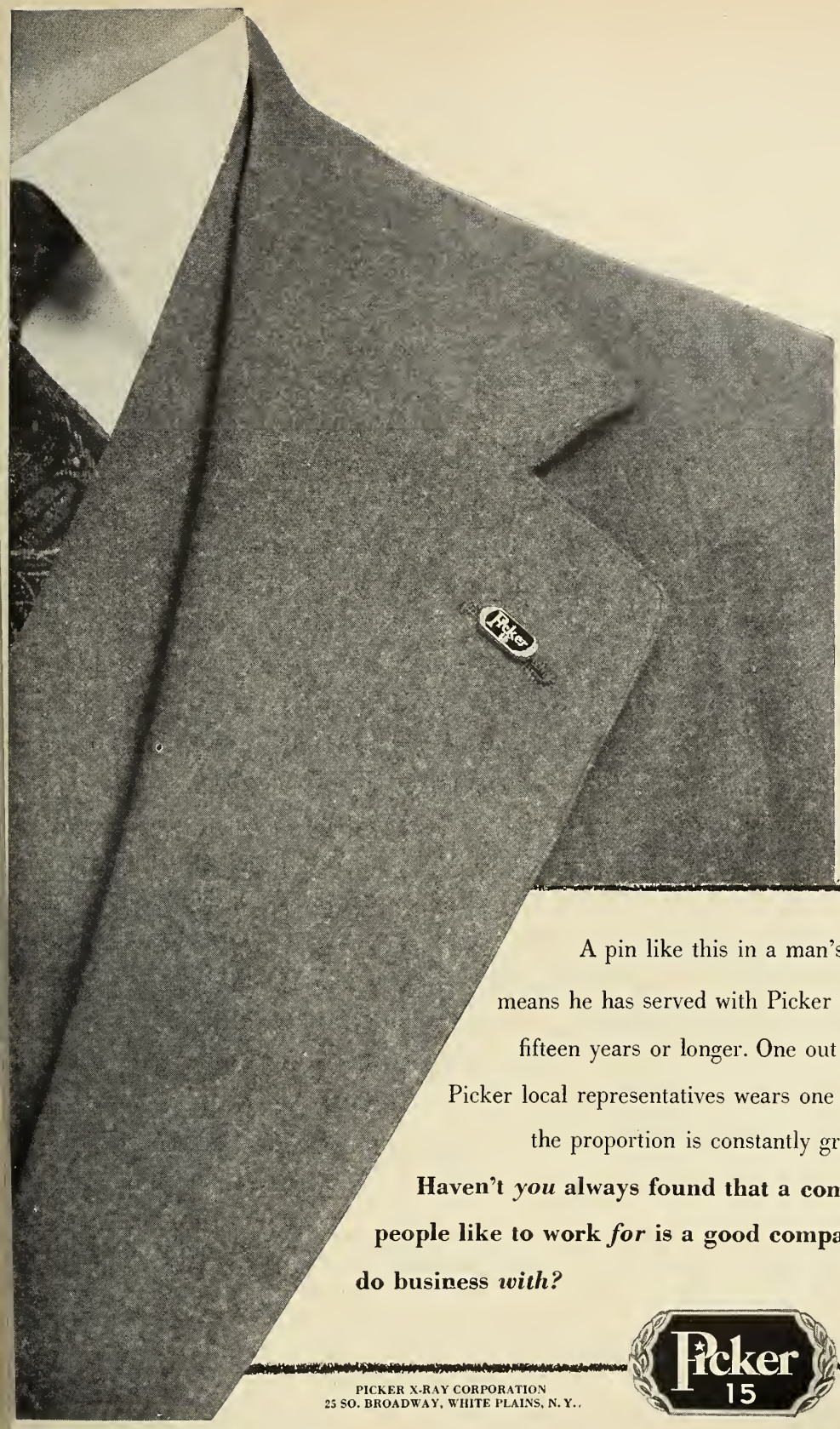
1. Better education for the young men who will follow in your footsteps and be charged with the responsibilities of carrying on the high traditions and standards of the profession;
2. Better health care for the nation as a whole
3. Tax savings at a time when every deduction is important, and
4. The knowledge that your philanthropic dollar has been well spent.

The medical profession has at its disposal the instrument and the wherewithal to establish the financial leadership of a project which will attract additional needed support from American Industry—support sufficient in size and quantity to put our medical schools on a sound financial footing. The great force of American Industry, however, waits and watches for the individual doctor to come forth with contributions in sufficient quantity before investing its dollars. A $100 contribution from every member of the Michigan State Medical Society would amount to more than $500,000 annually for distribution to our medical schools. The profession can't afford to neglect the health future of our nation.

Let us follow the lead set by Nebraska. Under the leadership of L. D. McGuire, M.D., the Nebraska AMEF committee has raised more than $60,000 in sixty days. And Nebraska has only 1,300 doctors of medicine. This should certainly indicate conclusively that the project is worthy of our support.

The job can be done in the four months remaining in this campaign year. This is America's greatest need. Write your check today. Make it your job to see that your fellow M.D.'s write the

(Continued on Page 1276)



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(Continued from Page 1274)

Checks should be made payable to The American Medical Education Foundation. You may earmark your contribution for the school of your choice, if you desire.

Let's contribute generously—and put Michigan in the lead!

Michigan contributors to the AMEF to August 1, 1952, include:

John Alexander, M.D., Ann Arbor; Carl Egbert Badgley, M.D., Ann Arbor; Paul Shirmer Barker, M.D., Ann Arbor; Roy C. Barlow, M.D., Ann Arbor; Robert C. Bassett, M.D., Ann Arbor; Gerhard Herman Bauer, M.D., Ann Arbor; Hugh McDowell Beebe, M.D., Ann Arbor; William H. Beierwaltes, M.D., Ann Arbor; Alvin Hermann Benz, M.D., Ann Arbor; Robert Berman, M.D., Detroit; E. B. Boldyreff, M.D., Custer; Clark D. Brooks, M.D., Detroit; James Marion Bryant, M.D., Ann Arbor; Howard Burrows, M.D., Dearborn; Irving F. Burton, M.D., Detroit; Duncan A. Campbell, M.D., Eloise; Mario S. Cioffari, M.D., Detroit; Ensign Engle Clyde, M.D., Plymouth; Frederick Amasa Coller, M.D., Ann Arbor; Clarence E. Crook, M.D., Ann Arbor; Arthur Covel Curtis, M.D., Ann Arbor.

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Robert Scott Ideson, II, M.D., Ann Arbor; Edna M. Jones, M.D., Northville; Edgar Adolph Kahn, M.D., Ann Arbor; Clifford Henry Keene, M.D., Ann Arbor; Earl Knaggs, M.D., Wyandotte; Leo August Henry Knoll, M.D., Ann Arbor; Theodore Kolvoord, M.D., Battle Creek; W. G. Mackersie, M.D., Detroit; Otto Tod Mallery, Jr., M.D., Ann Arbor; Donald Whitney Martin, M.D., Ypsilanti; Stephen C. Mason, III, M.D., Ypsilanti; J. J. McClintock, M.D., Detroit; Robert W. McClure, M.D., Detroit; Thomas H. McEachern, M.D., Ann Arbor; Harold Albert Miller, M.D., Saline; Norman Fritz Miller, M.D., Ann Arbor; Walter Neeb, M.D., Detroit; Reed Miller Nesbit, M.D., Ann Arbor; Erwin C. Nolte, M.D., Detroit; Carl Andrew Peterson, M.D., Hillsdale; H. Marvin Pollard, M.D., Ann Arbor.

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These 111 contributions were made to the AMEF.

Other contributions were made direct to medical schools. A list of contributors to the two colleges of medicine in Michigan will be published in The Journal MSMS at a later date.

Surveys show it costs the Federal Government an average of $10.00 to make out every purchase order, and the government seems pleased that it is that low. Fifty per cent of all purchases made by the government are for less than $10.00.

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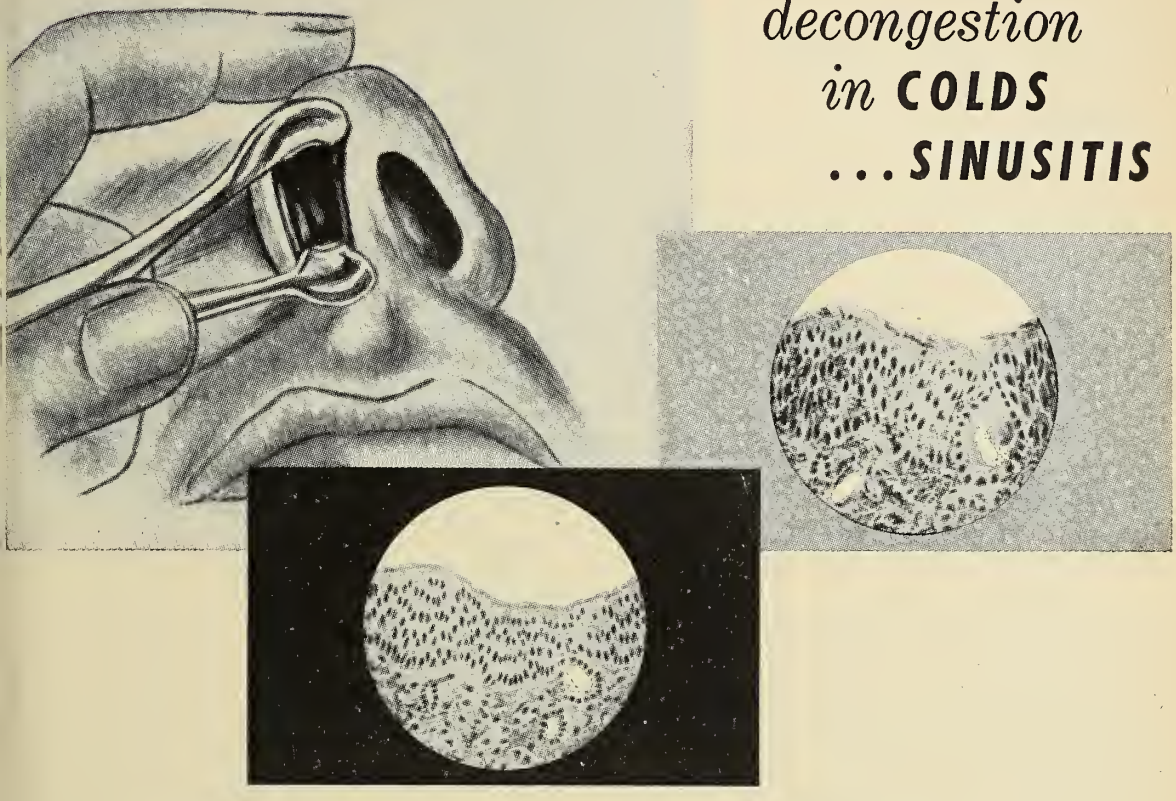
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Medicine in Korea

"Health and Welfare of Troops in Korea at New High," according to a *Newsweek* headline of August 11.

"Korea combined all the worst features of World War II battlefields—the disease and filth of the countryside, the high, rugged mountains and lack of roads, and the great extremes of heat and cold," according to Major General George E. Armstrong, Army Surgeon General.

But this week, after two years of war in Korea, the Army Medical Service reviewed the lessons it had learned in combat in the Far East and the consensus of Army chiefs was that the M.D.s in service had written "a bright chapter" in the history of military medicine. As General Armstrong states, "We have in fact been far more successful than I believed was possible at the beginning of this operation."

Progress in medicine and surgery has been so rapid that the mortality rate among those wounded in action has reached the impressive low figure of 2.3 per cent per thousand in Korea as compared with 4.5 per cent per thousand during the Second World War.

Malaria.—Because the rice paddies are heavily infested with mosquitoes, doctors had anticipated a serious malaria problem in Korea. Actually, the incidence has been much lower than in the Mediterranean and Philippine fighting in the Second World War. In August, 1943, the Southwest Pacific rate soared to 696 per 1,000 men a year, compared to 15 to 16 per thousand in Korea!

Smallpox.—In spite of the virulent type of smallpox in Korea, only forty United Nations soldiers contracted the disease—although in the first year of fighting, 50,000 South Koreans became victims and 12,000 died. There have been no American cases since May, 1951.

Typhoid-Diarrhea and Dysentery.—Water pollution in Korea is widespread, but there has been very little typhoid. On diarrhea and dysentery, General Armstrong comments: "Conditions in Korea are ideal for the propagation of these diseases . . . yet the actual incidence during the first year was less than half of World War II experiences in Italy and the Philippines, and less than one-fourth the incidence in the China-Burma-India theater."

Cholera and Typhus.—United States troops in Korea were protected from cholera by vaccination and from louse-borne typhus by Lindane, a DDT successor which is deadly for Korean mites.

Epidemic Hemorrhagic Fever.—The most baffling of all ailments among the troops is epidemic hemorrhagic fever, which broke out a year ago. So far more than 1,000 cases among U. S. troops have been reported, with some 100 deaths. By early diagnosis, the doctors have reduced the death rate from 15 per cent to about 6 per cent, but they have not solved this medical mystery.

Infectious Hepatitis.—While improvements have been made in the diagnosis and management of infectious hepatitis, the doctors still do not know how to prevent its spread in troops; the death rate is low but the disease brings a long illness of sixty to seventy days.

Encephalitis.—Nor has Japanese B encephalitis been conquered. More than 300 cases broke out in the summer of 1950; there were seventy cases last summer—but none so far this year. Scientists think they know the cause of the disease—a virus carried by the Culex tritaenior-hynchus mosquito.

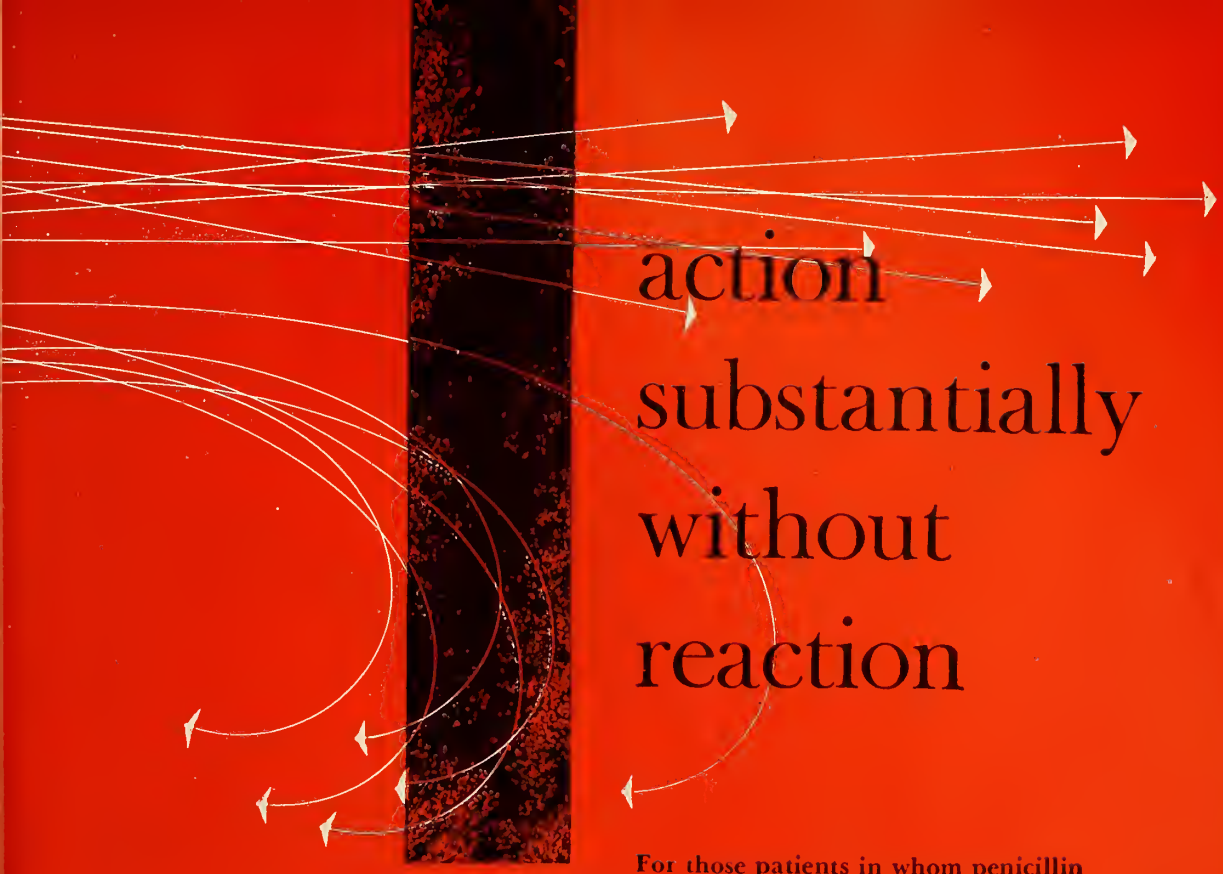
VD.—Venereal disease rates in Korea are 186 per thousand per year; in Japan, 272 per thousand, compared with the total U. S. Army rate of seventy-three per thousand.

The NPs.—By using psychiatric facilities both at the front and at evacuation field hospitals, Korean NP rates are remarkably low. Discharge rate for NP are two men per thousand per year, compared with twenty-four per thousand in 1943 and 16 per thousand in 1945.

If it were not for the work and science of medical doctors in Korea, Japan, and on the U. S. mainland, the death rate in Korea would be far greater. *It is to be noted with pride that this life-saving job is being accomplished only by Doctors of Medicine—not by practitioners of any other branch of the healing arts.*

(Sentence in *italic* is ours.—Editor JMSMS.)





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Editorial Comment

A LATE REWARD

A memorial is being constructed to Dr. William Beaumont through restoration of the historic American Fur Trading Co. store on Mackinac Island.

Almost everybody has heard of the great medical triumph of Dr. Beaumont, 140 years ago. But very few can recall his name.

It was an experiment by Dr. Beaumont—based upon an accident—that was responsible for one of the greatest advances in medical history.

In 1812 a young Mackinac Island trapper, Alexis St. Martin—his name, too, is known to few—was accidentally shot in the stomach. St. Martin lived but the wound was never healed.

With the genius of medical pioneers, Dr. Beaumont constructed a "window" through which he could look into St. Martin's stomach. He watched daily for the years St. Martin lived, carefully recorded what he saw and contributed marvelously to the knowledge of all doctors.

In financing the memorial to Dr. Beaumont, members of the Michigan State Medical Society are paying tribute to an exceptional individual with the knack of turning minor opportunity into major achievement.—*Detroit Times*, August 11, 1952.

THAT OLD ROCKING CHAIR

We doctors whose years in practice have passed the quarter century mark—my own age group, by the way—must be constantly on the watch that we don't let ourselves ease back in the old rocking chair. It's not scientific medicine that I'm talking about. Our medical organizations prod us into line if we show signs of getting slack. It's in the little things that we're likely to slip, like the way we run our offices, and in our dispositions and our dress.

When Joe Dokes comes in for that first consultation, he judges our office by what he can see. We've never been one to worry about appearances, but after a good many years of service the place may look down at the heels. We can't keep turning our equipment in for new models as long as the old fulfills the demands of modern medicine. But we can see to it that the office itself looks reasonably up-to-date and, above all, clean. We may be meticulous about the care of sheets and towels and sterilize everything with the greatest care, but if the surgery walls are gray with grime, Joe is likely to think that our instruments are dirty too.

And while we're cleaning house, it won't hurt to work on our dispositions a bit. We get so tired of the same old questions year after year and it's easy to turn Joe off and salve our conscience by reminding ourselves that he wouldn't understand an explanation anyway. But let us remember that when we were young and eager to build up a practice, we were glad enough to explain. Our Joe is an average intelligent patient, and he's entitled to the information he seeks.

As long as we want to remain in practice, we have to give that practice the best we've got. If respect for our profession won't do it, the cold hard facts of life in a competitive field will keep us in line. Then, when at last we take down the shingle we can get out the old rocking chair.—John H. Schlemer, *Detroit Medical News*, August 25, 1952.

REGISTRATION OF MEDICAL GRADUATES

The National Advisory Committee to the Selective Service System has issued an urgent appeal to all 1951 and 1952 graduates of medical schools who have not already done so to immediately register with their local Selective Service System boards under the provision of Public Law 779. Previous Registration under the general selective service law, the committee warns, does not exempt male physicians under the age of 50 from registration under Public Law 779, nor does the fact that a physician is deferred as a regular registrant. The only male physicians who are not liable for registration under Public Law 779 are those who are currently members of reserve components of the Army, Navy, and Air Force. Previous military service does not exempt physicians from such registration unless they are currently members of reserve components of the armed forces.

Preliminary study of the 1952-1953 survey questionnaire of interns, residents, and fellows in hospitals, being conducted by the Health Resources Advisory Committee of the Office of Defense Mobilization, indicates that there is a considerable number of interns, residents, and fellows who are not members of reserve components who have not registered under Public Law 779.

The National Advisory Committee is also asking its state advisory committees to check with state boards of medical examiners to obtain the lists of all physicians granted licenses within the past two years. These will then be checked against Selective Service Public Law 779 registration lists to discover those physicians who are not registered in accordance with the law.

In issuing its statement, the National Advisory Committee called attention to the fact that failure

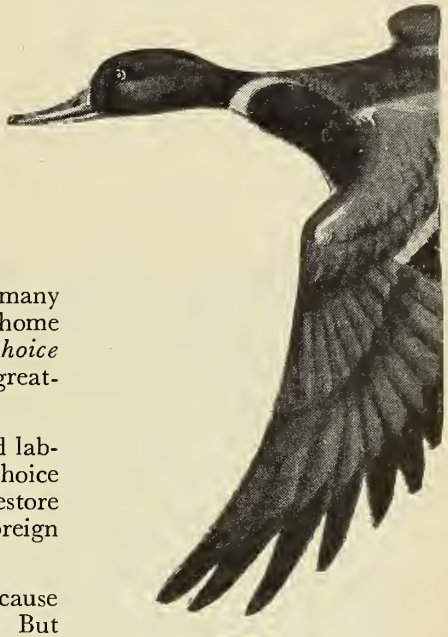
(Continued on Page 1282)





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Say you saw it in the Journal of the Michigan State Medical Society

REGISTRATION OF MEDICAL GRADUATES

(Continued from Page 1280)

to register as a special registrant makes such delinquents subject to investigation by the Federal Bureau of Investigation and liable to prosecution by the Department of Justice. It also pointed out that it believed that failure to register on the part of many 1951 and 1952 graduates has resulted from lack of understanding that they were required to register under both the general Selective Service System law and Public Law 779. Such failure, the committee stated, however, is a specific violation of the Selective Service law.—Editorial, *The Journal of the American Medical Association,* August 30, 1952.

REPUBLICANS OPPOSE SOCIALIZED MEDICINE

Every American who is interested in bringing the nation's health standards to the highest level—as well as in the perpetuation of freedom—will approve of one plank adopted by the Republican Party at Chicago. It reads: "We recognize that the health of our people as well as their proper medical care cannot be maintained if subject to Federal bureaucratic dictation. There should be a just division of responsibility between government, the physician, the voluntary hospital, and voluntary health insurance. We are opposed to Federal compulsory health insurance with its crushing cost, wasteful inefficiency, bureaucratic dead weight, and debased standards of medical care. We shall support those health activities by government which stimulate the development of adequate hospital services without Federal interference in local administration. We favor support of scientific research. We pledge our continuous encouragement of improved methods of assuring health protection."

It is reported that this plank, when read, drew more applause from both the delegates and the galleries than any other part of the platform. On a number of occasions General Eisenhower has expressed his unequivocal disapproval of socialized or politically-dominated medicine, so it is certain that the plank is in accord with his views.

All partisan considerations to one side, the Republican Party's statements point to the only way in which the standards of medical care can be steadily and markedly improved. This fact is sharply underlined by the tragic experience of England and other countries, where socialized medicine has ominously reduced those standards, even as it has placed a tremendous burden on the taxpayers. In any enterprise or profession, the hand of the bureaucrat deadens and destroys, and medicine is no exception.

Socialized medicine may be a major issue in the coming campaign. General Eisenhower and the party he now leads have taken their stand—and it is the only stand consistent with American traditions, ideals, and hopes.—Editorial, *The Mediator,* August-September, 1952.

RECORD PRICES

The Federal Treasury reported Thursday that its tax take for the year ended June 30 was a record-breaking $69,970 billion.

The Federal Bureau of Labor Statistics simultaneously reported a new rise in the cost of living with its retail food price index now standing at 234.9, as compared with the 1935-39 average of 100.

A million auto workers were apprised that they would receive a 3-cents-an-hour increase under the "escalator" clause in their contracts tying wages to living costs.

All three of these news items are closely related in the causes and effects of inflation, which constitutes the gravest single problem with which this Country is faced today.

As a result of inflated costs the Government must now pay at least twice as much for the same commodities and services as in 1939-40. That's one reason why taxes have shot up as they have. The other reason is that the Government has assumed new obligations at home and abroad for which the people must pay. A good many of these are unnecessary.

The total Federal, state and local tax collections this year are estimated at close to $90 billion.

While taxes have been creeping up to where they take more than 30 cents out of every earned dollar, inflation has been taking 47 cents out of the same dollar.

Yet the Government overspent its income last fiscal year by approximately $4 billion. The estimated Federal tax take in the current fiscal year is $68.7 billion, an increase of more than $3 billion over last year. Yet President Truman predicts another deficit of about $10 billion in fiscal 1953.—*Detroit Free Press,* August 23, 1952.

A THREAT TO MEDICINE

Dr. Joel T. Boone, medical director of the veterans administration, addressed a threat to the civilian profession of medicine that if there is not continuing coöperation with government medical projects it may mean the end of civilian medicine. He said that, in the absence of a relationship satisfactory to the bureaucrats, the government "would have to take over."

The Truman administration has for a long time talked in a large way of installing a system of compulsory health insurance and of resorting to various

(Continued on Page 1284)



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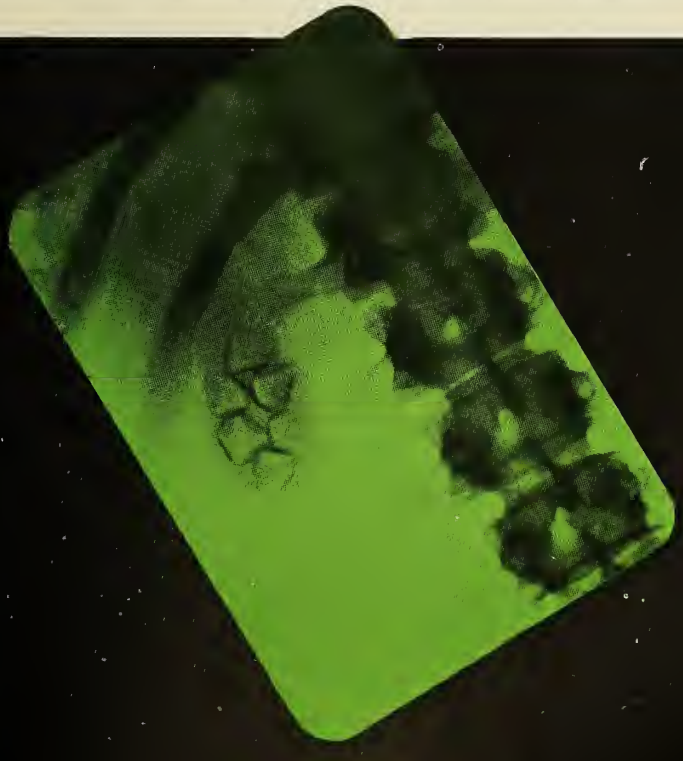
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Federal Medicine

VA HOSPITALS FORCED TO CLOSE

The Public Health Service is being forced to close four of its general hospitals as a result of Congressional cuts in Veterans Administration appropriations, Oscar R. Ewing, Federal Security Administrator, announced August 11, 1952. He explained that funds cut would have provided contract care for Veterans Administration patients in Public Health Service hospitals.

The hospitals, located in Kirkwood, Missouri, Mobile, Alabama, Portland, Maine, and San Juan, Puerto Rico, will discontinue admitting patients within a few days and will be converted to outpatient clinics as soon as provisions can be made for their present patients.

Dr. Leonard A. Scheele, Surgeon General of the Public Health Service, stated that this unexpected cut amounts to about $1.5 million and requires a reduction from 650 to 375 in the number of Veterans Administration patients cared for by the Public Health Service.

"When curtailment became necessary," the Surgeon General said, "these four hospitals were selected because their patient load is made up of more veterans and fewer Public Health Service beneficiaries than that of any of the remaining Public Health Service facilities.

"Aside from this loss, limited funds in fiscal year 1952 and in our 1953 budget have made it necessary to reduce staff in our hospitals by nearly 350 people during the past four months," Dr. Scheele said. "This additional and unexpected reduction in available funds can be met, therefore, only by curtailing our operations and by converting the four general hospitals with the smallest average number of patients to outpatient clinics."

In addition to the reductions in staff already effected, another 350 employes are involved in the closings. A few of the personnel will be retained to operate the outpatient clinics and as many as possible will be transferred to other Public Health Service hospitals or other Government facilities. Personnel officers of the Public Health Service are being detailed to each of the hospitals scheduled for conversion to assist employes wishing to remain in the areas of the converted hospitals to find employment either in Federal agencies or in private industry.

Patients in Public Health Service hospitals include American merchant seamen, officers and enlisted men of the Coast Guard, Federal employes injured in line of duty, and others for whom the Service is responsible under law.

Editorial Comment

A THREAT TO MEDICINE

(Continued from Page 1282)

devices to equalize medical attention between those more able to pay and those less able to pay. It has invariably insisted that it had no design for socializing medicine.

These declarations of innocent intent must be measured against Dr. Boone's clear threat and his peculiarly intimate relationship with the administration and the White House. As a rear admiral in the navy, he served as the White House physician during Republican administrations of the '20s, then returned to active duty with the navy. Last year he was appointed to his position with the veterans administration. Although listing himself as a Republican, he has been associated during his career of 38 years of active practice with state medicine, and he brings to bear a viewpoint sympathetic to government direction rather than to the freedom of the private practitioner.

The sense of the phrase to "take over" is well understood. It means that the government will assume command of the practice of medicine and of all those who engage in it. It means that government will decree the kind of medical attention given, who is to receive it, what the costs shall be, and how they are to be met. If the government were to "take over," the government would operate all hospitals, all medical schools, all research in medicine, all nursing, and probably all such related activities as dentistry, etc.

This socialist organization of medicine would be bound to rest upon compulsion. Once one major profession fell to the state, what would stop all others from going the same way? We should have a nationalized legal service, a nationalized press, and all of the rest of it, until finally no area of freedom survived and the Bill of Rights would have become a dead letter.

Perhaps the servitude of the professions might have a temporary attraction for the masses who had been led to believe they would get something more for nothing—or for what looked like nothing. But this attitude would quickly prove to be a delusion. The servitude of one group of free citizens soon becomes the servitude of all. The philosophy that the government can "take over" is the philosophy of total dictatorship.—*Chicago Tribune,* August 17, 1952.


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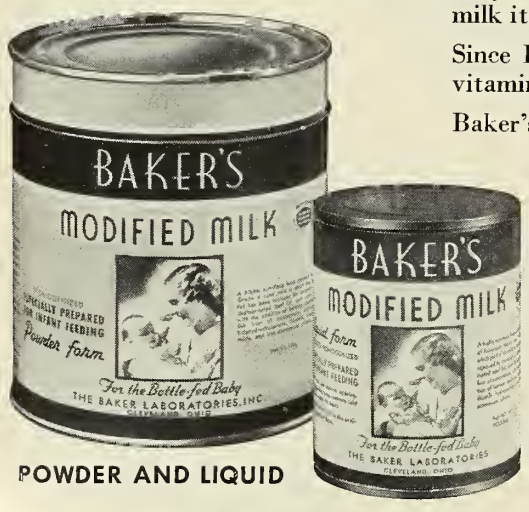
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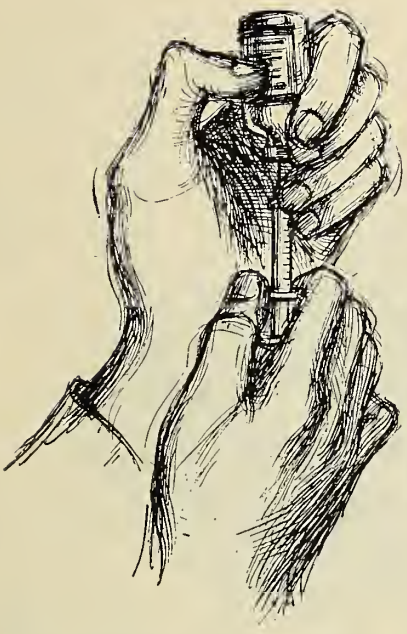
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How Can We Have Better Medicine?

By Paul de Kruif
Holland, Michigan

THIS TALK is dedicated to the memory of Dr. Andrew P. Biddle, father of Michigan's postgraduate medical education. May we always remember him with the reverence due an honest man—what's education but a life-long discipline toward honesty?

Straight-shooting. . . . That's the secret of better medicine.

But what's wrong with medicine now? Amid praise of its miracles we hear muttering. All is not so good. There is indignation—about cruel costs of medical care. There is anger—against surgeons said to be operating needlessly or when antibiotics might cure. There's resentment—by those who say their doctor pooh-poohs them when asked to consult with a specialist. We hear gripes about waiting-room weariness. And there is bitterness—about doctors who won't come to our homes when we're sick and scared in the night.

When we go to the root of them, most of these kicks blow up in their author's faces. Yet some do turn out to have a basis of fact. Beyond any other profession the doctors have a tough row to hoe—when we are ill we are scared and lonely and we (and our families) are in need of the not easy magic of the comfort only a natural-born doctor can give. And if we don't get it—right now—plus what we think is top scientific treatment—then—on the part of some of us it is just too bad for our doctor. And a black eye for *all* doctors.

This is the doctors' special burden.

If these kicks came only from crackpots, or pinkoes with an axe to grind, they wouldn't be so disturbing. . . . But, your speaker has friends—take Boss Kettering. He deeply admires the medical profession and detests regimentation. Yet Ket has said that if doctors don't look sharp they're going to get socialized.

Here's the doctor's dilemma. The rank-and-file practitioner now drags more people back from death than did the most expensive specialist, 20 years ago. Medicine is far and away the most beloved, most *trusted* profession. Yet today it's under attack . . . by an *untrusted* federal government. Washington's crypto-communist, mink-lined, deep-freeze regimenters are out to turn doctors into pen-pushing form-filler-outers, pill-passing robots. . . . No fooling.

It's especially because our doctors have been free to take the time and the care to do their best for us that we love and trust them. Okay. We'll go on doing just that, if the doctors do their best to make their medicine better and better. . . . Then we'll believe less and less in the verbal muck slung at medicine by untrusted federal government would-be socializers.

Many years ago Michigan's doctors faced up to the fact that it cost most people far too much to be sick and to try to keep from dying. This was an act of honesty. Led by Henry Luce, our state's doctors twenty-five years ago began to grope toward a practical way for families to budget for their health as they budgeted for groceries. . . . By voluntary, prepaid health insurance.

President Hoover's Committee on the Costs of Medical Care proposed it and drew a blast from the doctors' home office, the American Medical Association, 535 North Dearborn, Chicago—then the national medical powerhouse as the home

Andrew P. Biddle lecture delivered at the 87th annual meeting of the Michigan State Medical Society, September 24, 1952.

office of the United Mine Workers is John L. Lewis's personal powerhouse now.

Voluntary health insurance? "Socialism and communism, leading to revolution" boomed the then spokesman from the then powerhouse. Undaunted, Michigan's top doctors dug away in their grass roots and by 1939 came up with a plan jointly with the hospital people by which citizens might prepay to keep from going busted by the catastrophe of paying fees for big operations and board for long stays in hospital.

The doctors had to start from scratch; the nation's top insurance experts hadn't the foggiest notion what a family'd have to pay yearly to cover the doctor's services and keep the health plan from going busted. They badly mis-guessed the figures at the start and pretty soon the Michigan Medical Service—that's what it was called—went 500,000 bucks in the red. It wasn't the public, it was the doctors who'd lose if the plan went broke; they'd gambled their professional services. They had no federal Santa Claus to go to. There was grumbling, naturally, by many doctors. It took guts (the four-letter word for both faith and honesty) to keep them participating; there'd be no Michigan Medical Service now if it hadn't been for Henry Carstens, and its great success is due to tough men like your distinguished president, Otto Beck, Bob Novy, and others.

Michigan's doctors learned prepaid voluntary health insurance the hard way—till now, 82 per cent of the state's physicians are participating, and starting from nothing just twelve years ago, 2,600,000 Michigan citizens budget for health in Michigan Medical and Michigan Hospital Service—costing them only a bit over $100 a year, no matter how large the family.

For their great act of honesty, Michigan's doctors can take a bow for their pioneering of voluntary prepaid health insurance with more than 80,000,000 Americans already covered by one or another type of it, and it's this and this only that drove the Truman-Ewing regimenters back into their holes not long ago when they were out to make medical robots of all of us—doctors and patients alike—by compulsory government medicine.

But in the 1940's it was amazing and absolutely fantastic that Michigan's doctors and doctors everywhere—but notably those of Michigan, California and Colorado, fighting for better medicine, were in the doghouse at their Chicago home office. California, Colorado and Michigan doctors were accused of stirring up the animals by their "radical" activities. From the Chicago home office, then *still* the powerhouse, came lofty answers to public kicks about bad medicine to the general effect: *The public be damned.*

No wonder Fern Foster asked his famous question: "Why are we doctors individually pretty much 140,000 little tin gods to our patients and at the same time 140,000 so-and-so's—as a national organization?"

So Michigan doctors did another act of honesty, calling a conference of presidents of state medical societies not stooges of the home office powerhouse. The final upshot? As of June, 1949, the powerhouse lost its kilowatts. The AMA's home office became what it is today, a magnificent clearing house for action for better medicine, for deeds and plans pouring in from the medical grass roots, from county and state medical societies from coast to coast and from the humblest individual doctor. It's now the G H Q for better medicine, for *honest* medicine, for all Americans. Such now is the new American Medical Association.

This strong north wind of honesty, very bracing, hit your present speaker when he first met Elmer L. Henderson, then president-elect, and George F. Lull, general manager of the AMA. Said Elmer, looking me in the eye, "You'll find we're straight-shooters." His look said he did not mean maybe.

How you need straight-shooting to fight government domination is shown by the way one of the top modern life-saving discoveries nearly went into the ash can. . . . Thanks to the then government powerhouse. It's now history how Leo Loewe, the Brooklyn boy, changed nearly 100 per cent fatal subacute bacterial endocarditis to potentially 100 per cent curable—by his massive penicillin-heparin treatment.

But what, in 1944, nearly happened to Leo's discovery? Every dose of the then still scarce penicillin was under control of the federal Office of Research and Development, the OSRD. Big medical wheels had tried out penicillin against this murderous endocarditis. Dose—40,000 units daily. All victims died. From the OSRD went out the *Word:* Penicillin ineffective, none available for subacute bacterial endocarditis. But Leo Loewe had other ideas. . . .

Giving two, five, ten *million* units of penicillin daily by intravenous drip, he dragged twenty-five

endocarditis victims—doomed—back to life. The late Jack Smith, penicillin production genius at Pfizer, bootlegged all penicillin needed by Leo. OSRD threatened government proceedings against Jack—for his crime of disobedience—that saved those lives. Your present speaker, writing Leo's discovery for *Reader's Digest,* was warned by an emissary from the government wheels that Leo "was at least potentially dishonest." But the *Digest* editors bet their blue chips on Jack Smith and Leo, and pretty soon Leo had cured so many incurable victims, it would have been a real stink if OSRD hadn't released penicillin for endocarditis. . . . So they did.

Had those big wheels wanted the poor devils to die? Of course not. What they had was what Boss Ket calls the instinct of negativity, meaning we did not discover it so it cannot be so.

Michigan's doctors can sniff out and scotch negativity. It is one of the purposes of the Michigan Foundation for Medical and Health Education. Investigatory action.

This negativity is likely to lurk wherever there is that intangible powerhouse, scientific authority. It's trying right now to tie the can to medication that may possibly check fatty degeneration of the arteries, champ killer in mid-life and after. It's surmised that sick, fatty livers may be at least in part at the bottom of this degeneration of the arteries, atherosclerosis.

Now it has long been known, experimentally, that lipotropic substances (including the B vitamins choline and inositol and the amino acid, methionine) move deadly fat out of livers—of dogs. Among other investigators, Dr. Henry A. Rafsky of New York, has observed the good effect of a lipotropic combination—Methischol—plus high animal protein, high vitamin diet—on human cirrhosis of the liver.

(Indeed, it's a safe bet this talk tonight would not have been given if Dr. Rafsky hadn't chased the fat out of your present speaker's cirrhotic liver . . . with the aid of Methischol. . . .)

It's Henry's hunch that we're really as old as our livers, and there's a hint, repeat *hint,* of hope for retarding and even reversing the atherosclerosis dangerous to heart and brain, if patients are religiously maintained on high animal protein, low fat, high vitamins—plus lipotropics. Debatable, but not disproved.

What, then, was your present speaker's amazement when his son, Hendrik de Kruif, M.D., reported a remark made by a scientific authority at a round-table conference on atherosclerosis at the AMA meeting, last June. "I trust nobody here is so bold"—said this authority—"as to admit that he prescribes lipotropic substances for atherosclerosis."

"Dismissed them. Just like that. Gave no evidence," said Hendrik.

"What's really wrong with medicine?" your present speaker not long ago asked Elmer Henderson and his surgeon competitor and friend, Josh Lukens of Louisville, Kentucky. "Just one thing, professional jealousy," said Josh. "Right—absolutely," said Elmer.

Professional jealousy isn't, by a long shot, confined to general practitioners who may now and then give the brush-off to families asking for a specialist's opinion. This envy can operate at high levels. Last summer the distinguished surgical investigator, Charles Huggins, of the University of Chicago, got a rising ovation at the end of his Ramon Guitéras lecture before the American Urological Association, at Atlantic City.

Huggins told them, modestly, how his new operation, total adrenalectomy, had eased the pain, returned to strength, and was prolonging the lives of some—but by no means all—patients on whom he'd performed it. These were victims of far-advanced cancers that had started in the prostate or breast. Huggins made no claim of cure. He stressed that this operation was the last thing to try when all else had failed.

The novelty of this surgery excited the audience, for how were these victims to live at all—with no adrenals? The chemical miracle stirred the listeners. These patients lived and felt fine just by taking 50 milligrams of cortisone by mouth—two little 25 milligram pills, twice daily. Huggins showed them a movie of a moribund man, with no adrenals, but now back at work as a boilermaker. He showed a movie of a woman given up for dead, who'd gained 40 pounds and now looked lovely in her garden. He told of cases where adrenalectomy had failed but said the operation was safe in the hands of competent surgeons and hormone men.

It's only a last ditch hope, for some hopeless. Yet what alert family doctor would turn down this slim chance for his dying patient? How many poor wretches, far-gone with advanced cancers of breast or prostate, cachectic and in pain—yet still wanting to live—wouldn't risk this new adrenalectomy?

Especially, when their doctors knew that this operation was simply a solid, scientific step beyond the orchiectomy—removal of gonads—by which, long before, Huggins had added years to lives of prostate cancer victims?

Your present speaker had no sooner finished writing this story—it's going to appear in the AMA's *Today's Health,* and *Reader's Digest*—when came a blast—from a scientific authority—to the effect that Charles Huggins was a fake and he would not send a *dog* to Huggins. So said this authority.

(We wonder why such authorities do not themselves discover remedies for ills over which they are authoritarian.)

Professional jealousy can make the difference between life and death; and in one medical field there has been a vast saving of life because doctors have subdued this childish paranoia. Chicago's doctors pioneered this, by routinely calling in obstetric consultation for childbirth too tough for their own skill. The result?

Largely because they put the fight for life ahead of their personal vanity, they've beaten mother and newborn deaths down to worldwide, all-time lows. Herman Bundesen led Chicago's doctors in this fight for life. He has one simple measure of better medicine: *his yardstick is the down of the death rate.* Bundesen's prescription against professional jealousy (including his own) is a motto, "You can get anything done, if you don't care who gets the credit." Consultations? "They're a human right as in the law it is the right of all of us to courts of appeal," says Herman.

In Boston there works a mild, kindly, gray-haired, terrific little man, William G. Lennox, M.D. Some of you have heard of him; some not. To Lennox this doesn't matter. He's too busy as he has been for thirty years, beating the devil out of epilepsy—by an utterly selfless teamwork of neurologists, pediatricians, electroencephalographers plus plain general practitioners. They've transformed epilepsy from dark and demoniacal to a temporary electrochemical storm in the neurons of the brain. It is now a definitely hopeful disorder.

Lennox's forthrightness brews the better medicine now robbing seizures of their old devilish horror. This is the way Lennox lays it on the line: "Thousands of patients are still having seizures because of failure to get enough of the right medicine. Many patients, after visits to many doctors, are bewildered, discouraged and still convulsing." "This need not be," writes Lennox. And if he were saying it, his low voice, so brave and true, would go round the world like short-wave radio.

Why need it no longer be? Because of a big battery of powerful chemicals: phenobarbital, Dilantin, Tridione, Mesantoin, Mebaral, Phenurone, Hibicon, Milontin, Aureomycin and the new M-144. But also, because of you doctors. "The medical doctor (and that includes general practitioners) interested in the patient as a person, up-to-date and open-minded about calling expert aid," says Lennox, "is usually in the best position to care for most patients."

Surely, this new hope for 850,000 epileptics is of interest to your Michigan Foundation. Interest in the patient as a person would be out, if doctors were to become compulsory government medicine robots. A robot has no heart for friendship.

A new, selfless teamwork by doctors has spread statewide in California. Its State Medical Association, working with citizens, has transformed the most precious of all medicines—human blood—from deadly scarcity to routine availability—for all needing it, whose lives may be saved by it. California's doctors have formed a blood brotherhood with citizens, a statewide chain of community blood banks all sponsored by the CMA. They've organized routine blood generosity unattainable by the Red Cross.

It began only six years ago. It has grown so that blood's magic is now on tap day and night for 10,000,000 people 365 days a year, and when you ask the doctors, "who is dying for lack of blood in California?" they look you in the eye and say—*"nobody."*

What about Michigan? The doctors of Holland, Michigan, led by Otto van der Velde, have built a marvelous little blood bank system in their town. In some ways it's even better than California's. But Holland's doctors haven't even been able to spread it to include all of Ottawa County. In all the rest of Michigan there's no system like Holland's, whose physicians have made the capital discovery that the citizens—Dutchmen and you know how *they* are about money—are generous about their blood. A $64 question: Why not a blood brotherhood for all Michigan? And for every state in the Union?

The general practitioner is the G.I. Joe of medi

cine; it is not here the intention to butter him up and slobber over him as the gentle old doc with the beard at the bedside of the dying child. He no longer has the beard; and the children don't die. He is medicine's white hope. He is in danger, from his own miracles.

Now when a patient has acute chest pain, coughing, feverish, it is easy to say: "Don't take him to the hospital, it's only pneumonia." Pneumonia a few years ago—captain of the men of death. Thank God for the antibiotics. Now when a young man or woman has early infectious syphilis the general practitioner can cure it, nine chances out of ten, in his office in one five minute session. Penicillin-aluminum-monostearate—PAM. What hath God wrought!

Not so long ago the general practitioner was mainly pretty much the bedside comforter and it was the public health men who were downing the death rates. Telling about the late great Cy Young, founder of Michigan's State Health Department Laboratory, Greg Christian, your veteran fighter for better medicine, put it this way—

"Cy Young—not an M.D.—will be remembered as saving more lives in the last twenty-five years than all of us Michigan M.D.'s put together."

Now the ghost of the great Cy Young has life-saving company, the general practitioner. But here is his danger. It's fine not to have to take the patient's sputum to a laboratory for the verdict the nice little mice give about the type of pneumonia. Just give him a big shot, or so many capsules, of the best antibiotic. Here's the catch: Slap-dash diagnosis, say of virus pneumonia, may miss something—more sinister—early lung cancer.

Medicine hasn't yet simplified itself into a quick shot in the buttock. Yet, keeping up with science, it is amazing what the general practitioners can do in their offices or in a patient's home. Your present speaker knows a husky Alabaman, Sherman Curtis, today driving a Diesel locomotive on a fast run on the Seaboard railroad. Three years ago in hospital he was dying, fever spiking to 108, frightful pain, fulminating rheumatism. Sherman's doctor took him by ambulance to Tom Spies who then had the only cortisone in Birmingham. One shot of cortisone.

Then, home. Three shots of cortisone three times a day for four days by Sherman's own doctor. The fifth day Sherman was up in the morning getting coffee and orange juice for his wife and himself.

But how does the general practitioner know on what patients to try cortisone and ACTH? How is he going to use these marvelous hormones, safely? Many ivory tower highbrows seem more interested in warning how dangerous they are than in how they may be used to drag sick people out of needless misery.

Tom Spies (whose insight it is that disease is only chemical and chemically correctable) at a cortisone conference in Birmingham, showed 500 doctors a parade of fifty people (now he has hundreds like them). They'd all been so sick with disorders from rheumatoid arthritis to deadly lupus erythematosis that they'd lost their livelihoods. Spies had given them cortisone and/or ACTH. Short courses, at intervals. None staying in hospital, all treated at the clinic. They were not cured, but they were virtually free of pain and all working and self-supporting—rehabilitated and looking the world in the eye.

The average doctor is hot to learn this new science. The present speaker asked his friend, Dick Bloemendaal, why he was so keen about the great Michigan State Medical Society project, the Beaumont memorial. "Beaumont's our best inspiration, showing what a general practitioner can do," said Dick, "because he was so gentle to St. Martin, and worked with no laboratory, no gadgets to make his discovery—just his eyes, his brains and his two hands."

Last year John W. Cline, then president of the AMA, told your medical society about medical chiselers. He said that 95 per cent of doctors obey their code of ethics. "It is the code of a gentleman in the practice of medicine," said John Cline, himself as able and fighting a gentleman as this speaker has seen. But 5 per cent of *congenital* chiselers constantly embarrass the decent 95 per cent of ethical doctors. Said Cline—"These congenital chiselers no longer deserve to be in the company of gentlemen and should be excluded from your company."

This is medical honesty at its top; it's the job of local grievance committees with teeth, as they have in Colorado.

Even after you'd tossed all your chiselers out, all would not yet be sweetness and light between patients and doctors. The California Medical Association has faced the fact that doctors have far too many dissatisfied patients. Sponsored by the CMA, the Alameda County Association's secretary, Rollen Waterson, launched an inquiry—by

a chap who really knew human beings. This was Ernest Dichter, Ph.D., of New York.

The results were outwardly innocent; their implications—terrific: What do patients think of their doctors; what do doctors think of their patients; and what do doctors think of other doctors? The upshot of the investigation is epochal. It has resulted in a new job, a new dignity for the old family physician—the last of the independent medical Mohicans. In the Alameda plan the general practitioner becomes a *personal physician* —a specialist in the whole human being.

This new personal physician is the general manager of his patient's health, guiding him through the confused maze of modern medicine. He does all he himself conscientiously can to diagnose and to treat his patient. Then, if a specialist is needed, he says why and calls the specialist in the patient's presence, finds out the probable cost, gives the patient a buildup, as a person, to the specialist. The personal physician doesn't leave it at that: he follows through till the sickness is cured, or over, for better, for worse.

He's constantly and always available for anything relating to his patient's health. He guarantees his services regardless of the patient's inability to pay. (As our own Pat O'Brien, the world's ace TB fighter, long ago proposed, the personal physician can see to it that free consultation is provided, if necessary.)

When we're sick, we're often desperate for a friend who really knows the score. The personal physician is the friendly and effective advocate for us before the unfamiliar and awesome court of medical appeal. The personal physician is our economic friend, too, holding himself responsible if a specialist tries to soak us; he defends us from that iniquitous 5 per cent of chiselers.

This personal physician does not look down his nose at his patient as a layman. The Alameda plan recommends the word layman be dropped from the medical vocabulary. This new doctor tells the patient all he knows about his illness, what the treatment's going to be; and he comes clean about what the patient may hope for; so the patient becomes a doctor along with his doctor.

The know-how of the conscientious personal physician is going to cut down our medical bills; he'll see to it we're not needlessly—as now often happens—given the x-ray and laboratory diagnostic works in hospitals. He treats us as often as he can in office and home.

We can't have that kind of personal physician if the government takes our doctors over; we would be numbers; our doctors would be robots. And we cannot have a real personal physician in a closed panel prepaid insurance plan where the doctors are hired hands, not free. David de Kruif, M.D., the present speaker's younger son, recently quit the spectacularly successful (financially, that is) Permanente Health plan in California—because its streamlined efficiency kept him from continuous contact, from follow-through, with his patients.

This personal physician will certainly be welcomed by mothers of families; it's here suggested that the women's auxiliary of your society take a close look at the Alameda plan.

Now to end it, dropping into the first person singular. My salaams to you doctors of medicine. Three times in the past twenty-seven years you've saved my life, but that isn't the point. Yours is a sacred, not scientific activity. The Biblical good Samaritan (good Sam they call him in California) did his stuff just once. You've got to be good Sams night and day.

You do not fathom the power of your mercy, fantastically expanding, for the hurt, the sick, the sad, the crazy, the hateful, the dying and all in despair. You of all men (if we can keep this rickety old shebang, civilization, together) have our future in your hands.

It touches me beyond words that you have found me worthy to speak to you. This is my promise: from federal and all other shover-arounders I'll try to do my bit to keep you free.

THE CASE AGAINST THE INCOME TAX

The great weight of the burden of the average taxpayer has come to be recognized by the medical profession as a definite mental oppression upon many of our people. In a quiet, homey talk with an eminent physician recently, he stated that many psychopathic cases can be laid at the door of the income tax laws. Frustration, discouragement, and the inability of people, he says, to accommodate their minds to these oppressive and dictatorial laws bring them to the verge of "cracking up." Often members of their families literally have to drag them to competent medical advisers. Then starts a long and protracted fight to restore their health. In truth, he said, it is difficult even for the stolid, sturdy individual, let alone the weak and the sick, to withstand the pressures brought upon them by the government.—From "Man to Man," by Bernard N. Ward, C.P.A., The Caxton Printers, Ltd., Caldwell, Idaho, 1952.

Milestones in Our Knowledge of Diabetes Mellitus

By Bruce C. Lockwood, M.D.
Detroit, Michigan

OUR PRESENT knowledge of diabetes mellitus is not yet complete, but the story of the development of that knowledge forms an interesting part of medical history. It is interesting not only to the internist but to all other branches of medicine. Diabetes is an old disease. It is seen as a complication in most specialities, and it has been a part of most phases of scientific medical advances.

Diabetes is also of interest in that advances in the disease, and medicine in general, have usually followed advances in the ancillary sciences of astronomy, physics and chemistry, and more recently biology and biochemistry.

Another point of interest is that the ups and downs of diabetes, and medical history, have closely accompanied the ups and downs of economic and political stability from nation to nation, during different periods.

The Papyrus Ebers, 1500 B.C., contains the first reference to diabetes, describing polyuria and its treatment by a concoction of plant and berry extracts with honey.

Celsus, 10 B.C., according to Allen[1] gave the first clear description of diabetes, "polyuria without pain but with emaciation and danger."

In 50 A.D. Aretaeus again described the disease and gave it the name Diabetes from the Greek meaning siphon or to run through.

In 1492 historians tell us that Columbus sailed west from Spain hoping to find a shorter route to India and the Orient for the transportation of spices. Those spices were pepper, cinnamon, camphor, cubebs, aloes, cloves, nutmeg, onions, sassafras, cochineal and garlic, all of which were used as medicines in the multiple herb concoctions used by the Europeans to treat disease, including diabetes, at that time.[6] They were light and lucrative cargoes for ships and caravans which plied their perilous way to and from the Orient. Competition was keen between the countries for this business. At first the Venetian Republic controlled it and rose to power and wealth. Then the Portuguese took it by finding a way around the Cape of Good Hope. Then the Dutch who were great sailors took the business from the Portuguese. The English sea power developed in the sixteenth and seventeenth centuries, and by defeating the Dutch ruled the seas, and took possessions in eastern countries. Thus it is seen that the founding of the British Empire as well as the discovery of America has its root in medical history.

Columbus did not find a shorter route to India and the Orient and he did not take back spices. He did however take back syphilis, a disease which rapidly found its way throughout Europe.

During the period of alchemy, 1500-1600, heavy metals were used extensively in the treatment of all diseases, including diabetes. The practice was accelerated by the discovery of the value of mercury in the treatment of syphilis. Paracelsus was the chief proponent of this therapy. He also made a contribution to knowledge of diabetes in that he found that crystals were formed on evaporating diabetic urine, which he, however, mistook for salt.[9]

The century, 1600-1700, was a period of general scientific advancement.[5] There was separation of chemistry from alchemy; founding of the Royal Society of London; the period of Harvey, Leeuwenhock, Hooke, Boyle, Newton, Malpighi, Wirsung, Glisson, Bartholin, Willis, Peyer, Brunner, Graffian, Havers, and other notables.

In 1675, Thomas Willis, a professor at University of Oxford, discovered that the urine of diabetics was sweet to the taste, like honey. Matthew Dobson, also a professor at the University of Oxford, in 1775, confirmed that diabetic urine was sweet to taste, and also that diabetic blood was sweet to taste. He evaporated diabetic urine and got a crystalline mass which was very sweet and which fermented the same as grape sugar; thus the first grasping of the fact of sugar in the urine came about.

In 1790, Cullen, Professor of Medicine at Edinburgh, added the word mellitus to diabetes to distinguish the condition from diabetes insipidus. In 1796 John Rollo (England) first treated diabetes by diet. He gave mostly animal food, protein and fat, with much clinical improvement of patients.

During 1800-1850, diabetes was considered to be a disease of the stomach in which vegetable foods were changed to sugar. Treatment was by diet, chiefly of animal foods, especially fatty meat, grease, lard, suet and oils. This type of diet often

led to nausea, vomiting, anorexia and semi-starvation; hence began the earliest use of high protein (present day tendency), high fat (Newburgh), under-nutrition (Woodyatt, Wilder), and starvation (Allen, Joslin) types of diet treatment.

Trommers qualitative test for sugar was developed in 1840; the Fehling test for sugar in 1850. Claud Bernard (France), the father of physiology, did the first quantitative blood sugar estimations in 1850. He also discovered glycogen and postulated that high blood sugar was due to overproduction by the liver.

Bouchardot, 1870, a clinician in Paris during its seige by the Germans, made many advances in the management of the diabetic. He advocated daily urine tests, exercise, under-nutrition, fast days, green vegetable days, twice boiled vegetables, and the use of gluten bread, all of which are yet valuable, even in the days of insulin.

In 1875 Kussmaul (Germany) gave the first detailed description of acidosis. Kulz, in 1880, discovered oxybutric acid in urine of diabetics. Naunyn, Lenné, Von Norden and others in 1885-1905 advocated diet of low carbohydrate and protein with high fat, fast days, and alkalies for acidosis.

In 1889 Van Mering and Minkowski found that pancreatectomy in dogs always led to a severe and fatal diabetes. After this discovery there followed much unsuccessful research attempting to obtain a potent non-allergic pancreatic extract for the treatment of diabetes. Opie reported degeneration of Islands of Langerhans in 80 per cent of diabetes in 1900.

During 1910-1920, Guelpa, Allen, Joslin, Wilder, Woodyatt and others used undernutrition, starvation, low carbohydrate, protein and fat, with fast days.

In 1921, Banting and Best discovered a method of extracting a potent useful pancreatic extract of Insulin. They found that insulin in watery pancreas extract was destroyed by the external ferments. By macerating fresh pancreas in 50 per cent alcohol the external ferments were destroyed while the insulin was held in solution; the filtrate containing the insulin was then precipitated by 95 per cent alcohol, filtered and re-dissolved in water.

Newburgh, in 1926, advocated moderate carbohydrate and protein with high fat to cover normal caloric requirements, fat as high as 3.8 gm. to carbohydrate 1 gm. was used. This same year, Abel isolated pure crystalline insulin, a protein high in cystine (sulphur) combined with zinc. Ten years later (1936) Hagedorn combined insulin with protamine and zinc to make a slow acting repository insulin.

Research by Hussay in 1936 showed that depancreatized dogs with the pituitary also removed, had a very mild diabetes with no acidosis but if fasted, died of hypoglycemia.[7] Long and Lukens proved that the same is true if the adrenals are removed.

In 1937 Young found that by injecting anterior pituitary extract into dogs a permanent diabetes could be produced with swelling and fibrosis of the Islands of Langerhans.[10]

Bailey and Bailey, 1943, produced a selective destruction of the beta or insulin producing cells of the Islands of Langerhans by the intravenous injection of Alloxan, a substance chemically related to uric acid.[2]

In 1945 Cori and associates demonstrated *in vivo* and *in vitro* that both anterior pituitary extract and adrenal cortex extract inhibit hexokinase, a liver enzyme necessary to initiate the change of glucose to glycogen. They also demonstrated that insulin inhibits the effect of anterior pituitary extract and adrenal cortex extract on hexokinase.[4] This mechanism is diagramed in Fig. 1.

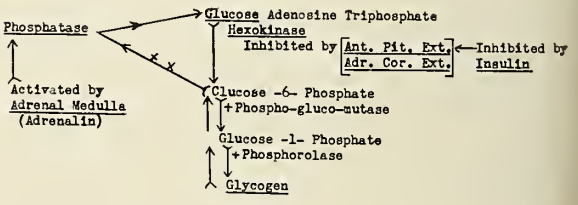


Fig. 1.

Conn, in 1948, showed that an animal can be protected against the diabetogenic effects of alloxan by the injection of glutathione, a normal constituent of the body.[3] In 1949 Conn found that a transient diabetes could be produced in animals and humans by ACTH. This transient diabetes was accompanied by (1) a decreased blood glutathione; (2) an increased urine uric acid; and (3) a decreased renal tubular absorption of glucose. Conn hypothesized that with this purine upset, there was produced a purine metabolite which had an Alloxan-like effect, reducing the intracellular availability of free sulf-hydryl (-SH)

groups which are necessary for the normal activity of many enzyme systems. A combination of decreased intracellular -SH tnd increased intracellular purines impaired the functional activity of the insulin producing island cells, and also interfered with the peripheral glucose utilization by inhibiting those enzyme systems requiring -SH groups. It also decreased renal tubular absorption of glucose by inhibiting the enzyme system within the tubular epithelium. In other words Glutathione sulf-hydryl (G-SH) acted by impairing those enzyme systems which need free sulf-hydryl groups for normal function, namely, (1) systems involved in utilization of glucose; (2) renal tubular resorption of glucose; and (3) systems responsible for production and release of white blood cells.

During 1950-51 several clinical refinements have been further utilized, notably, (1) the earlier detection of diabetes by popularizing more frequent urine examination; (2) the use of a balanced diet moderately low in carbohydrate and fat and moderately high in protein, covered by adequate insulin; (3) refinements in the use of medium long acting insulin; (4) the recognition of hypopotassemia during coma by electrocardiographic examination.

Summary and Conclusions

In this chronological review of diabetes mellitus twenty centuries of observation is narrated in about twenty minutes. Perhaps it has been oversimplified.

History shows that progress and regress in our knowledge of diabetes, as well as medicine and science in general, has been concomitant with political and economic stability or instability in the various countries.

History also show that much that appears to be new may be old things rediscovered and refurbished. The dietetic treatment of diabetes has been cyclic since 1800.

Our knowledge of the biochemistry and pathophysiology of diabetes has made great advances since the isolation of insulin in 1921. The most fertile fields for future investigation lie in the study of the hormonal control of enzymatic tissue processes, and the behavior and fate of radioactive tagged nutritional components.

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ON THE RUN . . .

There is increasing doubt as to the efficacy of alcohol in angina and in peripheral vascular disease.

. . .

Those with evidence suggesting glaucoma should not be given belladonna or its analogues and such patients should always be questioned as to their recent use of these drugs.

. . .

Latent jaundice is always present in patients with congestive heart failure. When the jaundice becomes manifest the prognosis is bad.

. . .

Work demand on the heart results first in increased systolic blood pressure, next in pulse rate and last in diastolic blood pressure.

. . .

Hemochromastosis may develop in patients given multiple whole blood transfusions such as for aplastic anemia.

. . .

Serious shock seldom develops in the burned patient who maintains a steady, adequate urinary output.

. . .

Multiple sclerosis rarely occurs before the age of fifteen or after fifty-five.

—Selected by W. S. Reveno, M.D.

Comparison of Diabetic Control with NPH and Globin Insulin

Preliminary Report

By Joseph T. Beardwood, Jr., M.D.,
C. Robert Tittle, M.D.
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Robert M. Packer, Jr., M.D.
Abington, Pennsylvania

THIS STUDY was undertaken to compare the effects of globin and NPH insulin in the twenty-four hour control of a series of diabetic patients studied under hospital conditions.

NPH insulin differs from protamine zinc insulin in that it contains about 40 per cent as much protamine and this is in a re-crystallized form. It also differs in that there is practically no free protamine in the mixture. It has a pH of not less than 7.1 and not more than 7.4.

Globin insulin is a clear, almost colorless solution; the U-80 strength possesses a pale amber color while the U-40 strength, being more dilute, is practically colorless. The insulin is modified by the addition of 3.8 mg. of purified globin (derived from beef hemoglobin) and 0.30 mg. zinc, as a zinc salt, per 100 units of insulin. The solution also contains 1.5 per cent glycerin in order to make the solution isotonic and thus minimize any possible local irritation or discomfort. The product is sterilized by filtration. The addition of phenol, 0.25 per cent, as well as the acidity (pH 3.6), contributes to the maintenance of sterility during storage and use by the patient.

It is not pertinent to this paper to review completely the voluminous literature on modified insulins, but it has been accepted in the literature for some time as the majority opinion that the action of globin insulin with zinc extends on the average of 16 to 18 hours and reaches its maximum approximately 8 hours after administration.

Peck[4] states that globin insulin behaves much like a mixture of 3 parts regular and 1 part protamine insulin, having significantly less duration of effect than a 2:1 mixture. This experience, however, was based on fasting blood sugar levels only. Colwell's[5] studies, on the other hand, show a somewhat greater intensity of action of globin insulin from the twelfth to the sixteenth hour compared with a 2:1 mixture and slightly less pronounced later effects. Peck noted that Colwell's curves were obtained, because of his method of study, in relatively mild diabetics who could have been treated for long periods without insulin. Consequently, the duration of the effect of all preparations tested may have appeared prolonged beyond the time commonly observed in treating severe cases clinically. Colwell further pointed out and first reported the possibilities of using single injections of globin insulin in large doses. He felt that the time action blood glucose curves with 60 unit dosages reveal no significant differences for the three intermediate insulins, NPH, globin and the 2:1 mixture. Therefore, the choice must be made on other considerations than their timing characteristics, and this choice could be determined only by trial and comparison of the response by different degrees of severity of diabetes. Globin insulin is a clear insulin, which may have some advantages clinically over NPH, which is cloudy suspension.

Sugar and Alpert[6] found that with diet and activity constant, comparisons of globin, NPH and 2:1 mixtures showed the best control was obtained with globin, although they did not make blood glucose determinations between 4:00 p.m. and 8:00 a.m. the following day.

The Council on Pharmacy and Chemistry[1] of the AMA stated that "the pharmacologic action of NPH is similar to that of other insulins and that its blood sugar lowering action is intermediate between globin and protamine zinc insulin." This "official statement" has been accepted in the literature and it is our attempt in this study to determine the time action of globin and NPH insulin throughout a twenty-four period.

This study represents a report on twenty-two consecutive diabetic patients admitted to the Metabolic Services at Abington Memorial Hospital and the Graduate Hospital of the University of Pennsylvania who met the following criteria:

1. They were considered to be adequately controlled by accepted standards and were using NPH insulin in greater dosages than 20

From the Metabolic Services of the Abington Memorial Hospital and the Graduate Hospital of the University of Pennsylvania.

This study was financed in part by a grant from Burroughs Wellcome and Company, Inc.
Globin insulin used in this study was Globin Insulin B. W. & Co.

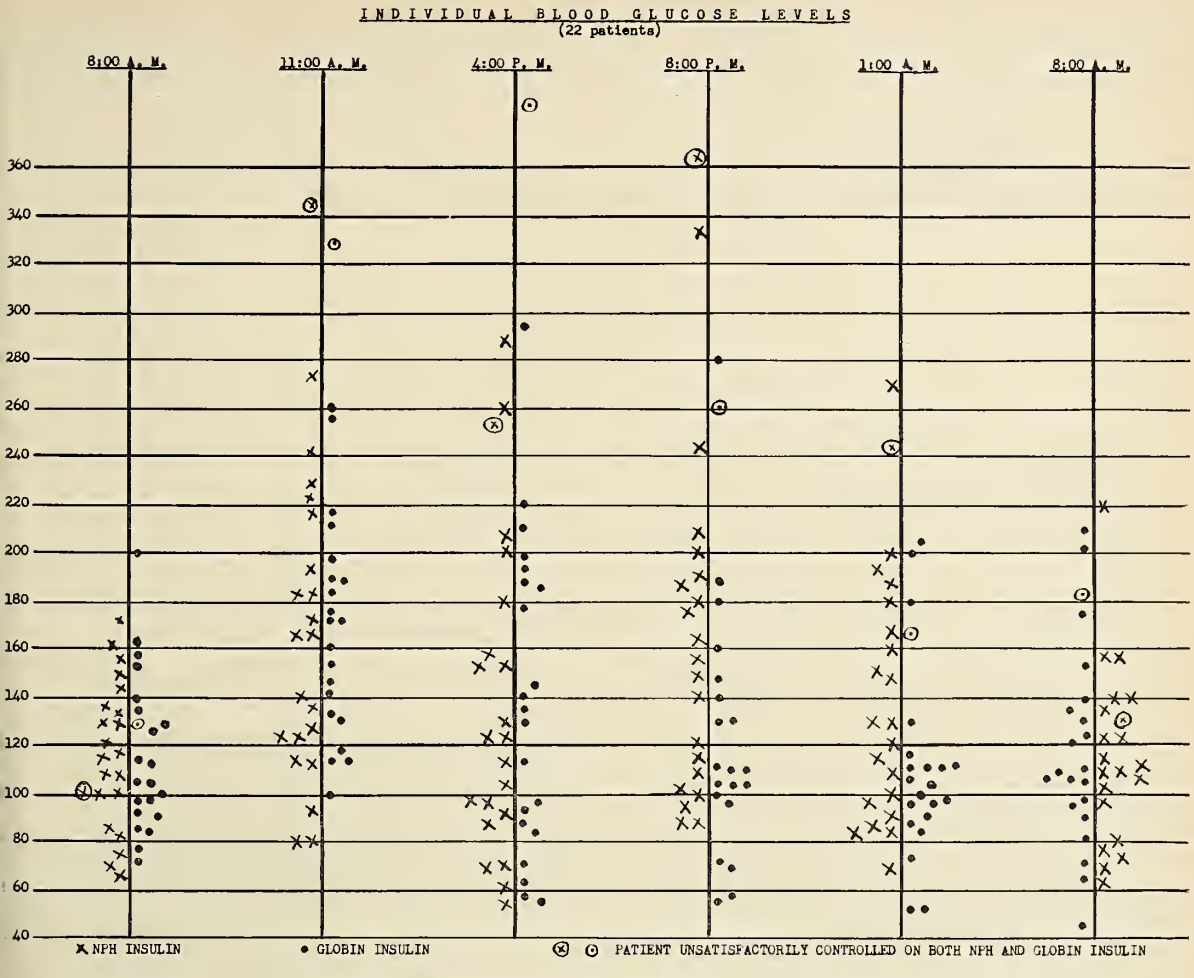


Fig. 1. Individual Blood Glucose Level (22 patients)

units daily. Patients taking less than 20 units daily can usually be standardized without difficulty on any one of the available types of insulin. Also all of our patients accepted for this series had been standardized and were on NPH insulin continuously for periods varying from two weeks to two years.

2. They were free from any condition which would complicate diabetic control such as infection, electrolytic imbalance or recent discovery of their diabetes.

3. They were hospitalized continuously for the duration of their study, and no patient once admitted to the group was dropped from statistical evaluation and report.

Method of Study

All patients in the series were hospitalized, either for this study or for treatment of a condition offering no complication to the control of diabetes mellitus. Whenever possible, the patient was kept on an ambulatory status and no attempt was made to revise his normal routine, to limit his exercise, nor to adjust his diabetic control during the study.

The patients were standardized on NPH insulin by the accepted method of standardization of the two Clinics participating in the study, i.e., a fasting blood glucose within normal limits and a 4:00 p.m. blood glucose not more than 40 mgm. above the fasting level. The patients were on diets which averaged 160 gm. carbohydrate, 80 gm. protein, and 90 gm. of fat, equally divided so far as carbohydrate, protein and fat were concerned in the three meals. While on NPH insulin, three of them also required night feedings to avoid nocturnal hypoglycemia. Immediately after the fasting blood sugar was drawn, breakfast was served at 8:00 a.m., luncheon at 12:30

p.m. and dinner at 5:30 p.m. Since the diet time in both institutions is rigidly adhered to, the timing of blood glucose in relation to the food intake was quite constant. None of the diets were changed during the period of study.

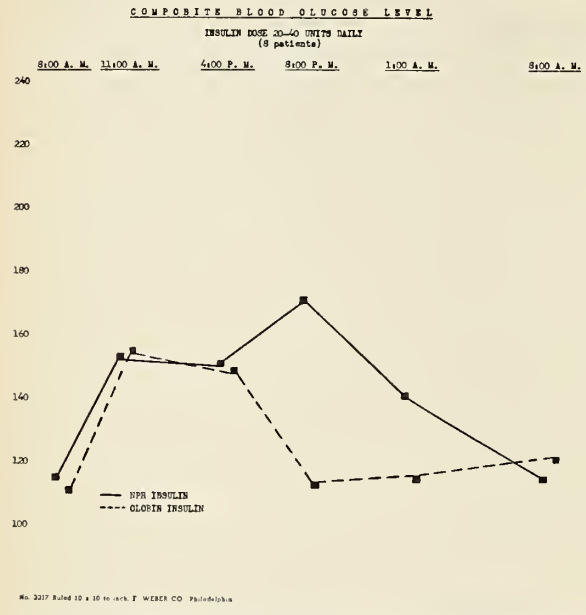


Fig. 2. Composite Blood Glucose Level (Insulin Dose 20-40 Units Daily (8 patients)

This is in contrast to the method of Izzo,[2] who felt that adjustment of the quantity and distribution of the carbohydrate content was necessary with the various types of long-lasting insulins in order to obtain a satisfactory time action curve.

Blood glucose determinations were made on each patient at 8:00 a.m., 11:00 a.m., 4:00 p.m., 8:00 p.m., 1:00 a.m., and 8:00 a.m. the following morning. These interval blood sugars were timed to provide determinations at two fasting levels and three hours after meals, with the 8:00 p.m. and 1:00 a.m. blood sugars to evaluate the prolonged action of these two insulins through the night.

With the patient adequately controlled on NPH insulin, interval blood glucose determinations were done throughout a twenty-four-hour period. Each patient was then placed on an equal dose of globin insulin for a minimum of three days to allow adequate time for the action of the previous NPH insulin to be exhausted. Colwell and others[5] found very little evidence that NPH insulin had a sugar lowering action for more than 24 hours. Then similar interval blood glucose determinations were made. No alteration was made in the management routine and the patient was not made aware of the change in insulin. Only one such curve was run for each type of insulin on each patient and where hyperglycemia occurred with either NPH or globin insulin, no attempt was made to readjust the insulin dosage. This will account for the marked hyperglycemia on several instances in the scatter pattern (Fig. 1).

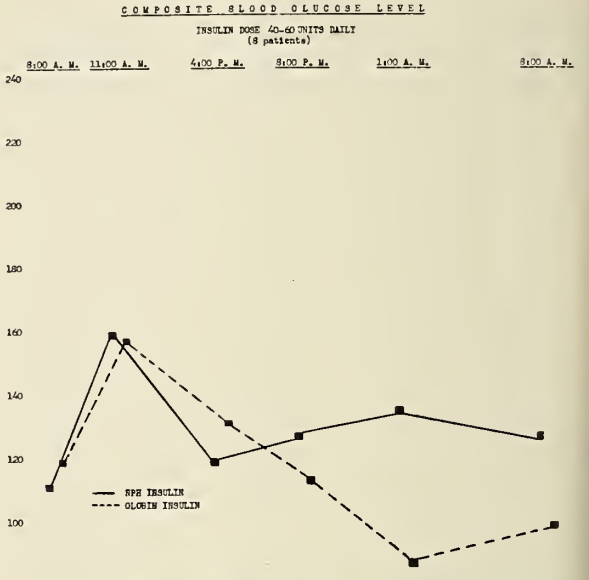


Fig. 3. Composite Blood Glucose Level (Insulin Dose 40-60 Units Daily) (8 patients)

These twenty-two patients were the only cases meeting the criteria outlined above, who were admitted to our Metabolic Services during the period of the study. For purposes of the study, we arbitrarily divided them into three groups depending upon their daily insulin requirements:

Group 1. Those patients taking 20 to 40 units of insulin daily. (Fig. 2)
Group 2. Those patients taking 40 to 60 units of insulin daily. (Fig. 3)
Group 3. Those taking 60 or more units of insulin daily. (Fig. 4)

In adequate evaluation of insulin action in the control of diabetes, the importance of multiple blood glucose determinations throughout the twenty-four-hour period, and particularly from 8:00 p.m. to 8:00 a.m., is well shown in cases No. 19

and No. 21 (Table I) where standardization of these patients by fasting blood sugars alone would give the impression that either NPH or globin

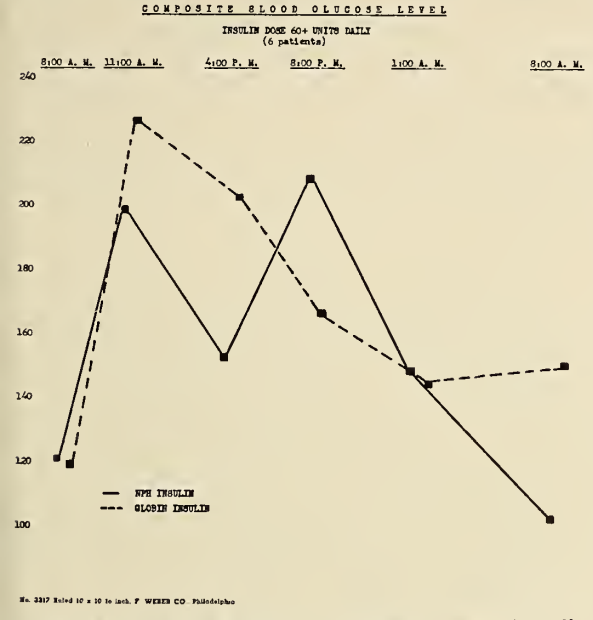


Fig. 4. Composite Blood Glucose Level (Insulin Dose 60 plus Units Daily) (6 patients)

insulin was adequate, whereas there was actually marked hyperglycemia during the twenty-four-hour period, particularly during the first twelve hours.

In Figure 5, a striking similarity in the two insulins is seen with the fasting levels being 116.5 mgm. per cent with NPH and 117.3 mgm. per cent with globin insulin. This graph shows, in our opinion, that globin insulin has a more prolonged effect than previously reported in the literature and that adequate twenty-four-hour control could be maintained in our series by either NPH or globin insulin. It is interesting also that in dividing this series into the aforementioned groups, we found little variation in the "blood sugar lowering action" of the two insulins studied in those patients requiring a larger daily dosage of insulin. This was possibly due to the fact that the insulin requirement for these patients had been previously established. They had been "controlled" diabetics for some period of time and there is some thought that the "controlled diabetics vary from the "labile" diabetics in that the "controlled" group has developed a compensatory action of their insulogenic mechanism. Endogenous insulin may be secreted or not dependent upon the degree of glycemia and thus help maintain a relatively normal blood sugar with the aid of the exogenous insulin. This is a theory, but it may

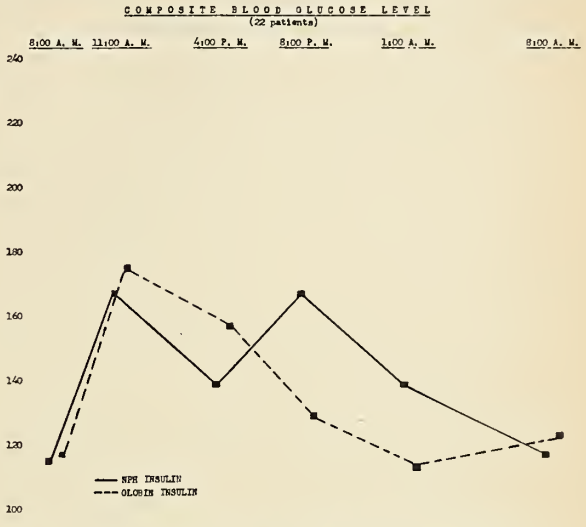


Fig. 5. Composite Blood Glucose Level (22 patients)

TABLE I.
INDIVIDUAL BLOOD GLUCOSE LEVELS

Patient No.	Age	Insulin Dose	8:00 A.M.	11:00 A.M.	4:00 P.M.	8:00 P.M.	1:00 A.M.	8:00 A.M.
1	45	20 NPH	134	112	131	118	147	124
		20 Globin	93	133	130	104	113	107
2	76	20 NPH	82	136	149	121	87	79
		20 Globin	98	131	94	130	88	108
3	76	20 NPH	172	228	260	200	160	158
		20 Globin	140	160	220	160	200	202
4	59	25 NPH	144	217	201	243	200	158
		25 Globin	158	191	188	140	130	141
5	72	25 NPH	75	123	154	209	180	105
		25 Globin	105	176	217	112	100	124
6	49	30 NPH	108	194	131	180	91	111
		30 Globin	85	190	140		107	110
7	76	30 NPH	66	94	60	140	85	75
		30 Globin	98	115	71	100	85	81
8	59	35 NPH	149	127	124	157	188	115
		35 Globin	115	147	135	57	97	107
9	51	40 NPH	118	166	113	150	121	114
		40 Globin	114	173	97	110	74	45
10	69	45 NPH	130	224	207	100	150	107
		45 Globin	100	173	178	148	92	99
11	56	50 NPH	108	172	92	190	110	125
		50 Globin	155	119	114	110	104	131
12	47	50 NPH	130	114	98	88	130	98
		50 Globin	72	155	145	180	110	90
13	77	50 NPH	86	182	152		270	220
		50 Globin	200	216	185	108	116	210
14	70	50 NPH	120	79	99	166	84	81
		50 Globin	76	115	59	59	52	72
15	63	50 NPH	136	165	104	110	116	140
		50 Globin	84	100	88	72	52	96
16	49	55 NPH	69	183	89	89	100	136
		55 Globin	162	217	197	131	97	65
17	59	60 NPH	100	140	54	95	130	63
		60 Globin	137	256	94	98	110	154
18	54	65 NPH	118	123	71	190	70	70
		65 Globin	90	198	62	70	99	130
19	66	65 NPH	161	240	289	335	195	140
		65 Globin	130	260	211	280	204	175
20	44	70 NPH	100	79	69	103	98	
		70 Globin	125	142	57	114	114	134
21	48	80 NPH	101	345	255	363	243	130
		80 Globin	130	327	502	260	166	203
22	57	100 NPH	157	274	180	176	168	113
		100 Globin	113	184	294	184	180	121

well explain the variations between the "labile" and those diabetics more easily controlled. However, it is not pertinent to our study as we were comparing unit for unit one insulin with another in a group of controlled patients; the type of patient representing the vast majority of diabetics physicians are called upon to treat.

The "labile" diabetics, those patients with infection or surgical conditions and those patients with electrolyte imbalance, were purposely omitted from this paper, but will be reported upon in a subsequent study. This group of patients obviously represents a very small percentage of diabetics handled by the average physician.

Figs. 2, 3, 4 and 5 bring out certain points which we feel warrant further discussion.

The charts show the dual action of NPH insulin in practically all patients, i.e., the lowering of the blood glucose level in the mid-afternoon, followed by a rise at 8:00 P.M. to 1:00 A.M. and then another drop through the night.

Globin insulin, after an initial rise in the forenoon, showed a continuous drop through the afternoon and through the evening. It is interesting that this occurred without dropping the blood glucose to the shock level even in patients taking as much as 100 units of globin in a single dose. In very few cases was there any significant rise in the blood glucose level from the 1:00 A.M. reading to the 8:00 A.M. reading. In the vast majority of patients the 8:00 P.M., 1:00 A.M. and 8:00 A.M. blood glucose determinations were lower than the 4:00 P.M. reading. The difference in the 11:00 A.M. and 4:00 P.M. readings was not very significant except in the group taking more than 60 units of insulin a day, but this group showed a continuous and satisfactory drop from 4:00 P.M. until the fasting level the next morning. We feel it is of significance also to note in Fig. 1, there is seen a more uniform grouping of the blood glucose determinations with globin than with NPH insulin with fewer high levels and only a minority of low blood glucose readings.

It would seem, from these comparative studies under identical conditions, that the twenty-four-hour action of globin insulin was established as being equal to that of NPH in a group of patients who, we felt, were adequately standardized. This is somewhat at variance with the opinion one obtains from the literature. Mosenthal[3] states that globin insulin has a blood sugar lowering action of twelve to eighteen hours duration and on the basis of this many physicians have given globin insulin twice daily in the standardization of many cases.

Conclusion

In an attempt to compare the action of globin insulin and NPH insulin, twenty-two patients were studied. They had been previously standardized on NPH insulin as their only insulin for two weeks to two years. They were admitted to the hospital and a twenty-four-hour blood glucose curve obtained. They were then placed on the same dose of globin insulin for three days, after which another twenty-four-hour blood glucose curve was obtained.

It was our experience that there was no appreciable difference in control of the diabetes in the action of these two insulins at the end of the twenty-four-hour period. This is true of patients taking doses of insulin varying from 20 to 100 units daily in a single dose. It would seem that globin and NPH insulin might give approximately the same degree of diabetic control and the insulin of choice should be determined by the physician's experience and the individual's response.

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Diabetes Starting in Childhood

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FOR THE past thirty years, insulin has been used in the treatment of diabetics both young and old. It seems pertinent at this time to attempt to evaluate the results of this treatment, with particular attention to the childhood type.

This study will deal with sixty cases of diabetes with the onset between ages sixteen months and eighteen years and will show that good dietary and insulin control pays out in the long run.

All of the sixty cases were treated for most of their diabetic life in my office. Some of them were hospitalized at the start because of the severity of the condition or the inability of the parents to learn the routine of diet and insulin therapy soon enough to establish control promptly.

The diets used in these cases are all computed as to normal height and weight for the age, and were weighed for accuracy. The protein content was kept up to 1½ to 2 gm. per kilo per day in the young group and gradually reduced to 1 gm. at age twenty. This was not true in the case of those treated before 1930 when it was the accepted practice to feed less protein. This pertains to only two of these cases. The carbohydrate content ranged between 140 and 180 gm. and the fat content 90 to 110 gm. per day.

Since the diets for childhood diabetics are usually prepared by the mother, she was fully instructed in each instance on the abnormal physiology of the disease, the principles of diet management, methods of substitution, and accurate weighing. As soon as the child reached an age where instruction was practical, then the child was taught to care for his own diet, with careful supervision by the mother.

Insulin therapy was started at the onset and was used in sufficient amounts to keep the 11 A.M. blood sugar at a point between 110 to 140 mgm. per cent. The urine tests were done at intervals and at various times during the day. If it was apparent that adequate control was not being attained, then twenty-four-hour blood sugar curves were done to help in readjusting the dosage to insure as nearly a level curve as possible throughout the day and night.

TABLE I.

Age at Onset	No.	Sex		Age		Deaths		Rating on Physical Condition			
		M	F	Av.	Oldest	No.	Age	I	II	III	IV
Und. 2 yrs.	4	3	1	14	30	0		3	1		
2- 4	3	1	2	22	24	0		2	1		
4- 6	3	1	2	10	12	1	8	1	1		1
6- 8	6	4	2	21	26	1	25	2	3		1
8-10	10	4	6	17	27	1	13	6	1	2	1
10-12	8	4	4	19	28	1	17	5	1	1	1
12-14	8	3	5	18	27	1	15	6		1	1
14-16	11	5	6	26	37	2	29	6		3	2
16-18	7	6	1	29	46	0		3	2	2	
Total	60	32	28	20.5	46	7		34	10	9	7

In those cases treated from 1924 until the advent of the slow acting insulins, unmodified insulin was used in either three or four injections daily. Since then Protamine Zinc and unmodified insulin combinations have been used, either in separate injection or in a mixture of one part Protamine Zinc to two parts of unmodified insulin. A few cases have been adjusted on ratios other than one to two in order to maintain a more level twenty-four-hour curve. In the past few years, NPH insulin has been substituted for the Protamine Zinc and regular mixtures in some cases.

The children were examined at my office each month and were watched for evidence of complications and childhood diseases. These frequent visits to the physician played a large part in the successful outcome of many of the cases. Church attendance on Sunday strengthens the resistance against sin the rest of the week; in like manner, these frequent visits to the physician helped to keep them on the straight and narrow dietary path.

Degree of Achievement of Successful Management

No diabetic routine in childhood can be successful without good cooperation between the mother, the patient and the doctor. My experience is no different from that found by other doctors. Many mothers are careless and indifferent to the welfare of the child. Many of them have large families and are too busy to watch the child properly. Many do not have the intelligence necessary to properly carry on the treatment. So for these several reasons, many children do not have the benefit of good control and many of the vascular complications in later life are due to this lack of cooperation in the home.

TABLE II.

Control Rating	No. Cases	Avg. Years on Insulin	Age at Onset			Sex		Present Rating Physical Cond.			
			Avg.	Youngest	Oldest	M	F	I	II	III	IV
Under Five Years on Insulin											
A	12	1.6	11.7	21 mo.	14	5	7	12			
B	1	3	18	18	18	1	0	1			
C	5	3.2	12.4	5	16	3	2	1	1	1	2
Total	18	2.4	12.4	21 mo.	18	9	9	14	1	1	2
5 to 10 Years on Insulin											
A	7	6	12	4.6	16	2	5	6			1
B	3	7.7	7	1.3	13	2	1	2	1		
C	4	7	10	4	11.5	4	0		2		2
Total	14	6.6	10.1	4	16	8	6	8	3		3
10 to 15 Years on Insulin											
A	3	12	6	2	9	1	3	3			
B	3	11	9	8	10	1	2	1	1	1	
C	6	10.7	13	6	18	3	2	1	1	4	
Total	12	11	10.2	2	18	5	7	5	2	5	
15 to 20 Years on Insulin											
A	3	17	12.7	10	15	1	2	3			
B	2	18	8	2	14		2	1			1
C	3	18.7	6	3	9	3				2	1
Total	8	18	9	2	15	4	4	4		2	2
20 Years and Over on Insulin											
A	4	22	10	3	16	3	1	3	1		
B	2	27	9.4	1.8	17	1	1		2		
C	2	22	8	6	10	2	0		1	1	
Total	8	24	9.2	1.8	17	6	2	3	4	1	
All Groups											
A	29	8	10.9	1.7	16	12	18	27	1		1
B	11	12	9	1.3	18	5	6	5	4	1	1
C	20	10.4	10.7	3	18	15	4	2	5	8	5
Total	60	9.6	10.5	1.3	18	32	28	34	10	9	7

We have another problem which is difficult to handle (Table I). It became apparent during this survey that when the diabetes started under ten years of age, much better cooperation was obtained from the child. They obeyed better and seldom rebelled against the routine. The diabetic child of twelve to eighteen years of age is apt to become too independent and careless with the treatment. This problem requires painstaking effort on the part of both the physician and the mother to keep the child conscious of the seriousness of inadequate control. It is too bad some method cannot be devised to impress the parent and child that once retinal changes have taken place, no degree of adequate control can reverse the process, and blindness is inevitable.

However, I do not want to create the impression that this pessimistic situation is the rule. By far, the majority of the cases are controlled in homes where cooperation is maintained at a high level. Their blood tests are done regularly and when visits to the physician at regular intervals are not possible, frequent urine tests are run. Their diets are prepared and measured with the greatest of care. It is these patients who live on for years without evidence of vascular disease.

Evaluation of Results

In this study (Table II) the degree of diabetic control was based on the results of frequent check-up examinations and a careful observation of the home life and diligence of the mother and child. When careful supervision of the diet and insulin therapy was obvious, the visits to the office for examination were frequent and hyperglycemia was not present except during short periods of infectious or childhood diseases, the case was given a control rating of "A" (Table II). When the supervision in the home had been only fair, with periods of carelessness resulting in hyperglycemia, even though a return to good control took place after several months, the case was rated as "B." When there was a total disregard for the dietary and therapeutic instructions over periods of months and years, with only short periods of careful management, the case was rated as "C."

The cases have been rated also as to the physical condition at the time of the survey. A rating of I (Table II) was given to those cases showing no evidence of vascular disease, either retinal, peripheral or renal. As far as has been possible, they have been checked by ophthalmoscopic examination, palpation of peripheral vessels, x-rays, as well as urinalysis and blood nitrogen. A rating of II was given to those cases where there was no evidence of vascular pathology, but other complications appeared such as pulmonary tuberculosis, rheumatic heart disease, dwarfism, et cetera. A rating of III was given to those cases showing definite evidence of either retinal, renal or peripheral vascular disease. Those who died were classified as IV.

During the first few years of diabetic management, it is seldom that vascular pathology appears, even those patients who are obviously poorly controlled may go for years without vessel lesions. Eighteen cases in the first group in Table II have been on insulin for an average of 2.4 years. Fourteen of the eighteen have remained free from complications. The two deaths and the two with complications were definitely due to poor control with careless routine on the part of the parents.

Eight of the fourteen cases in the second group (Table II), with an average of 6.6 years on insulin, have shown no evidence of vascular disease, but three have complications attributable in one way or another to their poorly controlled diabetes and three have died. The deaths will be discussed later.

As the years of diabetic life lengthen, we begin to see more evidence of the effect of poor control. In the third (Table II) group, with an average of eleven years on treatment, seven out of twelve have already begun to show vascular or other complications. It often takes a number of years of relatively poor control for the vessels to degenerate and a reversal of this process is seldom, if ever, seen.

In the fourth group, consisting of cases under treatment for over fifteen years, there are eight cases averaging eighteen years on insulin. Four of them are still free from complications, even though one of the four was not too careful in following dietary instructions. Two of the other four have already developed serious complications and two have died.

In the last group there are eight patients who have been on treatment for an average of twenty-four years. Three of the eight have been very faithful to their routine and still show no obvious vascular changes, while the other five have developed complications.

A long term study of this nature cannot help but show that evaluation of the efficacy of a method of diabetic control on a few years of observation is not conclusive and is liable to lead one to draw false conclusions. Many diabetics on a carelessly measured diet or no diet at all, showing small amounts of sugar rather consistently, have continued to feel well and appear in good health for as much as fifteen years. However, very few cases so indifferently controlled pass the twenty year mark without serious complications, usually vascular.

An interesting fact was brought out by the study. Of the twenty-eight female patients in the list, seven became pregnant and were delivered of normal children. Control of the disease during the pregnancy was easily accomplished but more frequent examinations were conducted during the period of gestation. Only one of the seven was unsuccessful from the mother standpoint. She developed post-partum convulsions and died two days after delivery.

TABLE III.

No.	Sex	Age Onset	Yrs. on Ins.	Rate of Control	Cause of Death
1	M	15	9	C	Strep. Infection. Coma
2	F	14	19	A	Calcification of arteries at 26. Died of nephritis.
3	F	8	5	A	Influenza—Coma. Possible potass. def.
4	F	5	3	C	Mother regulated control without medical guidance. Lobar pneumonia.
5	M	6	19	C	Nephritis. Possible Kimmelstiel-Wilson.
6	M	12	3	C	Absolute disregard for diet—Coma Possible potass. deficiency.
7	F	11½	6	C	Poor control. Pregnancy. Post-partum convulsions.

Causes of Death

The seven deaths are listed in Table III and are selfexplanatory. Potassium deficiency was probably a factor in two of them, one long before that factor was recognized and the other due to insufficient potassium therapy. It is most likely that a better control during the previously existing diabetes would have allowed better results from the coma therapy in five of the seven cases.

Conclusions

It is possible to obtain good diabetic control in childhood diabetes only by careful and proper instruction of the mother and patient and frequent check-up examinations of the blood and urine.

Vascular lesions as diabetes complications are the result, in most cases, of poor or inadequate control early in the disease.

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Diabetes Detection

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MODERN MEDICINE has added much to the comfort and longevity of patients with diabetes mellitus. Prompt and adequate treatment can prevent or modify many complications of diabetes. Diabetes detection is therefore important. Approximately 2 per cent of the population has known diabetes. Recent surveys,[2] sampling 60 to 70 per cent of a given area, reveal the astonishing fact that for every four known diabetics, three new cases were discovered. A large portion of the population therefore has undetected diabetes mellitus. One reason for this is that diabetes, particularly in the older age groups, is insidious in its onset and subtle in its manifestations. A detectable chemical imbalance will exist long before the individual realizes he is ill. Most diabetics are discovered accidentally in the course of routine physical, employment or insurance examinations when the urine is tested for sugar. Urine is the easiest of body fluids to obtain; the test can be performed in less than five minutes for a cost of less than five cents. Any degree of positivity should create suspicion of diabetes and should be confirmed by appropriate blood sugar studies.

A concerted diabetes detection effort is being sponsored by the American Diabetes Association—the fifth annual program this year will be during the week of Novmber sixteen to twenty-two. Many physicians are annoyed by such special disease programs. The story is different, however, for the person found to have a disease as a result of these efforts be it diabetes, cancer, tuberculosis or others. The impetus of such programs is far-reaching. The profession is alerted to the intelligent use of detection tools. The public is educated as to the nature and potentialities of detectible chronic disease; and the known sufferers of a disease, especially diabetes, are stimulated to better coöperation with their physicians. Too often there is a laissez faire attitude toward a mild glycosuria on the part of physicians and a passive neglect of a mild diabetes by the patient until ketosis, gangrene or blindness result.

Diabetes detection is not a one-week affair, however. The program of the American Diabetes Association in coöperation with state and county societies is a perennial reminder that diabetes mellitus is ubiquitous and insidious and should be constantly looked for. The detection program throughout the country assumes various degrees of activity and effort. No single pattern is applicable to all communities. The program is dignified by being conducted and controlled by doctors of medicine without solicitation of funds for the effort. To this end it is an excellent public relations project. Financing has been at the state or county level by the societies, through health departments or voluntary contributions. The physician's office is the best detection center. Some areas rely solely on publicity regarding the nature of diabetes and urge people to consult their physicians. Others have elaborate displays and facilities for testing urine and blood for sugar. In these instances no pretense is made of making a diagnosis of diabetes but the person with suspicious findings is referred back to his physician for definitive diagnosis.

Continuous screening of large segments of the population can be carried out subtly in other ways. Among these are camp and school examinations of children which should include a urinalysis. Although diabetes in the young age group is usually abrupt in onset, occasionally a case is picked up in this way. Recently among 1,900 students screened in one Detroit high school, three new diabetics were discovered. Another method is through employment and periodic physical examinations of industrial groups. Most large concerns have well integrated medical departments where urine testing is routine. Many have facilities for blood sugar follow-up on positive reactors. Examiners for some small plants, however, fail to test the urine, the examination being confined to the heart, blood pressure and presence of hernia. A majority of women as housewives will not fall in the above categories and must be tested by their physician or at centers when available. The sex incidence of diabetes rises to 6.1 over fifty years of age with women in predominance. Women's auxiliaries, service clubs and farm groups can serve well in stimulating interest in diabetes detection programs.

The detection of diabetes necessarily becomes the function of the private physician. Through the stimulus of the American Diabetes Association state medical societies have formed diabetes committees (in Michigan it is a subcommittee of the Geriatric Committee). In turn county societies are urged to form committees at the local level for

educational and detection purposes. In 1951 there were thirty state society committees and 636 county society committees throughout the country. In Michigan forty-two county societies (approximately 50 per cent of the state) had diabetes committees. This number has increased rapidly in the past five years indicating the impact of the national program and the growing appreciation on the part of the profession of its significance. A wholesome liaison exists with state, county and local health departments which is important.

The tools of diabetes detection are relatively simple and generally available: these are urine and blood analyses for sugar. Two fallacies exist which should be overcome from the standpoint of accuracy and expense. First of these is reliance on the early morning urine sample. This is routine procedure in many offices and hospitals. A fasting urine negative for sugar does not rule out diabetes since many mild diabetics "spill" only late in the day or after meals. Hence urine collected two hours after a meal rich in carbohydrates will be more significant. Glycosuria of any degree then should be confirmed by blood sugar estimates. If time or cost precludes a standard glucose tolerance test, a blood sample may be drawn an hour and a half or two hours after a meal high in carbohydrates. A sugar level of over 170 mg. per cent at this time is strongly suggestive of diabetes. The technique of self-testing has been analyzed and leaves much to be desired.[1] Of those who received the kits 60 per cent used them. Those who participated most accurately did so out of fear of the disease or knowledge of it in the family. Six per cent had positive findings, yet only one quarter of these sought the advice of their doctors in accordance with directions.

The second fallacy, a corollary of the first, arises in dependence on the fasting blood sugar. As a routine hospital and office procedure it is too often a waste of time, talent and money. As a guide to insulin therapy or in the diagnosis of islet cell tumor it is of value. A fasting level of over 130 mg. per cent is suggestive of diabetes; with an associated glycosuria it is diagnostic. This is often not the case with mild or early diabetes wherein the postprandial blood samples are much more significant. Too, the after meal blood sugar will spot the "high threshold" individual whose after-meal urine may be negative for sugar.

Blood level values suggested by the American Diabetes Association as highly probable of diabetes are as follows:

Venous blood: Folin-Wu method—
over 130 mg. fasting.
over 200 mg. after meal.
Somogyi (true glucose)—
over 110 fasting.
over 150 mg. after meal.

Capillary blood: Folin-Ralmos method—
over 140 mg. fasting.
over 240 mg. after meal.
True glucose—
over 120 mg. after fasting.
over 200 mg. after meal.

A simple kit is now available which tests capillary (finger) blood for true glucose at two levels, one at 130 mg., the other at 180 mg. The test requires about five minutes time and precludes the more elaborate techniques of standard blood sugar methods. Its accuracy has been established.

Diabetes knows no sex or age limitations. In children it is prone to appear around puberty. In women, pregnancy may be a precipitating cause. All glycosurias of pregnancy should be checked with blood sugars. Women who have borne large babies seem particularly prone to diabetes later. Obesity is present in 80 per cent of most diabetics. The duration of the obesity is important, thus individuals who have been too fat too long are likely candidates for the disease. The hereditary aspect, as a recessive characteristic, is generally accepted. Hence blood relatives of diabetics deserve watching. Parents of diabetic children and children with a diabetic parent will wisely be tested for sugar periodically. Tangently, diabetes in cousins, aunts and uncles may be a clue of the trait in the family heredity.

The following five brief histories illustrate some of the above points:

Case 1.—K. J., a gas station attendant, age 20: Glycosuria discovered in June, 1949, after 30 lb. weight loss in 3 months; thirst, frequency and weakness. Fasting blood sugar 250 mg. with 4 plus urine sugar. Weight in Aug., 1949—135 lbs., in June, 1950, 150 lbs. Fasting blood sugar in June, 1950, 138 mg. on 42 units of mixed insulins; 106 mg. on 38 units NPH in June, 1952 (illustrates early onset, classical symptoms, good response).

Case 2.—R. H., dentist, age 60. Family history: paternal uncle died in diabetic coma; cousin has diabetes; mother, age 80, has diabetes; brother, age 53, has coronary disease and diabetes. Had easy fatigue since virus

pneumonia in 1947. No thirst or frequency. Weight in March, 1948—186 lbs., urine negative at breakfast and supper, trace at lunch. Tolerance test:

Blood:
F. 112 ¾ hr 294 1½ hr 294 2½ hr 270 3½ hr 147 mg.
Urine:
neg. 4 plus 4 plus 4 plus 4 plus

On a reduction diet, in April, 1949, weight 178 lbs., blood sugar three hours after meal—101 mg. Active, strong. (Emphasizes strong family history, role of overweight, significance of only a trace of sugar and the fallacy of relying on fasting sugar (112) for diagnosis of diabetes.)

Case *3.*—A. R., physician, age 50: Glycosuria found at insurance examination in April, 1948. Blood sugar three hours after meal was 160 mg. No symptoms, negative family history, weight 197 lbs. Tolerance test:

Blood:	F. 178	1 hr 310	2 hr 310	3 hr 206 mg.
Urine:	neg.	2 plus	2 plus	2 plus

On 1200 calorie diet. In April, 1949, weight 170 lbs., blood sugar two and one half hours after meal—104 mg. (Absence of symptoms, casual discovery, negative fasting urine with high fasting blood sugar, obesity.)

Case 4.—H. M., executive secretary, age 40: In 1942 on routine examination weight was 183 lbs. (excessive for build), fasting urine negative, after supper urine presented trace of sugar. 1945 mid-day urine was negative. In March, 1948, weight 184 lbs., complained of dysuria. Balanitis present, urine 4 plus sugar, fasting blood sugar 141 mg. Father had recently developed diabetes. Weight dropped and symptoms cleared on diet. June, 1948, weight 165 lbs., blood sugar one and one half hours after meal—143 mg. (Lapse of six years before symptoms brought patient back for investigation. With overweight in 1942 and trace of sugar and abnormal tolerance test might well have been obtained had proper investigation been pressed.)

Case 5.—C. R., motor executive, age 52: Son developed diabetes so patient consulted company medical director, tolerance test done:

Blood:	F. 125	½ hr 22	1 hr 270	2 hr 196 mg.
Urine:	neg.	trace	4 plus	4 plus

Sister had diabetes. Patient had series of boils in May, 1949. Cholesterol—340 mg. Dietary restriction produced negative urine with after meal sugar of 119 mg. Business pressure demanded rapid pace and excessive drinking. Patient expired suddenly of heart disease in December, 1949. (Role of family history with offspring manifesting diabetes before it was apparent in the parent; arteriosclerotic heart disease with its sudden termination undoubtedly fostered by co-existent diabetes.)

Summary

Diabetes mellitus is more prevalent than it has been assumed to be. Group screening will detect the unsuspected case of diabetes. Diabetes can be detected readily if kept in mind and when looked for in the obese, when there is family history of the disease and when all instances of glycosuria are thoroughly investigated. Prompt diagnosis and proper treatment will keep the diabetic economically active and physically well.

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PROFESSIONS SHOW RISE IN EARNINGS

The average physician last year earned $12,518 or $980 more than in 1950. The average lawyer made $9,375, or $303 more than in 1950, and the average dentist, $7,743, or $450 more.

These figures, made public today by the Office of Business Economics of the Commerce Department, are based on recent mail surveys of the three professions. They are the average earnings, *before taxes,* of physicians, lawyers and dentists regardless of whether they were independent or salaried practitioners.

A breakdown of the figures showed, however, that as in the past, the independent physicians fared better than those on salary. The average net income of the independent physician in 1951 was $13,378, while the salaried members of the profession made $9,522. Of an estimated 175,000 physicians, about 38,500 are salaried.

It was the other way around with the legal profession, however, with the salaried lawyers earning on an average about $10,197 and the independent ones making $8,936. Salaried lawyers represent about 35 per cent, or 73,500 of an estimated 210,000 attorneys in the country.

While the report showed that the average independent dentist made $7,856 last year, it said that there were too few returns from the salaried dentists to permit estimates. According to the Bureau of Census, the country has about 77,000 dentists.

The report noted that from 1949 to 1951, incomes of physicians (independent and salaried) rose 13 per cent, while dentists and lawyers reported increases of about 10 per cent.—*New York Times,* July 23, 1952.

The Implications of Diabetes Mellitus Complicated by Pregnancy

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SINCE THE advent of insulin therapy in diabetes mellitus, the problem of diabetes complicated by pregnancy has become of increasing importance. Prior to insulin therapy, few diabetics with onset before or during the childbearing age lived long enough to bear children. Moreover, those who did live either were infertile, presumably due to their poor nutritional status, or were unable to carry the increased load of pregnancy without intervening keto-acidosis. Joslin[9] reports a survey of duration of diabetes at death among 12,281 diabetics over a period of fifty-four years. The survival of the groups of diabetics of pre-childbearing and childbearing age, i.e., zero to nine, ten to nineteen, and twenty to thirty-nine years of age at onset, rose from the period 1897-1914, in which survival after onset was 1.3, 2.1 and 4.3 years respectively, to 18.8, 16.7 and 19.1 years, respectively, in the period 1944-1951. Some of the earlier students of the disease report that they had never seen a pregnant diabetic woman.[4] Recent reports indicate that the incidence of pregnancy in the diabetic woman is comparable to that in the non-diabetic.[2,15] There are an estimated 80,000 diabetic women of childbearing age in the United States at present and some 50,000 "juvenile" diabetics who are reaching or can be expected to reach the childbearing age. As the treatment of diabetes becomes progressively improved, more former juveniles will attain the childbearing age each year.

It is a recognized fact that foetal survival in the diabetic woman is less than that in the non-diabetic. Henley,[8] in a survey of the world literature to 1944, reported a foetal mortality of 37.6 per cent in 1,269 cases. Others more recently in smaller series report from 8 per cent to 70 per cent foetal mortality.[6,12,13,15] The etiology of this inability of the diabetic woman to approach the non-diabetic in foetal survival is not definitely clear. It is apparent that no one factor can explain it totally. Certainly in the pre-insulin period and even during the period in which depot insulins were unknown, a large number of foetal deaths were due to chronic poor control and malnutrition or intervening diabetic catastrophes which are now preventable by adequate control of the diabetic state.

The great majority of diabetic pregnancies that will come under the care of the physician are in patients who have already been diagnosed as diabetic prior to pregnancy. A small percentage of women will first be diagnosed as diabetic during the course of their pregnancy.[15,17] Diagnosis of diabetes during pregnancy is made by the classical procedures and criteria used in any patient. One must be cautious, as ever, not to make the diagnosis on glycosuria or reducing substance in the urine alone. Blood sugar levels and glucose tolerance tests must be employed.

One must be conscious of the natural course of diabetes in evaluating the pregnant diabetic woman. The diabetic in the course of years is subject to accelerated and premature vascular disease. This is manifested by (1) retinal vascular changes, diabetic retinopathy, microaneurysms, exudative lesions and retinitis proliferans, (2) nephropathy, Kimmelsteil-Wilson syndrome or "diabetic nephritis," and (3) peripheral vascular disease with both intimal atheromatous and medial calcific and hyaline changes, not only in the larger vessels but in the arterioles and small arteries. The factors which influence or determine the extent and severity of these changes are (1) duration of diabetes and (2) age at onset. The longer the duration, the more likely these changes are to occur. Likewise, the acceleration and rapidity of the changes are related to onset early in life. In addition, more and irrefutable evidence is being presented each year to prove that good physiological control of diabetes retards the above processes.

White[9] has developed a classification of pregnant diabetic women through experience with 702 diabetic pregnancies which is based on the above-mentioned factors. It is a sound and logical guide for prognosis and therapy. Further, it certainly should be adopted universally for evaluation and research in methods of therapy of the pregnant diabetic.

Class A includes those patients in whom the diagnosis is made only by glucose tolerance test and who require no insulin for good control.

Class B is the true diabetic with onset in adult life, i.e., one who is over twenty years of age, whose diabetes is less than ten years in duration, and who shows no evidence of vascular disease.

Class C includes onset from ten to nineteen years of age, or duration from ten to nineteen years, and no evidence of vascular disease.

Class D includes those with onset under ten years of age, duration over twenty years or those showing retinitis or calcification of vessels in legs, irrespective of age at onset or duration.

Class E covers those showing calcification in pelvic arteries by x-ray.

Class F comprises those with demonstrable vascular or diabetic nephritis.

The above classification lays emphasis upon the importance of vascular disease in the diabetic.

When one considers the effects of diabetes on pregnancy, four principal factors stand out: (1) toxemia, (2) hormone imbalance, (3) foetal oversize and (4) intrauterine death.

Toxemia or toxemia-like states are reported by most observers.[1,7,10,11,15] Toxemia may vary from mild edema and mild elevation of blood pressure, over 140 systolic and ninety diastolic with slight albuminuria, to preclampsia and actual eclampsia. The incidence of toxemia of any severity varies with the group reporting from 8 per cent to as high as 70 per cent. Reis[14] reports no greater incidence of toxemia in diabetic than in normal pregnancies. It would seem logical that hypertension, albuminuria, edema and nitrogen retention would be more common in the diabetic woman who is subject to premature vascular and renal disease. It is a well-known fact that the woman undertaking a pregnancy who has recognized preexisting renal damage, whether it be of vascular, bacterial or previous toxic origin, runs a calculated risk of toxemia-like states. The majority of toxemias in the non-diabetic occur without previous knowledge of renal damage, although it is not common to do exhaustive renal function tests routinely in early pregnancies. The diabetic thus may show, for the first time during the stress of pregnancy, manifestations of previously undiscovered renal impairment. It would also follow that duration of diabetes and age at onset would be reflected in a higher incidence of toxemia. Reis's[14] low figures for toxemia may be due to the fact that he was dealing with diabetics of short duration and with onset after childhood, i.e., Classes A and B. White's[9] high incidence of toxemia is certainly correlated with the fact that 70 per cent of her cases fall in Classes C to F. However, it must be stated that White differentiates toxemia from nephritic or essential hypertensives. All patients showing albuminuria and/or hypertension with onset past twenty-eight weeks gestation are classified as toxemias; those prior to twenty-eight weeks are classified as nephritic or essential hypertensives.

Hydramnios most certainly is a factor in many diabetic pregnancies. No two authors agree upon the incidence. White's series, the largest reported and probably the most carefully and closely followed, shows a high incidence of hydramnios. It is interesting to note that the groups reporting the lowest incidence of hydraminos are those who advocate free diet and pay little or no attention to glycosuria. One wonders if the polyuria and dehydration that must be associated with this plan of management influence the lack of hydramnios.

The incidence of spontaneous abortion in the diabetic woman also differs widely from group to group. White[9] reports a high percentage, while Reis[14] reports no increase over non-diabetics. Again as in the incidence of toxemia, the difference lies in the dissimilarity of the duration and age at onset of the two groups. Spontaneous abortion, while difficult to evaluate, must be recognized as a hazard, especially in the women falling into Classes C through F.

Intrauterine deaths past the age of viability (thirty-two weeks) are markedly increased in the diabetic. All observers agree in this and most report that over 50 per cent of the foetal deaths occur in this manner.[3,10,11,15] The etiology of this increase is not clear. Some have attributed it to maternal ketosis, others to foetal oversize, and still others to toxemia.[7,9] White[9,17] believes that it is influenced by hormone imbalance and presents rather convincing evidence that it is preventable by correction of this imbalance.

Foetal oversize is decidedly a recognized factor. Birth weight exceeding that expected for the period of gestation is noted in both live and stillborn infants. It is contributed to by three factors: (1) edema, (2) fat, and (3) visceromegaly. As will be pointed out later, it is an important factor in the selection of the mode and time of delivery.

The role played by hormonal imbalance is a highly controversial one at the present time. Smith and Smith[16] in studies on toxemia of pregnancy

reported that an imbalance of the hormonal factors influencing and associated with pregnancy was responsible for toxemia of pregnancy. White[9] in 1938 in a search for methods increasing the foetal salvage in diabetic pregnancies started an intensive study of the hormone patterns in her patients. She found that chorionic gonadotrophin levels rise abnormally and pregnanediol and estrogen levels fall below normal as pregnancy progresses. Substitution therapy with stibesterol and progesterone in increasing doses guided by serial determinations of chorionic gonadotrophin level and pregnanediol excretion, and by observation of clinical course (onset or increase of toxemia, hydramnios, et cetera) was instituted. (For details of therapy the reader is referred to Joslin's "Treatment of Diabetes Mellitus," Ninth Edition, 686-690, Lea & Febiger, Philadelphia, 1952.)

White,[9,17] in addition to classifying her cases A, B, C, D, E, and F, as described, further divided her cases into classes based on normal or abnormal hormone levels, normal untreated and treated, abnormal treated and untreated, and abnormal treated with response, i.e., correction of chorionic gonadotrophin levels and pregnanediol excretion. All patients received identical care, exclusive of hormone therapy. The comparison of results between the abnormal untreated and the abnormal treated are impressive. For the group with normal, untreated pregnancies there were 96 per cent live births; those with abnormal levels and untreated, 52 per cent live births; those with abnormal levels who were treated had 90 per cent live births. Analysis by class showed little statistical difference in A and B between treated and untreated. Class C, treated, showed 79 per cent live births, untreated 48 per cent. Class D, treated, showed 78 per cent live births, untreated 32 per cent. Class E, treated, revealed 46 per cent live births and untreated 13 per cent live births. The difference between the untreated and treated groups is apparently significant in the Classes C through F.

Others who have evaluated hormone therapy report less impressive results. Palmer, et al,[6] reported on a series of twenty-one pregnancies with 52 per cent survival. These were treated with oral stilbesterol and intramuscular progesterone in smaller doses than used by White. Keltz, et al,[10] followed thirty pregnancies, twenty-seven of which received progesteron intramuscularly and oral stilbesterol, and report a survival of 66.7 per cent. They make a number of interesting observations. In their successful group, there were ten multiparas, seven of whom had had a total of nine previous pregnancies after the onset of diabetes mellitus with only two live births. Three of the ten multiparas had a total of fifteen pregnancies prior to the onset of diabetes with twelve live births. In spite of the overall survival of only 66.7 per cent, the increase in survival rate in multiparas who had already failed to produce a live child is of value and importance. Many other reports appear in the literature that report foetal survival without hormones comparable to White's series. The majority of these deal with patients in the favorable classifications as to duration, age at onset, et cetera.

No investigator to date has attempted to duplicate White's methods of treatment, hormone evaluation, et cetera. Until this is done, one can only accept White's hypothesis. It is obvious that a co-ordinated study by many groups should be undertaken, because very few groups, and no individuals, have the volume of diabetics comparable to the White and Joslin groups. White's work is impressive and she has certainly been the most devoted and persistent student of this problem over the years.

Pregnancy has certain well-known effects on the metabolism of the non-diabetic which are amplified, and are factors to be contended with, in the diabetic. The "renal threshold" for sugar is reduced so that glycosuria occurs at much lower blood sugar levels. This is important, in that, if this is not recognized and control is based on glycosuria without benefit of close supervision of blood sugar, insulin reactions may result from overdose of this drug. It is also important when it is realized that with a lowered threshold the patient may spill large quantities of glucose up to 50-70 per cent of daily intake. When this occurs, ketosis is likely to occur. There is a markedly increased tendency to ketosis in pregnancy under any circumstance and this is magnified, of course, by the diabetic state.

Pregnancy may bring to the surface clinically unrecognized renal disease and it may accelerate pre-existing renal disease. Urinary infections, of course, are more common in pregnancy. All of these should be watched for and evaluated by frequent urinalysis, blood chemistries and physical examination. It is generally agreed that maternal

mortality is low and is not a factor to consider if the diabetic is carefully controlled and watched throughout her pregnancy.

Therapeutic abortion should never be done because of diabetes alone. Therapeutic abortion is justified in the following instances: (1) severe retinitis, (2) diabetic nephritis with constant daily albuminuria, nitrogen retention and/or hypertension, and (3) chronic recurrent urinary infection with diabetic nephritis of any degree.

Management

The management of a successful diabetic pregnancy requires the intimate co-operation of the internist, obstetrician and pediatrician. The internist and obstetrician should work in close association during the course of the pregnancy; the pediatrician assumes a major role at the time of delivery in the special care of the infant.

Upon undertaking the responsibility of the care of a pregnant diabetic, the physician, at the beginning, must do two things. He should discuss the necessary care and added inconveniences over and above the routine adequate day-to-day control of diabetes with the patient and her husband. The increased incidence of fetal loss coincident with diabetic pregnancy should be pointed out, not in an "alarmist" vein, but as a means of better understanding on the part of the patient, the reasons for the added care and "inconveniences" clearly explained. Next, the patient should be evaluated as to duration of diabetes, age at onset, presence of vascular and renal complications and success or failure of previous pregnancies, both prior to and following the onset of diabetes mellitus, along with details of treatment and complications, if any. Needless to say, all the factors and evaluation common in good routine obstetrical care should be checked.

X-ray studies of legs, pelvis, chest and abdomen should be done to determine presence of vascular calcification. Fundoscopy by a competent individual with careful search for evidence of vascular change and retinopathy is essential. Evaluation of the renal function should include routine complete urinalysis, non-protein nitrogen creatinine, phenolsulfon phthalein excretion, concentration-dilution test and total protein-A:G ratio. Further renal studies such as intravenous pyelography and even retrograde pyelography should be done if indicated. Adequacy of diabetic control should be investigated by blood glucose levels, fractional qualitative urine glucose tests and twenty-four-hour quantitative urine glucose determinations. Any remedial condition such as urinary infection or dental infection should be treated immediately.

Diabetic management should be carefully handled. Adequate chemical and clinical control should be maintained at all times. The aim of control should be minimal glycosuria with as close to normal blood sugars compatible with freedom from frequent mild insulin reactions or occasional severe insulin reactions.

Diet should be measured or weighed and adjusted to conform with the needs of both diabetes and pregnancy. Caloric intake should be adjusted to weight requirements. Thirty calories per kilogram of increasing body weight should be used. This figure can be raised or lowered depending on need for weight loss or gain. Weight gain of over twenty pounds if not due to fluid retention should be handled by caloric restriction. Protein levels of two gm. per kilogram of body weight are desirable. Carbohydrate should not be below 150 gm. and not above 250 gm. Fat is used to complete the caloric prescription. Carbohydrate should be enough to allow for 960 gm. of milk per day. Reduction in calories can be accomplished by reduction of fat. Skimmed milk as a substitute for whole milk will reduce the caloric intake by 300 calories.

The fact that the majority of pregnancies are in young adult or juvenile diabetics means that the majority will need insulin. As with juvenile and young adult diabetics in the non-pregnant state, "intermediate" insulins such as N.P.H. or mixtures of protamine zinc insulin and regular insulin are most efficient for control. Most patients can be successfully controlled with one daily dose each morning. Supplemental regular insulin before each meal may be necessary to control excessive postprandial hyperglycemia and glycosuria. As stated before, the physiological lowering of renal threshold may cause increasing excretion of glucose up to 50-100 gm in 24 hours. When glucose utilization falls below 100 gm. in 24 hours, ketosis occurs easily. Thus, in addition to qualitative urine tests two to four times per day, routine twenty-four-hour quantitative urine glucose should be done at least every two weeks, oftener if excessive glycosuria is suspected. The patient should also perform a "spot" test for acetone daily. It is the rule and not the exception that insulin requirements increase during pregnancy, providing nothing interferes with normal dietary intake. Many

patients' insulin requirements drop sharply, even below pregnancy levels, following delivery. This observed fact is difficult to explain. It is postulated that it may be due to sudden decrease in pituitary activity or even to withdrawal of placenta-produced ACTH.

Hormone therapy as a tool in prevention of toxemia and foetal deaths is, as stated above, still a very controversial subject. At the present time the methods for control and the materials recommended by White are of such magnitude of cost that it is not feasible to suggest hormone therapy on a universal basis. Women coming under Classes A and B need no hormones. Those judged to lie in Classes C and D should be further evaluated by the physician charged with their care. Past obstetrical history is a determining factor. Failures to obtain live births in the past, following the onset of diabetes mellitus, should be carefully screened. If no specific cause remediable by usual care is apparent and if it seems that toxemia, hydramnios and late intrauterine death was present, hormone therapy should be considered. This is particularly true if the patient is in Classes C through F. Again the patient and husband should be acquainted with the probabilities of foetal death in late gestation. The increased inconveniences and cost of therapy should be weighed carefully against the desire for a child and the probabilities of foetal loss. If, as in most localities, hormone assays are not available, the schedule advocated by White[9] should be followed, i.e., daily doses of stilbesterol and progesterone intramuscularly, with increasing dosage each month. Increasing dosage in advance of the timetable set up should be based on clinical evaluation. The next higher dose level should be instituted if evidence of toxemia or hydraminos appears.

In view of the high incidence of *in utero* deaths during the last four to six weeks of gestation, the following precautions are of major importance:

1. All patients in Classes C through F should be hospitalized one to two weeks prior to the expected delivery date. In this manner the patient is at partial rest and can be carefully watched from day to day.
2. Timing of delivery date is made on the classification. Class A should be allowed to go to normal term, Classes B and C to thirty-eight weeks, Classes D and E to the thirty-sixth week if there is no toxemia, increasing evidence of renal damage, foetal halo by x-ray, or gross recognizable foetal oversize. Emergency delivery once the foetus is past the date of viability should be done for the following: (1) pre-eclampsia, (2) hydraminos, (3) foetal halo and (4) sudden loss of foetal movement while heart tones stay audible.

Obstetrical judgment will determine the type of delivery. If, at the time selected, the patient's cervix is favorable, induction of labor by rupture of the membranes is attempted. A trial of labor is given. If the progress is not satisfactory, a caesarean section should be done. Prolonged labor is not well tolerated by either the foetus or its diabetic mother. Even the slightest suspicion of dystocia should interdict pelvic delivery. During labor sedation should be kept at the lowest levels possible. Low spinal or local block are the anesthesias of choice.

Diabetic control prior and postoperatively in caesarean sections should be carried out with the patient under six hour emergency management as described by Colwell.[5] Starting just prior to surgery, 1,000 cc. of 10 per cent dextrose in distilled water should be given slowly, intravenously. This prevents any possible maternal hypoglycemia.

Immediate post-natal care of the newborn is of utmost importance. One must realize that even though the infant may appear mature physically it is immature chronologically and may be expected to react as a premature infant. The pediatrician is part of the team that is present at the time of delivery. The infant is passed immediately to him. A number ten soft rubber catheter is used to aspirate the mouth, pharynx and stomach of the infant. All possible sources of material that could be aspirated are removed. The infant is then placed immediately in a heated incubator with oxygen running constantly at 7 liters per minute. Hypoglycemia in the infant is an uncommon occurrence. However, one should be on the alert for the rare cases in which it does occur. The common manifestations of hypoglycemia are restlessness, extreme irritability, marked increase in suckling reflex and high-pitched hunger cry. This may be treated by administration of 50 per cent glucose solution orally with an eye-dropper. Foetal edema when present should be treated by restriction of fluid intake in the first twenty-four to forty-eight hours. All feeding other than repeated small amounts of 50 per cent glucose should be withheld. This will often result in a weight loss of one pound or more

in the first two days. Following this, a 2 per cent milk formula or breast milk may be started. It has been observed that the average diabetic mother cannot breast feed her infant adequately; thus formula feeding is advised.

The high incidence of respiratory difficulty and lethargy which are the result of overweight and edema of all tissue, especially the lungs, necessitates special care. The infant should be kept in an incubator with constant oxygen for five to seven days. Each day the oxygen flow should be decreased and the infant watched carefully for evidence of respiratory distress. If, at the end of five days, the infant is able to get along without oxygen, it is safe to discontinue it. The infant, however, should be watched carefully following cessation of oxygen therapy until discharge. Frequent change in position and mild physical stimulation should be carried out constantly. The infant should be kept in the newborn nursery at least two weeks or until all signs of prematurity are past.

Conclusion

The pregnant diabetic presents new problems for the internist, obstetrician and pediatrician. As physiological treatment of diabetes improves, and as increasing numbers of these patients reach the child-bearing age and are able to conceive, more problems become apparent. Extension of the life expectancy and the increase of the child-bearing potential of the diabetic woman has created problems not before open to observation. They were practically unknown thirty years ago. Today, the pregnant diabetic faces risks of foetal loss obviously far greater than those of her non-diabetic sister. The etiology of this increased foetal loss is not clearly understood. It is certain that it is not due to any single factor. Many things contribute: vascular and renal damage, hormone imbalance, metabolic derangement, and possibly genetic weakness. Much investigation is yet to be done to clarify the etiology of, and subsequently develop corrective therapy for, these deficiencies. An extensive and co-ordinated program carried out by many investigators is essential. Rigid standards and classifications must be set up to properly evaluate the various theories as to etiology and therapy of this problem.

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TELEPHONE SOLICITATION

Among the many telephone calls which doctors receive there is one type, the telephone solicitation for money, which is sometimes difficult to manage. Some of the calls come from legitimate and well-known organizations, and occasion no difficulty because they are well known.

Others originate from unfamiliar sources, and include requests for purchase of advertising space in previously unheard-of newspapers, magazines and bulletins. In campaign years funds are solicited by many political committees other than the official party organizations. In addition there are also many charitable enterprises approaching the doctor with a financial appeal.

The Better Business Bureau advice on this subject is simple and easy to follow. If the solicitee is tempted to donate to a cause with which he is unfamiliar, he should do so only after he has investigated. Information may be obtained from Better Business Bureaus or from the local Chamber of Commerce.—Editorial, *Journal of the Indiana State Medical Association,* August, 1952.

Breast Carcinoma Study: Relation to Thyroid Disease and Diabetes

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[T IS the purpose of this paper to review 306 cases of breast carcinoma entering Butterworth Hospital between January 1, 1939 and January 1, 1949; with special regard to clinical endocrinologic factors.

Although 306 cases entered the hospital, only 274 had any surgical treatment. This treatment ranged from simple biopsy to complete radical mastectomy, with and without x-radiation therapy.

In this institution, the surgery staff consists of members with varying amounts of surgical training. Several different principles of management are represented in that training. These statistics are, therefore, representative of many smaller open-staffed hospitals in this country. The contrast in surgical staffs and operative techniques, together with the results of treatment, makes an interesting comparison with larger university hospitals where surgeons tend to adhere to one technique and one method of handling surgical problems.

Roentgen therapy was used in the majority of cases. The technique and dosage have been uniform. About one half of the patients received treatment from radiologists in private practice.

Histological sections with equivocal microscopic diagnosis have usually been forwarded to the University of Michigan pathology department for confirmatory studies.

Follow-up information was obtained in approximately 80 per cent of the cases. All cases without follow-ups have been considered as non-survivals.

In the statistical analysis we have included only those cases up to 1944, during which time 141 cases were operated on for breast carcinoma. The first five years of the case studies are of no value to clinical survival statistics; therefore, they will be excluded from any computations.

Seventy-one (50 per cent) of the patients survived for five years. Of the remaining cases, twenty-nine had no follow-up and forty-one expired. The causes of death were as follows: nineteen from carcinoma of the breast, seven from unrelated causes, and twelve unknown. There were three surgical deaths, two of which were due to pulmonary emboli. This is a survival rate of 50.3 per cent. All those without follow-ups (20 per cent) were considered as non-survivals.

Of the seventy-one patients who survived five years, twenty-eight (39.4 per cent) had axillary metastasis, and forty-three (60.5 per cent), no axillary metastasis at the time of operation.

It is a well-established fact that between 70 and 75 per cent[3,11] of patients with breast carcinoma and no axillary metastasis survive five years after radical breast operations. Also, it has been established that 20-25 per cent of patients with axillary metastasis survive five years. According to Harrington,[5] four years is the average survival of patients with breast carcinoma who have no treatment at all. Averaging the above survival percentages, it is seen that 45-50 per cent of the total number of patients with and without axillary metastasis, treated by surgical methods, survive five years. This figure coincides with the figure of 50 per cent five year survivals at this hospital. Also, it should be noted that thirty-five (50 per cent) of the seventy-one patients who survived for five years had simple mastectomies. The extent of surgery beyond complete removal of the breast tissue apparently did not affect the survival rate appreciably.

Statistics taken from American Cancer Society data[8] show that the incidence of breast carcinoma among all females is 58.4 per 100,000; and the death rate 24 per 100,000. These figures imply that 50 per cent of all patients with breast cancer are being cured without regard to number of years survival. This may not be the usual method for computing clinical survival statistics but it would seem that a national survey of thousands of cases would be a more accurate means of analysis than computations from isolated series of a few hundred cases.

The average age of onset in this series is 57.4 years and this is in agreement with most authors. Hoopes and McGraw[6] reported 51.2 years as the average.

Finney and Merkel[1] in their report found that 74 per cent of patients with breast carcinoma had passed menopause. In this series of cases, 65 per cent were postmenopausal.

The youngest age of onset of breast carcinoma was reported by Sears[2] as occurring in a ten-year-

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TABLE I. THYROID DISEASE IN FEMALES

Incidence	Age Group	Rate	Per Cent
†Expected	20-64	10.9-14.2/1000	1.09-1.42
with Breast Cancer	18-75	120/1000	12

†Data from Metropolitan Life Insurance Co.

TABLE II. DIABETES IN FEMALES

Incidence	Age Group	Rate	Per Cent
*Exepected	15-84	6.77/1000	.67
with Breast Cancer	18-75	49.1/1000	4.9

*Courtesy of American Cancer Society.

old girl. Peck[7] gives credit to Blodgett who reported a case in 1897 occurring in a girl twelve years old. In this series, there were three patients under twenty years of age, which fact is remarkable in that only eighteen cases of breast carcinoma in females under twenty years of age had appeared in the literature up to 1943.[2]

Endocrinologic Study

Special attention was directed to recording incidence of endocrinologic disorders. It soon became apparent that an unusually large number of cases had associated thyroid disease, and possibly diabetes mellitus. To prove this, figures from the Metropolitan Life Insurance Statistics Division in New York City[9] were obtained.

The incidence of thyroid disease for both men and women of all ages is .62 per 1,000. For women between the ages of 20 and 64 years of age (Table I) the incidence varies between 10.9 per 1,000 and 14.2 per 1,000. Thus, the incidence of thyroid disease in the same age group as this breast carcinoma series averages twelve per 1,000 females (1.2 per cent). Thirty-six of the 305 females with breast carcinoma had, or had had, thyroid disease at the time of their admission to the hospital. This is an incidence of 118 per 1000 or approximately 12 per cent and is ten times the expected incidence. Although the Metropolitan Life Insurance group considers all thyroid disease in their statistics, we have included only those cases where a history of thyroidectomy was obtained or where a goiter was present on physical examination. Moreover, many of the cases had incomplete histories, and it is not unreasonable to assume that even more cases of thyroid disease were present. Geschickter[4] in 1948 recommended that a history of whether or not thyroid disease is present be included in each breast tumor workup. He did not give any further information as to incidence or the significance of this finding in relation to breast cancer.

In regard to diabetes mellitus (Table II), Spiegelman and Marks[10] found the incidence to be 4.52 cases per 1000 (.45 per cent). In females between the ages of fifteen and eighty-four years, it was 6.77 per 1000 (.67 per cent). In this series of cases, there were fifteen persons with known diabetes mellitus, which constitutes an incidence of 49.1 per 1000 (4.9 per cent) or eight times that which normally occurs.

In addition to the above findings, other evidence suggestive of hormonal imbalance was found. Fifty-seven (25 per cent) of 306 females had or had had pelvic operations. This figure includes hysterectomies for fibroids, carcinoma, and endometriosis; several oophorectomies for carcinoma and endometriosis; several Cesarean sections and a few dilatations and currettages for abnormal bleeding. Sixteen patients had menorrhagia; twenty-seven had metrorrhagia; and six had oligomenorrhea or amenorrhea. The incidence of sterility was 10 per cent.

Waggoner[12] reported a study of breast carcinoma in the premenopausal female in 1948, in which he called attention to the numerous deviations from hormonal balance in the group of patients he analyzed. The above findings, including the increased incidence of diabetes and thyroid disease are only an enlargement of his theory.

Conclusions

1. Although this hospital is smaller than most university hospitals, and has a surgical staff with varying amounts of training and with varying attitudes toward the treatment of breast carcinoma, the clinical survival statistics are comparable with the larger teaching-center hospitals.

2. One half of the patients who survived five years following surgery for breast carcinoma had simple mastectomies.

3. The incidence of thyroid disease is ten times and the incidence of diabetes mellitus eight times as great in women with breast carcinoma than in women of comparable ages in the general population.

4. A general hormonal imbalance accompanies breast carcinoma.

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(Continued on Page 1335)

The Family Doctor and Diabetes

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IF THE diabetic is to be uncovered early, there is only one who can do it. He is the family doctor. Most cases picked up early are easy problems, both for the patient and the physician. Any capable G.P. can instruct and handle most diabetics. The unruly and brittle can't be controlled well by anyone. Our specialist friends should be allowed the chance to help them.

Complicated diabetics usually first approach their own doctors when trouble assails them. We are the first to see infections, vascular complications, acidosis, and hypoglycemic coma. Treated early, all these are much more amenable to therapy. A few hundred units of insulin early in coma make a tremendous difference, as Dr. Joslin brings out so well. Dr. Frank Allen of Lahey Clinic, who was with me in Toronto in 1922 when insulin was introduced, spoke at Women's Hospital here a few years ago and stated flatly that most diabetics should be cared for by G.P.s.

Personally, I treat all my cases and find it no harder than most, and a lot easier than many diseases to care for. Great pains to explain the disease and its care very minutely to the patient pays dividends. Everyone can, with the clinitablets, test for sugar and acidosis, so there is no excuse except carelessness for so many bad results. Patients should be taught that meticulous care pays off in better health and longer life with fewer complications.

I almost never see a coma or severe insulin shock except in emergency calls on patients of other doctors or clinics. Constant hammering at the importance of control and repeated warnings of possible blindness, loss of limb or even life, causes most to mind their P's and Q's.

I would like to suggest a few reasons why the family doctor may be able to handle diabetics even better than the specialist.

Firstly, the neighborhood doctor not only knows the patient, but also the family, in-laws, siblings, wife, parents, grandparents, neighbors, local merchants, et cetera. If the patient steps out of line the doctor hears of it from one of these sources promptly and is able to sit down and talk it over with them and find out the difficulty and re-explain the dangers they are courting.

Secondly, in being a friend most patients regard their doctor similarly so he can explain that he would feel badly if they should break treatment, pointing out that they hurt not only themselves but their wife and children, and also let their doctor down, casting a reflection on his professional ability. This deters most conscientious people.

Thirdly, almost everyone admits that anxiety states and nerve tensions aggravate the disease. A specialist might not hear of friction at home as people often try to hide these things. Local contacts are informative regarding such matters and it is possible for the doctor to institute corrective measures early.

Lastly, I find that even though focal infection is generally conceded to be a factor in aggravating the disease, and most men correct dental and tonsillar infections, genital focal infections are ignored, i.e., chronic prostatitis and endocervicitis. In my practice we always check and correct these and have had many diabetics improve remarkably after eradicating the infection.

Many internists think that the G.P., by and large, should not treat diabetes, but most leaders, as quoted above, and others, such as Dr. Wilder, Dr. Palmer, and Dr. Barnes, who recently spoke at our Mt. Carmel Mercy clinics, and also our own Dr. Frank Scott Perkin, assure me differently.

When Dr. Allen addressed the G.P.s he spoke so kindly that in discussing his paper I stated that it was a great pleasure to have him, and pointed out that we appreciated the fact that he didn't talk down to the G.P., and further complimented him because he didn't throw out a smoke screen of words to cloud the issue and befog the already burdened minds of the G.P.s. Many men seem to delight in trying to make simple things seem complicated. I have noticed that they are always the lesser lights in medicine. The nationwide leaders always get their message across clearly and succinctly, and with a sincere desire to help the patient. Others often seem to me to try to frighten both the doctors and the patients by making the case seem horribly complex, thereby inducing them to go only to specialists. In my opinion this impedes the progress of the control of diabetes immeasurably and increases the

cost of medical care. Haranguing over a few units of insulin or a few calories doesn't fool even the patient. They soon learn there is a wide safety factor and we end up like the boy who cried "wolf" once too often.

Poppycock of the most inane type still appears in our medical journals. Within the year I read a very exhaustive article by a professor at a medical school printed in a journal read almost 100 per cent by G.P.s which stated that in order to distinguish between hypoglycemic and acidotic coma a blood glucose must be done. This is ridiculous. I have been called three different times to an old diabetic in coma. He goes to a hospital clinic as an outpatient. The family always thinks Granddaddy has had a stroke. He is crowding eighty and has taken insulin for many years. His spells usually occur Sunday morning after extra activity on Saturday, with no reduction in his protamine zinc insulin. He is invariably in deep coma of more than an hour's duration. To wait for blood studies might finish him. I give glucose, 50 per cent, I.V. and he always wakes up in minutes. Glucose can't hurt him even if he is in diabetic coma. I have heard specialists harangue at great length on how to differentiate them but this seems so simple. Furthermore, we have always been gravely warned of the dire fate in store for these hypoglycemic victims, i.e., cerebral and coronary thrombosis, serious brain damage, et cetera. I'm sure that chronic hypoglycemia may directly or indirectly, by cerebral anoxia associated with the drop in blood pressure and resulting poor brain circulation, cause irreparable brain damage; but the case cited above has convinced me that in spite of age, advanced arteriosclerosis, et cetera, there is not necessarily any grave risk if these cases are not allowed to languish while the laboratory make the diagnosis, and that can be quite a wait in many communities on a Sunday or a holiday, especially if the doctor is called to the outlying districts.

I'm sure that many of my G.P. friends take better care of their diabetics than many men who limit their practice. Everyone should be evaluated on his own merit. One can only use the brain that God gave him and honestly try to practice good medicine for the greater good of the patient. Some may think that medical papers shouldn't preach sermons. I don't, and think we are often too scientific, to the adverse interest of the patient. Many forget that Medicine is an art, not an exact science. I shall cite one case to show that some specialists may be so short sighted that they miss the ramifications even when it is in their own field.

Mr. George McL., age 54, a bachelor of Scottish Canadian origin, employed for years in a responsible position requiring good vision, was referred to me shortly after I returned from Service, with this history—While I was in the army he noticed failing vision so he consulted a well known oculist who told him his fundi showed a diabetic-like retinitis, but because there was no sugar in the urine, he assured him this was not the cause and sent him on his way. When his vision regressed further he consulted another oculist equally well known who told him the same thing, after also taking a fasting blood sugar. After more years, and losing his good job because of loss of vision, and having to accept a position as watchman, Mr. McL. finally consulted another oculist who repeated the performance, but added these magic words, "go and see your family doctor." A short study revealed by a glucose tolerance curve that he was diabetic. Diet plus rutin, without insulin, stopped the progress but we couldn't push the water back over the dam. I asked if there had been any history taken and was told none had been. It would have revealed that his mother was diabetic and had lost a leg in pre-insulin days.

As I talked to Mr. McL. one day in the office, he pointed to the picture of the beloved Family Doctor that hangs on the office wall, and asked me if I knew who the doctor was. I promptly replied that he was Queen Victoria's personal physician, et cetera, but he wanted to know if I knew his name. I did not, so he told me it was Sir James Clark, his great-great-et cetera uncle. I remembered that Osler had lauded him for his care of the dying Keats in Italy, in a paper given in his early days at Hopkins. I was spell-bound by Mr. McL.'s story and I seemed to hear a whirling sound. Was it his great-great-uncle turning over in his grave?

Fracture of the Maxilla

By Claire L. Straith, M.D., and
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Detroit, Michigan

IN THIS mechanical age, auto injuries cause a great percentage of our fractured maxillae and for this reason we will deal primarily with injuries of this type.

In a personal record of fifty consecutive cases coming for various facial injuries following automobile accidents, we found that only eight of these persons were drivers, eight victims in the back seat and thirty-four of the patients were riding in the front seat beside the driver, most of them women. It is a well known fact that most fatalities occur in the guest passenger seat and therefore we have rightly termed it, I believe, the "death seat."

There are, in general, three types of injuries sustained by persons riding in this position. (Fig. 1.)

1. When the patient is thrown forward the head hits the wind-shield glass and often a wide hole is made in this glass and the face comes down on the jagged edge, receiving numerous and jagged cuts of the facial skin, as well as occasionally fractures of the nose, malar or maxillary bones.

2. Type two is even more disastrous to the maxilla because in this type the head strikes the windshield first and then the face is thrown forward on the top of the dash where often are located numerous gadgets, knobs, or at least a metal covering which is accountable for many crushing injuries of the face.

3. The third type is designated as that type where a patient's face is thrown directly into the dash and this is often accountable for many injuries, especially to women. Many babies are killed while riding on the mother's knee by their head being thrown forcibly into the dash at the time of accidents or sudden stops.

Occasionally, we do have another type causing severe maxillary fractures which is termed the "steering post" injury. Usually, the wheel protects the driver but occasionally the head of the victim driving the car is thrown downward and forward and the chin, teeth or face strikes the steering post or rim of the wheel with such force that fractures result.



Fig. 1. There are three types of guest passenger injuries. As per the diagram: Type 1.—The victim is thrown into the windshield and receives multiple facial cuts. This type is by far the most frequent.

Type 2.—The windshield is hit first, then the face comes down on the dash with crushing force.

Type 3.—Children and short people are frequently thrown directly into the dash. The last two cause most of the crushing facial fractures.

One cannot consider factures of the maxilla without including the malar bone fractures. The malar bone, being more prominent than the maxilla, is often the first site of impact and therefore frequently injured. The examination of facial bones is a very important feature. Swelling occurs so rapidly after such an injury that unless early, careful examination is made, fractures of the malar and often of the maxilla are missed and a resultant deformity causes a rather embarrssing situation. (Fig. 2.)

As early as possible following injury, one should make a careful examination by passing the index finger of each hand simultaneously around the orbit. Beginning at the root of the nose with rather heavy, deep pressure, in spite of the pain, the fingers are passed laterally, noting especially the attachments of the malar bone to the frontal. Oftentimes a definite tenderness is elicited at this point or in fact a depression or crepitus when there is a fracture of the malar with considerable separation from the frontal. As the finger is passed around the rim of the orbit the most likely place for a fracture is at the infraorbital foramina directly under the orbit on one or both sides and on deep pressure the affected side will show that the finger is much more depressed than the one following the rim of the orbit on an unaffected side. Emphysema is sometimes found in tissue over the antrum. The fingers are then passed up toward the nose and sometimes fractures of the entire maxilla with a falling away of the middle third of the face can be elicited on the lateral walls of the nose. The nose is then examined manually. The first two fingers of the left hand hold the upper nose firmly and with the other two fingers

From the Straith Clinic for Plastic and Reconstructive Surgery.



Fig. 2. Malar bone injuries are common in Type two and three injuries. They should be diagnosed and operated early for best results. Note crushed right malar and result after intra-oral elevation.



Fig. 3. Depressions of the zygomatic arch can be elevated through the same intra-oral incision, as illustrated here.



Fig. 4. Under local pentathol or other anaesthesia, a small incision is made above the last molar tooth and a curved elevator inserted through the mouth. The malar can usually be forced upward and into position quite easily by this means.

of the other hand lateral motions are made to elicit fractures of the nasal bone.

The zygomatic arch is palpated by extending the fingers backward from the malar bone along the arch. Depressions or irregularities of the bone can often be felt without much difficulty. (Fig. 3.) The maxillary fractures are often missed entirely simply by the fact that people do not look into the mouth carefully and feel the upper arch.

If the lips are retracted one can often notice the downward dropping of the entire maxilla in case of severe fractures. Then the finger inside the mouth is passed along the anterior edge of the maxillary wall and on the affected side, or both sides. Definite sharp protrusions of the thin egg-shell wall of the antrum can often be felt. Sometimes the depressed malar can be moved by finger pressure. If the teeth are grasped the entire maxilla can often be pushed upward or pulled downward and laterally in cases of severe fracture. Midline fractures of the maxilla, of course, are easily detected. One rather characteristic thing in fractures of the maxilla is that the entire middle third of the face is unduly elongated in comparison with the rest of the face.

X-rays, of course, should be taken if the patient's condition permits but they should be done cautiously without too much movement of the head due to the possibility of brain injury or skull fracture.

In the malar bone fracture, there are several very common symptoms, the first being anesthesia of the upper lip and side of the nose on the affected side. If the malar is badly dropped in position, the orbit follows and there is usually a double vision and together with this posterior position of the depressed malar, we find that the coronoid process on opening the mouth impinges on the rear surface of the malar; therefore the patient encounters difficulty in opening the mouth completely.

The treatment of, first, the malar bone fracture should be instituted early if possible, for the longer the treatment is delayed, the more difficult it is to elevate a depressed malar bone into proper position. Several methods are applicable, of which one might mention the Gillies method. This consisting of introducing an elevator from the tempo



Fig. 5. Result of unreduced malar fracture leaving heek depressed and eye (artificial) dropped down. Preerved cartilage was introduced into the orbital floor and nder skin over cheek bone to correct the deformity.



Fig. 6. Open bite malocclusion produced by an impacted maxillary fracture. Elastic traction anteriorly should be applied early between upper and lower teeth.

egion down underneath the zygomatic arch and nalar bone, and with a bandage as a fulcrum gainst the skull, the zygomatic arch and malar one is forced outward and forward.

An old method seldom used consists in using a irge towel clip anteriorly which is passed through ie skin, grasping the entire malar bone and forcig it outward. Some prefer to enter the antrum irough the inferior meatus and elevate the deressed malar with an antral trocar. Some insert small rubber balloon in the antrum and inflate to maintain elevation of the orbital floor.

In our Clinic, we have for years preferred the itra-oral method of elevating the malar bone. Fig. 4.) This can be done quickly with little or o danger of infection and very little subsequent action. In the intra-oral method, one simply eans the inside of the oral cavity inside the lip id under the malar bone and applies iodine or me other antiseptic. Under local anesthesia, penthol or general anesthesia, a quarter inch incion is made above the last molar tooth and behind e lower attachment of the malar bone. A curved emostat, scissors, or other instrument is introiced into this opening and by forcefully lifting the malar bone, it usually snaps back into sition with very little difficulty. Extra pressure made from the outside toward the mid line to use some impaction of the fragments on the sal side to hold the bone in position. The ound is left open for drainage and antibiotics e administered following the operation.

When the malar bone is very badly commited it may require more radical treatment, and this event, a one inch incision is made in the outer angle of the orbit or just above the eyebrow, the edges of the frontal process are isolated and the malar bone is held in a forceps while a small hole is drilled in the end of each fragment. A steel or silver wire is passed through these openings and the malar bone pulled up in position by tightening the wire. The wound is then closed with subcuticular sutures and very little scar will result from the operation.

Delay, on the other hand, results in a lowered orbital floor with an eyeball dropped considerably and often causing double vision and considerable deformity. This can subsequently be corrected by insertion of cartilage implants under the eyeball or artificial eye and around over the malar prominence to restore it to normalcy. (Fig. 5.)

Maxillary fractures *per se* are of several varieties, unilateral, transverse, comminuted, et cetera. The driver whose face hits the steering post or the passenger whose face contacts the dash, often receives impacted transverse maxillary fractures resulting in an open bite malocclusion, namely, the closure of the molar teeth with the incisors wide apart. Early treatment of this condition should consist of manual movement of the maxilla to dislodge the impaction and application of wires to the upper and lower teeth. Elastic traction in the proper direction between the upper and lower jaw can be introduced and will usually cause a correction of the deformity within forty-eight hours. (Fig. 6.)

Unilateral maxillary fractures are more rare and can be treated by forcing the depressed fragment up into position, then wiring the teeth in the unaffected maxilla to the mandibular teeth. The

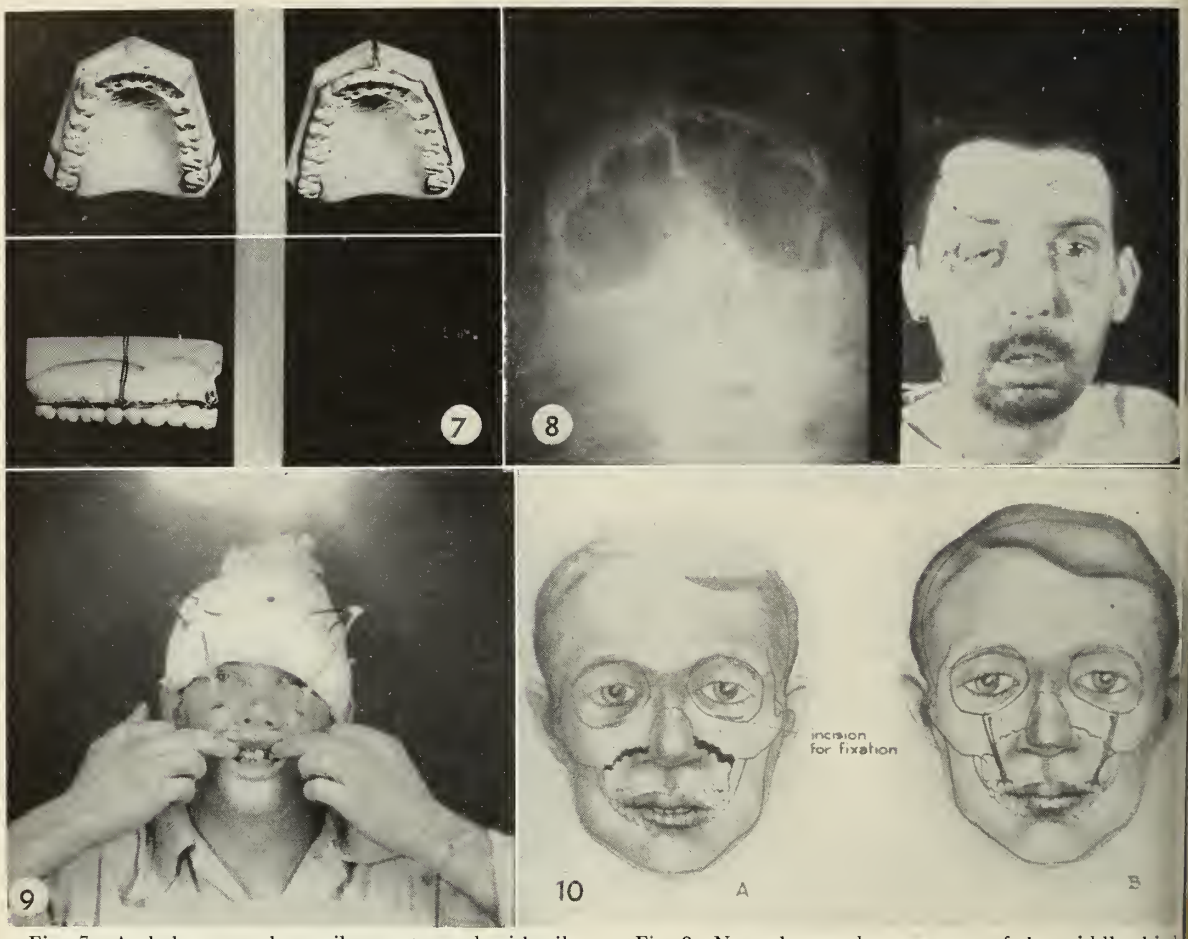


Fig. 7. Arch bars can be easily constructed with silver, steel, or bronze wire, twisted first around the last molar, then brought around the arch and twisted anteriorly. The arch wire should then be wired to several teeth. (Risdon method wiring.)

Fig. 9. Typical plaster head cap with coat hanger wire attachments. Suspension wires pass through the cheek to the maxillary arch wire (Feiderspiel method).

Fig. 8. Note elongated appearance of the middle third of the face. X-ray shows badly separated and depressed malar and maxillary fracture, nose, et cetera.

Fig. 10. In some cases, stainless steel wires can be passed from drill holes in solid bones under the soft tissue to support the maxilla. (Adams method).

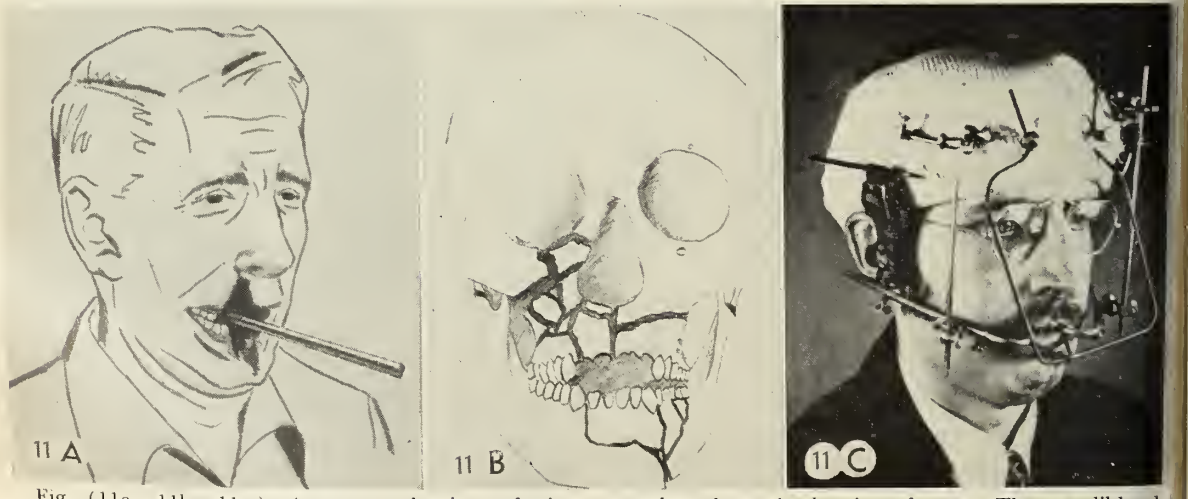
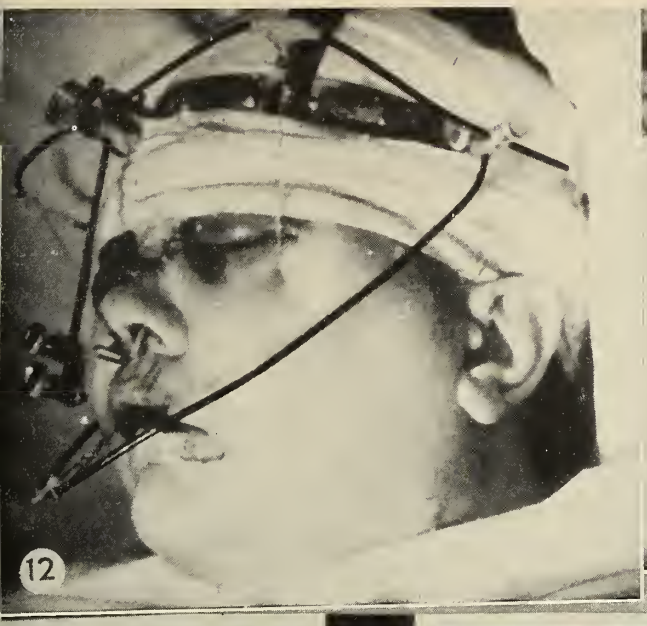
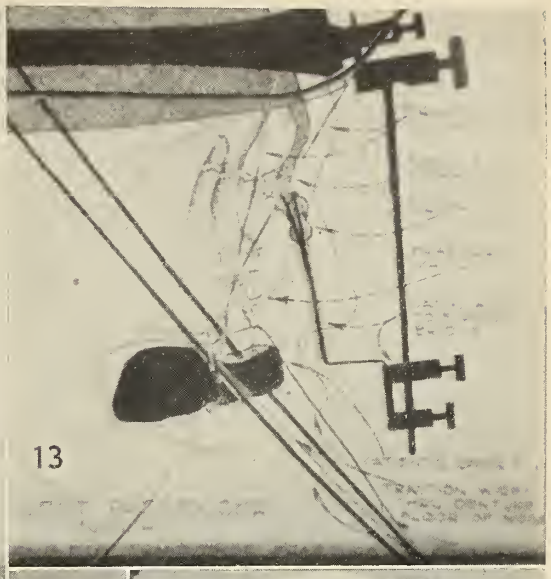
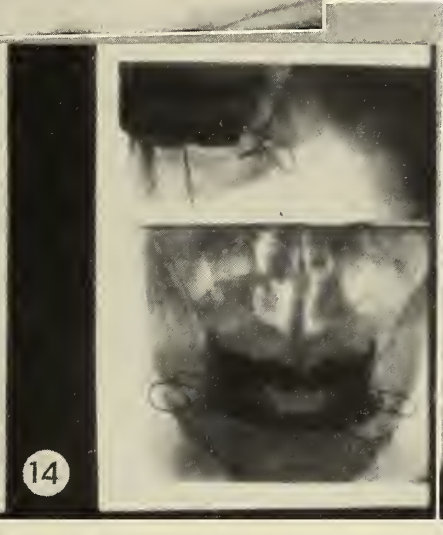


Fig. (11a., 11b., 11c.) A goose-neck piece of pipe was blown into this patient's face, lodging in the antrum and floor of the nose. The maxilla was badly comminuted as shown in drawing of x-ray. The mandible also had several fractures.









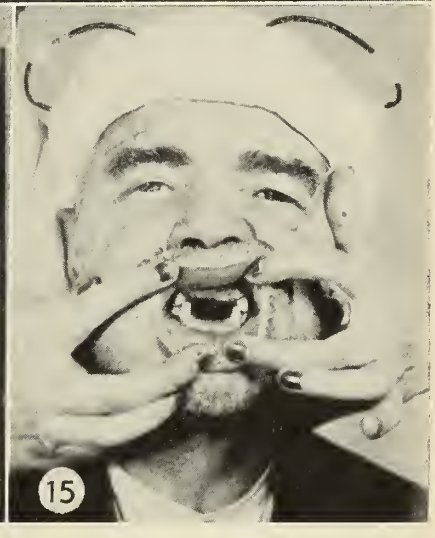


Fig. 12. The maxilla here was "suspended in space" y rigid bars fixed to head cap attachment until con- olidation took place (see Fig. 11). Note also elastic action to anterior bow to produce anterior positioning entire maxilla.

Fig. 13. Drawing from x-ray-edentulous fracture of axilla supported by Feiderspiel wiring to upper plate hich acts as sling. Anterior traction supplied by silver ire passed through floor of nose, palate and upper plate id out under upper lip. Elastic traction from silver wire coat-hanger arch wire. Note also wired nasal fracture id special support for crushed nose.

Fig. 14. X-rays of lower edentulous bilateral jaw frac- re show chin fragment pulled down at right angle. The wer plate was wired to the mandible and the upper d lower plates wired together and both suspended by iderspiel wires to head cap.

Fig. 15. Anterior teeth on plate were removed to fa- itate feeding (See Fig. 14). Both jaws suspended wires to head cap.



Fig. 16. Prevention of these crushing facial injuries as illustrated by the baby, is a compelling problem. Many children are killed annually by being thrown against the dash. The authors believe a crash-padded dash would prevent many deaths and serious injuries.

lower teeth act as a splint to hold the fractured maxilla up into position. An arch bar around the upper teeth wired into position often aids in maintaining proper position of the teeth. (Fig. 7.)

The Adams method can also be used.

Complete transverse maxillary fractures with a dropping of the entire fragments may almost be diagnosed by the elongated appearance of the middle third of the face. (Fig. 8.) A simple closure of the mouth and watching the compression action of the upper jaw will further make the diagnosis certain and this can be verified by simply grasping the upper arch and moving the maxilla en masse with the fingers.

The treatment consists in elevating this depressed maxilla to its proper position and maintaining this position until healing takes place—which is usually rather rapid. Under the Feiderspiel method, a head cast can be applied incorporating coat hanger wires or other attachments which protrude two to three inches over the corner of the orbit or malar region. (Fig. 9.) From a maxillary arch bar which has been wired to the teeth or from wires around teeth in the cuspid region, steel or bronze wires are threaded on a long abdominal needle and these traction wires passed up through the cheek. The wires are then shortened and fixed to the "horns" in the head cast or held up with elastic traction until the lower arch just comes up into what appears to be normal occlusion. This position should be maintained for three to four weeks.

To eliminate external appliances, incision can be made below the infraorbital rim, holes drilled in the rim and a steel wire passed through this opening and then down underneath the cheek into the mouth. The wire is then attached to the arch bar around the upper teeth and the upward traction on the upper arch is maintained by twisting these stainless steel wires until the upper jaw is held in the proper position of occlusion with the lower teeth as suggested by Adams. (Fig. 10.) Further traction on the posterior portions of the maxilla can be had by passing another wire from the molar region up behind the malar bone and fastening it to a small opening drilled in the end of the frontal prominence above the eyebrow.

Complicated crushing maxillary fractures may require much more attention. (Fig. 11A, 11B, 11C.) When the anterior antral walls are badly crushed and the maxilla displaced posteriorly, one can apply a cast metal splint cemented to the upper teeth and, by means of side-arms, the jaw can be suspended in place by rigid bars fastened to attachments on the head-cap. (Fig. 12.) Oftentimes the badly crushed maxilla has been forced backward well out of position and must be pulled forward. This can be done by elastic traction on the splint when the cast splint has been cemented to the upper teeth. Another arch bar is fastened to the head gear, passed around in front of the mouth and the elastic traction attached to the cast upper jaw splint.

Edentulous patients present further difficulties. The patient's old plate can be utilized as a sling. (Fig. 13.) Holes may be drilled in the rim of this plate and the jaw and plate suspended by wires by either the Feiderspiel or Adams method mentioned above. If anterior traction is necessary, a drill hole is made in the nasal floor behind the alveolar arch and also through the plate opposite this opening. (Fig. 13.) A silver wire is then passed through the plate through the maxilla and out into the nasal cavity, the upper end of the wire is re-introduced through the nose down under the lip and brought out above the maxilla into the mouth. Elastic forward traction can then be made on the entire plate, maxilla and all, and the crushed maxilla pulled forward and downward into proper position and maintained thus by constant elastic traction.

Combined fractures of the edentulous upper and lower jaws present even more difficult problems and can be treated by wiring the lower plate to the mandible by circummandibular wiring. (Fig. 14.) Then the upper and lower plates are wired together and the entire mass suspended by Federspiel wiring to the head cap. Anterior teeth on the plates are removed to facilitate feeding. (Fig. 15.) If necessary, traction wires can be again applied to mandible or maxilla to produce anterior positioning.

Prevention of such fractures is also a most important feature. Since most maxillary fractures occur as guest passenger injuries, the author has long advocated the removal of gadgets, cranks, et cetera, from the dash of automobiles and applying a sponge rubber crash pad as a permanent fixture or as an accessory. (Fig.16.) I firmly believe that this would eliminate a large portion of the crushing maxillary fractures and deaths which occur to those riding in the "death seat" of automobiles.

1713 David Whitney Bldg.

Abscesses of the Liver and Right Subdiaphragmatic Region

By Shattuck W. Hartwell, M.D., F.A.C.S.
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FEW SURGEONS or physicians see enough cases either of subdiaphragmatic or of liver bscesses to become familiar with the problems rel- tive to their diagnosis or their treatment. The ollowing cases, referred to the author for con- ultation and surgical treatment, are offered as xamples of the varied symptom complexes found n these disorders. They are also illustrative of he necessity for individualization in the clinical ssessment of such cases.

It is not the writer's purpose to review the istorical phases of the subject or to cover all the ossibilities in diagnosis, differential diagnosis, or eatment. A fairly comprehensive review of the ıore recent, pertinent literature on the subject, owever, brings to light some lesser-known facts ıd concepts which bear brief repetition and hich the following case reports emphasize.

Liver abscesses are of two main types: (1) nebic; and (2) septic or pyogenic. The most mpetent authorities estimate that from 5 to 10 r cent of the population of the United States, gardless of place of residence, harbor endameba stolytica in their bodies. Dysentery, or actively mptomatic amebiasis, occurs only in a small per- ntage of those infested. The occurrence of ogenic liver abscess is even less frequent than amebic abscess. Amebic abscess may follow patic trauma in an infected person. It is rare women. Either type of liver abscess, amebic or ogenic, may be acute or chronic. In the past, ortality from any type of liver, or of sub- ıphragmatic, abscess has been high. A primary er abscess may become also a sub- ıphragmatic abscess—and vice versa. Likewise, subdiaphragmatic abscess may perforate the ıphragm into the pleural space to produce a ondary empyema, or it may further perforate ough the lung to establish drainage through the cheo-bronchial tree. And the opposite can take ce; a lung or pleural abscess can perforate the phragm and create a secondary subdiaphrag- tic or even a liver abscess by direct extension. Loculation, or daughter abscesses, occur; distant, metastatic abscesses occur. Multiple pyogenic liver abscesses appear to be invariably fatal.

Amebic abscesses may occur without any preceding diarrhea. Recently a higher index of suspicion of amebiasis has led to earlier diagnosis. A better understanding of the clinical problem presented by amebic abscess has led to closed drainage plus emetine therapy with a very marked improvement in results in these cases. The primary surgical requirement in amebic cases is to avoid introducing secondary infection into amebic abscesses. Emetine, 1 gr. daily hypodermically, plays the major role in curing amebic abscesses and may be all that is required.

Because of the toxicity of emetine, there exists in the minds of most doctors a great reluctance to use it. Textbook doses are minimal instead of therapeutic. It should be acknowledged both by clinician and surgeon that any patient with an amebic liver abscess is already critically ill. Berne[2] says that because of the clinician's fear of emetine "many patients with amebic abscess of the liver have retained possession of excellent hearts but have died of insufficiently treated amebic abscesses . . . Amebic abscess is a special type of liver necrosis, as is a gumma, and emetine is approximately as much a specific as is neoarsphenamine." Open surgical intervention is contra-indicated; adequate emetine will cure the condition.

Contrary to most older teachings, the so-called "anchovy" or "prune juice" type of abscess content is not always present. In one third of one large series the abscess content was whitish, glary, puriform, some with very foul odor, some with no odor, but all were negative for pyogenic organisms upon both aerobic and anaerobic culture. Harrington[5] and others have pointed out that it may be necessary to curette the abscess wall to find the amebae—if open surgery becomes necessary or has been undertaken.

Berne,[2] reporting Los Angeles County Hospital cases of amebic abscess, states that previous to 1932 mortality was 85 per cent with many cases properly diagnosed only at autopsy. Of seventy-four cases of amebic liver abscess diagnosed in the next ten years, only thirty patients recalled any episode of diarrhea and six complained of constipation. The stools usually (forty out of fifty-five cases examined) contained cysts, trophozoites, or both. Fifty-eight per cent of cases presented an acute, severe process involving the right upper abdomen



Fig. 1.—Case 1. Roentgenogram of chest taken July 21, 1946, showing pleural fluid on the right.



Fig. 2.—Case 1. Roentgenogram of chest taken September 23, 1946, showing marked improvement (following use of emetine only).

after general systemic symptoms. Thirty-three per cent presented pulmonary symptoms primarily. "Four syndromes are seen: an acute costal margin syndrome, a chronic costal margin syndrome, an acute pulmonary syndrome, and a chronic pulmonary syndrome." Hepatomegaly is a constant feature. The most characteristic change with subphrenic involvement is elevation and immobilization of the diaphragm in the anterior and medial portion of the lower right chest. (DeBakey[12] considers this pathognomonic of amebic liver abscess with subphrenic involvement.) Night sweats are frequent in the chronic cases. Jaundice may occur.

Treatment

Berne[2] writes that of nineteen cases of amebic liver abscess treated by emetine alone and in eighteen more cases treated with emetine plus aspiration there were no deaths. In twenty-six cases treated surgically there were fourteen cases which received an adequate dosage of emetine; the mortality in these twenty-six cases was 53 per cent. "Surgery is usually necessary in four situations: for safety in exposing left lobe abscess, for . . . rupture (of an abscess), for pyogenic complications in the pleural cavity, and for drainage of amebic abscess complicated by bacterial infection." Ten of the seventy-four cases Berne reports were diagnosed at autopsy.

From the Mayo Clinic, P. W. Brown and C. H Hodgson[3] have written of amebic abscesses:

> "We have never seen any disease that is so definitely improved by treatment within thirty-six to forty-eigh hours as amebiasis after emetine is administered; thi improvement is apparent to both patient and physician."

If a draining sinus exists, even if as large as . fist, and if amebae can be demonstrated in its walls the administration of emetine may produce com plete healing with amazing rapidity. Leukocytos is moderate in amebic abscess; and contrary t general belief eosinophilia is not usually presen Often the neutrophiles are not increased in pe centage.

The following cases illustrate many of th clinical problems of diagnosis:

Case 1.—Mr. B. F., a white person aged thirty-thre was a veteran with military service in the South Paci and a history of malaria and amebiasis in the Servic On July 12, 1946, after having severe malaise and swea for four days he was hospitalized elsewhere and treat for malaria without relief or improvement. He w admitted to Hackley Hospital, July 20, 1946, with chil fever, malaise, and pain in the right lower quadrant the abdomen and in the legs.

There was dullness to percussion and absent breath ounds over the right lower lobe. Urinalysis was negative xcept for rare granular easts. Complete blood count vas negative exeept for 36.5 thousand leukocytes showing 7 per eent polymorphonuelear eells: sixty-three seg- ıented forms, twenty stab-forms, and four eosinophiles. 3lood smears were negative for malaria. Stools were egative for amebae. Chest x-ray showed fluid to the evel of the third rib eartilage with possible elevation of he right diaphragm.

Roentgenograms of the lungs, July 23, showed an inter- obular colleetion of fluid on the right. Thoracentesis vas done July 25. Straw-colored, cloudy serum was ound. Gram stains of smears of this fluid showed Gram- egative bacilli, microcoeei, and short-chain Gram-positive ocei; no acid-fast baeilli were found.

The patient's temperature was 103°F. on the day f admission. It was normal three days later. Treatment vas by Atabrine gr. iii intramuscularly on the first day, nd penieillin thereafter. He was discharged as an im- roved ease of pneumonia on July 29, 1946.

On July 31, 1946, the writer first saw the patient. Ie had a severe chill and his temperature went from 5°F. to 103°F. He had a profuse sweat. He was very oxic and had severe pain in the right lower chest and mbar area posteriorly. On August 1, 1946, he was admitted to the hospital for probable interlobar ıscess and empyema.

His admission temperature was normal. His highest mperature in a twelve-day stay was 100.3°F. Chest ray showed some clearing of the interlobar shadow, t fluid was persistent to the level of the third rib rtilage.

On August 5, 1946, four preoperative thoraeenteses odueed only cloudy serum from a thin inter-pleural er. The pleural fluid was therefore considered to be ondary to a right subdiaphragmatic lesion. In view the history of amebic dysentery while serving in the ıth Paeifie, and with negative laboratory reports for tubercle bacillus in the chest fluid, a trial of emetine rapy was undertaken in plaee of surgical drainage. e patient had his first injection of 1/10 gr. emetine- lrochloride August 7, 1946, and on the next day he and looked like a new man. The emetine was tinued, 1 gr. daily, and five days later the patient diseharged from the hospital, well.

'ollow-up chest x-ray showed marked elearing of the eity and marked reduetion in elevation of the right ɔhragm. He has been elinically well since.

Case 1, a case of amebic liver abscess, is illus- ive of the "acute pulmonary syndrome" and of remarkable curative effect of emetine.

ase 2.—Mrs. M. F., a white person aged seventy-one, had a gastro-enterostomy for pyloric obstruetion in 1). She was readmitted to Hackley Hospital on ıary 20, 1947, acutely ill with severe upper ab- inal pain, vomiting, cold sweats, and fibrillating t. She had had a similar attack a few weeks iously at which time her blood pressure had been

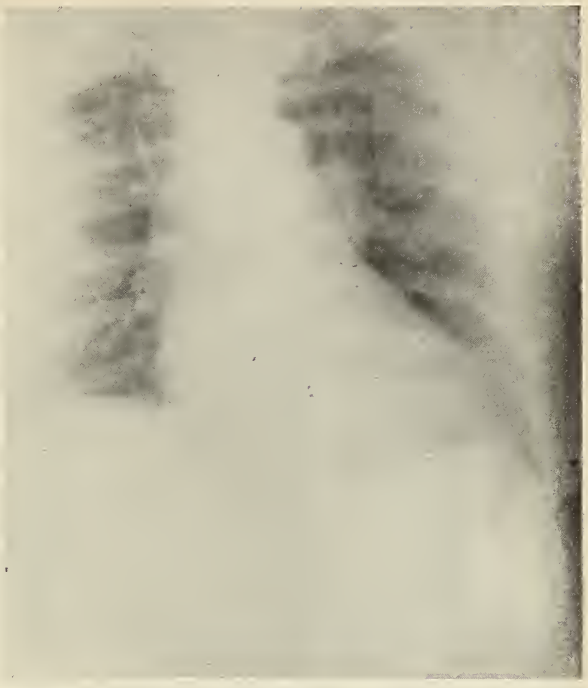


Fig. 3.—Case 2. Roentgenogram of ehest showing absence of elevation of right diaphragm.

272/110 and her heart rhythm regular. There was marked tenderness over the gall-bladder area.

The patient's admission temperature was normal, but it climbed steadily to 105°F in fifty-two hours. At this time her leukoeyte count was 29.5 thousand showing 92 per cent neutrophiles. Her temperature remained between 100.5°F. and 104°F. for three days, then between 99°F. and 102°F. for one week.

The third day of normal temperature, February 5, while the patient still presented a precarious cardiac condition, the patient's physieian undertook exploration of the gall bladder. The writer co-operated. Following separation of dense adhesions under the liver, it became evident that there was a complete, congenital absence of any extra-hepatic gall bladder or vestige of gall bladder. The patient's history and the extent and charaeter of the peri-hepatic adhesions suggested an underlying abscess. A soft area on the anterior and upper surface of the liver was found by palpation. This was aspirated, and thick, yellow-grey pus was obtained. The abseess was unroofed by exeising the overlying, semi- neerotic, liver tissue. The abscess cavity was roughly the size and shape of a distended gall bladder. Penrose drains and a strip of gauze were brought out a sub- eostal stab-wound and the ineision was closed. Cultures showed short, Gram-negative bacilli.

The post-operative eourse was uneventful. The pulse steadied; there was some bile-stained, purulent, and bloody drainage which subsided rapidly; and the patient left the hospital on the eighteenth post-operative day. She has remained well.

Whether this was a true liver abscess, or an empyema of a totally intrahepatic gall bladder, is not important.

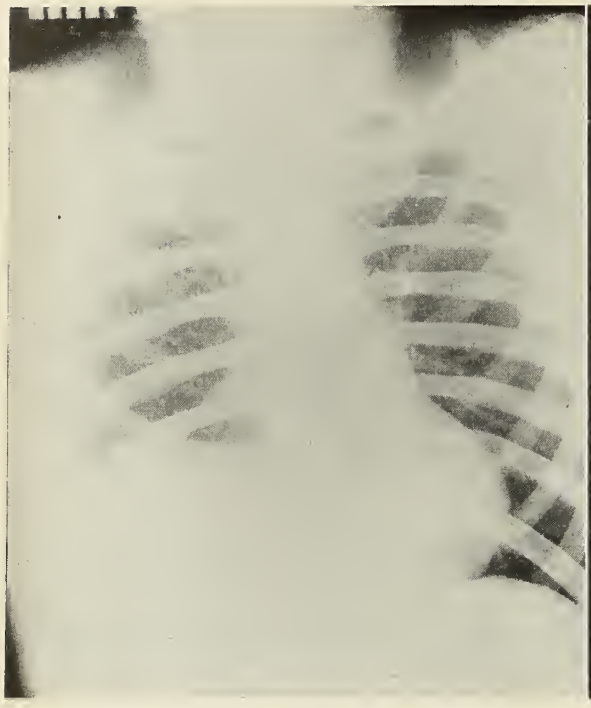


Fig. 4.—Case 3. Roentgenogram of chest taken August 16, 1947, showing marked elevation of right diaphragm and little if any pleural involvement.



Fig. 5.—Case 3. Lateral rontgenogram of chest showing marked elevation of right diaphragm with clear costophrenic angles.

For all practical, clinical purposes it was a pyogenic, solitary liver abscess, secondary to an acute cholangitis; it was recognized and drained, and the patient rapidly recovered good health.

Case 2, a case of pyogenic liver abscess, presents the acute "right costal margin syndrome" plus other toxic and cardiac symptoms which confused the diagnosis. The improvement following surgical drainage indicates that most of the symptoms were related to the pyogenic liver abscess.

Case 3.—Mr. L. R. C., a negro aged thirty-one, not a veteran, was admitted to Hackley Hospital August 14, 1947, following a fluoroscopic examination of the chest and with a roentgenologic diagnosis of liver abscess after the finding of a high right diaphragm. The following history was obtained: The patient had been seized with a severe chill and a pain in the right side in December, 1946. The pain and chills had been recurring intermittently since and had recently increased in severity. There were marked malaise, anorexia, pain in the right lower lateral and posterior chest on inspiration, and a 35-pound weight loss in the preceding eight months. There was no history of bowel abnormality, nausea, or vomiting. The pain radiated to the right scapula. The patient had lived in Tennessee; he had, by his discomfort, been forced to quit work.

Physical examination was negative except for weight-loss, sunken eyes, and a sub-icteric tinge to the skin. There was tenderness in the right lower lateral and posterior chest on percussion and on finger pressure. There was definite edema over the lower right ribs posteriorly and laterally. The right hypochondrium was tender. Both lungs were full of moist rales. Urinalysis and blood Kahn examination were negative. The leukocyte count was 19.8 thousand showing 90 per cent neutrophiles with 4 per cent stab-forms. There was a moderate secondary anemia. Hematocrit test showed 29.6 per cent packed cells. The icterus index was 7. An indirect van den Bergh test showed 2 milligrams of bilirubin Plasma protein was 7.42 grams per 100 ml.

In view of the likelihood of an amebic infection, the patient was given emetine. After the fourth daily injection of emetine, the temperature, which had been running from 96°F. to 102°F. daily with a concomitant pulse rate of 96 to 100, became normal. The pulse leveled off between 80 and 100. Blood cultures showed staphlococci. But the patient's pain, rales, cough, and malaise continued as did the local swelling of the panniculus over the right lateral and posterior lower ribs and interspaces. Sweats recurred. The picture was suggestive of some of the atypical malaria cases encountered in the South Pacific, and in spite of four negative malarial smears, atabrine and quinine were both given. Their administration demonstrated nothing. Chest roentgenogram on August 16, 1947, showed the right diaphragm smoothly rounded and elevated to the eighth rib posteriorly. Lungs and pleurae were negative.

The morning of August 22, after severe right upper quadrant cramps, the patient was relieved of pain, had a short episode of diarrhea, and "felt the best he had



Fig. 6.—Case 4. Roentgenogram of chest showing marked lateral elevation of right diaphragm.

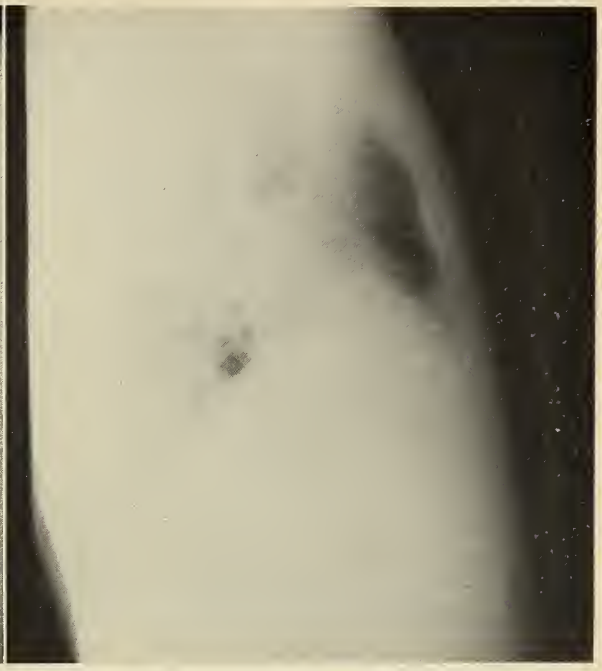


Fig. 7.—Case 4. Lateral roentgenogram of chest showing anterior elevation and fixation of right diaphragm with clouding of the anterior costo-phrenic angle.

onths." He had been scheduled for surgical exploration at day, but because this new episode was interpreted a spontaneous drainage of a liver abscess through the le ducts and bowel, surgery was postponed and the tient was observed. His chills, sweats, and pain recurred ring the next few days. On August 28, fluoroscopy owed lung tissue extending well down into the costo-renic angle with free descent of the right elevated aphragm on inspiration.

On August 30, the patient was explored through an lique incision just below the right costal margin. The terior surface of the liver was greatly increased in tent, but all was normal until the exploring hand found impossible to get between the liver and the diaphragm steriorly due to heavy adhesions. A very long, thickened pendix filled with fecaliths and lying laterally, adherent the posterior gutter, could be palpated and visualized tending up to the posterior margin of the liver. This ggested the possibility of a primary appendicitis and a er abscess secondary to it. Because the liver, or sub-phragmatic abscess, appeared to be pointing posteriorly, d because it was technically unwise to attempt ap-ndectomy through the high incision, the belly was sed. The patient was turned and the right eleventh was resected. In spite of the edema of the panniculus l overlying tissues, the subjacent costal-parietal and phragmatic-parietal pleura were thin and transparent l moved freely against each other with respiration. e above-mentioned pleurae were sewn together and he diaphragm to prevent contamination of the pleural ity. The wound was packed with gauze and left open. ur days later the diaphragm was incised through the pared approach, and a large liver abscess was drained yellow, flocculent pus which was sterile on culture and negative on examination of stained smears. A large rubber tube was left in place. The patient improved steadily and was discharged twelve days postoperatively, ambulant, with a small residual cavity which soon closed completely. The patient returned to his former occupation as a foundry worker.

Whether or not this was an amebic abscess or a pyogenic abscess is pure conjecture. The type of pus obtained was quite like that described by S. W. Harrington[5] in some of his amebic cases. Perhaps if preparations made from scrapings of the abscess wall had been examined, amebae might have been demonstrated. However, the patient had had emetine therapy as well as antibiotics. His excellent clinical response to emetine, and the type of glary, flocculent pus plus the negative culture of the pus incline the writer to classify this case as one of amebic hepatic abscess cured by the use of emetine and surgical drainage.

Case 3 is a chronic liver abscess with presenting symptoms so vague that the patient had continued working for six months. It presents the "chronic pulmonary" and "chronic costal margin" syndromes. Emetine was helpful, but surgical drainage was required.

Case 4.—Mr. C. L., a white person aged thirty-seven, entered Hackley Hospital, October 31, 1947. On September 30, 1947, he had had an appendectomy elsewhere, shortly after he had been seized with a severe pain in the right abdomen. He developed a postoperative fever. His wound partially opened, and on three occasions there were sudden large evacuations of pus

from it. He would feel better, and his temperature would subside—only to recur. The patient had been ambulant for two weeks, running a daily fever of 100°F. to 101°F., but he had been eating well and feeling well; bowel function had been normal.

Roentgenological examination on October 30, 1947, had shown marked elevation of the right diaphragm. The patient was then referred to the writer with a diagnosis of right subdiaphragmatic abscess. Examination of the chest was negative. Normal expansion of both lower costal margins was present. On percussion, the right lung base was elevated anteriorly two inches above normal and was fixed. Posteriorly the right lung base was normally placed with a normal descent of resonance on inspiration. Breath sounds were normal except for their absence in the region of the lower middle lobe on the right. The abdomen revealed only an open, granulating McBurney-type surgical wound. The finger determined an intact fascia but no palpable sinus tract. However, a curved hemostat found a tract leading upward toward the liver. No right lobe of the liver was palpable, but there was dullness in the lateral gutter region, while there was bowel resonance extending for 2 inches above the right costal margin anteriorly.

Urinalysis and blood examination were negative except for a blood count of 12.2 thousand leukocytes of which 45 per cent were netrophiles. Antero-posterior and lateral roentgenograms of the chest showed a "soft tissue mass in the anterior, lower right chest, most probably below the diaphragm." For the first two days after admission, the patient looked and felt well, and his temperature did not exceed 99.2°F. He was ambulant with no wound drainage; but on the third day he again experienced a sudden gush of pus from his open appendectomy incision.

On November 3, 1947, exploration was done through an upper right rectus incision. The preoperative diagnosis was postappendectomy intra-abdominal abscess with inadequate spontaneous drainage. The belly was filled with adhesions, but there was no sign of an abscess anywhere except for dense, recent, fibrino-fibrous adhesions between the anterior liver surface and the diaphragm, indicative of recent infection. The anterior liver border lay 2.5 inches above the right costal margin. The adhesions between the liver and diaphragm were separated up to the coronary ligament, but no actual pocket was encountered, although the exploring fingers in the abdomen reached the level of resonant lung base determined by preoperative chest percussion. Operation consisted of establishing direct drainage of the subdiaphragmatic, supra-hepatic area through the incision. The patient's postoperative course was uneventful; then about forty hours postoperatively he suddenly coughed up and expectorated a large amount of "pus-like mucus mixed with blood." His temperature, which had been 101°F. since surgery, dropped to normal, where it remained. He left the hospital walking and well on the fourteenth postoperative day. There was no further drainage of pus from his appendectomy wound which healed by normal secondary intention.

The patient has remained well since. He resumed his work two months after spontaneous drainage of the subdiaphragmatic abscess via the two routes: (1) abdominal incision and (2) the tracheo-bronchial tree. Cultures of the exudate were not obtained.

Case 4 is an example of the perforation of the diaphragm by pus burrowing from a subdiaphragmatic abscess with drainage through the tracheo-bronchial tree. The abscess probably never was intrahepatic, although the high elevation of the right lung base, anteriorly, and the x-ray findings closely resembled those which DeBakey feels are pathognomonic for amebic liver abscess.

Case 5.—Mr. L. M., a white person aged fifty-five, was admitted to Mercy Hospital, November 3, 1948, on complaint of pain in the axillary region of the lower right chest; shortness of breath; a hacking, non-productive cough which was paroxysmal at height of inspiration; and a fever of about 100°F. There was no hemoptysis; no pneumonia.

There was diminished chest expansion on the right. In the right postero-inferior lung field a few moist rales were heard, and tactile fremitus was absent. The patient had had chronic urethral stricture since age 22, accompanied by multiple perineal abscesses and multiple dilatations and a posterior urethrotomy. He had had urethral dilalation a few days before hospitalization.

No acid-fast bacilli were found in his sputum; sputum culture and animal innoculation were negative. Urinalysis demonstrated 40 to 50 leukocytes per high-power field, but was otherwise negative. Blood examination showed 3.59 million erythocytes and 13 thousand leukocytes of which 80 per cent were polymorphonuclear. Roentgenograms made November 3, 1948, showed increased opacity at the base of the right lung extending up to the fourth anterior rib in the antero-posterior view. In the lateral view opacity was localized to the posterior one half of the chest, apparently over the lower lobe. The roentgenologist's impression was that fluid, probably encapsulated, lay at the right base.

A diagnosis of empyema was made, and on November 13, 1948, thoracentesis was performed, entering through what was believed to be the ninth interspace in the midscapular line. Fifteen ml. of thick grey pus were removed. For three days following thoracentesis the patient's fever continued around 101°F. Blood examination showed 3.35 million erythrocytes and 21.8 thousand leukocytes of which 82 per cent were polymorphonuclear.

Surgical consultation was obtained November 17, and a diagnosis of probable lung abscess, right lobe posterior, was made; exploration and drainage were recommended. Before surgery, November 18, the point where the previous thoracentesis was made was found to be the eleventh interspace instead of the ninth interspace. The diagnosis was immediately changed to septic liver abscess. Two inches of the twelfth rib were resected, and non-odoriferous, creamy, greenish pus was drained from a large liver abscess. Two ⅜-inch rubber drains were brought out and secured by a stitch through the skin, and the wound was loosely closed. Beta-hemolytic streptococci were cultured from the pus.

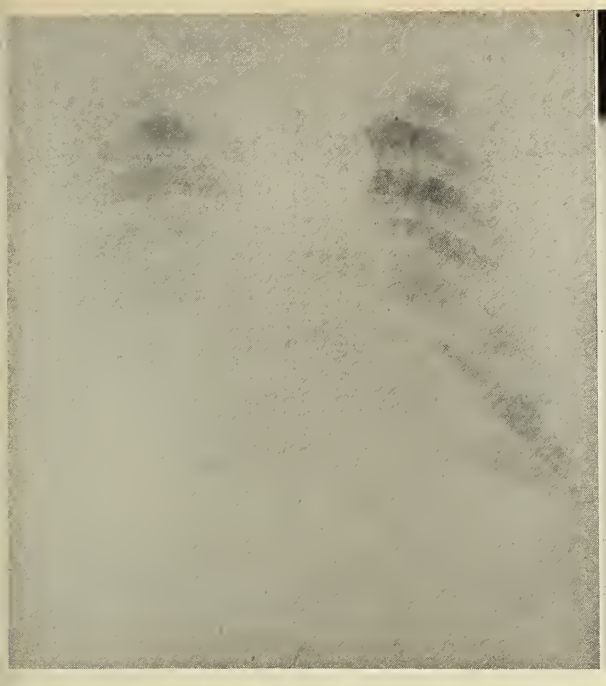


Fig. 8.—Case 5. Bedside roentgenogram of chest taken November 3, 1948, showing increased opacity, probably fluid, over the right lower lobe.

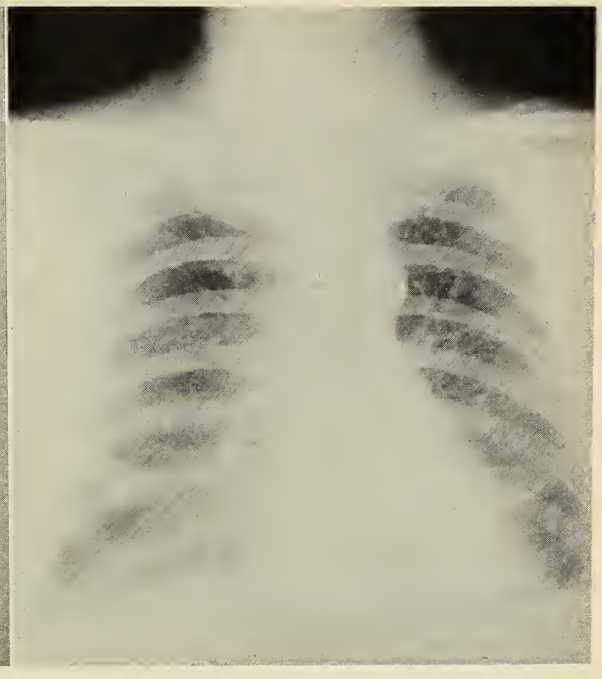


Fig. 9.—Case 5. Roentgenogram of chest taken April 5, 1949, showing complete clearing of the right pleural space and costo-phrenic angle (following surgical drainage of the underlying pyogenic liver abscess).

The patient's temperature dropped following drainage of the abscess, and his general condition improved markedly. Roentgenograms made November 30 with contrast medium injected into the drains demonstrated no residual cavity and no fistula; other findings were negative. The patient was discharged on December 6, 1948, ambulant, with no residual cavity but that immediately around the shortened drain tubes.

Mr. L. M. was rehospitalized at Mercy Hospital, January 22, 1949, on complaint of fever. The drain-sites had healed, pushing out the drains. Another abscess was forming at the site of the previously drained abscess. No roentgenograms were made. Blood counts were negative. Urethral stricture and heavy pyuria were then being treated by a urologist. A preoperative diagnosis of recurrent liver abscess with inadequate drainage and possible osteomyelitis of rib 12 was made. Operation on January 24 revealed no osteomyelitis but did show a small abscess cavity, of one or two ounce capacity, in the liver and arrived at by probing along the old drain tract. An opening admitting two fingers was made to the small abscess, which was then packed with gauze. Postoperative recovery was rapid and uneventful; the patient was discharged January 27, 1949, ambulant.

Three months later, on March 15, 1949, Mr. L. M. was admitted to Hackley Hospital with complaints of fever; disorientation; vertigo; severe, persistent headache; a hacking, non-productive, persistent cough; and athetoid movements. A brain abscess was suspected as a possible sequel to his liver abscess. No supportive laboratory or further physical findings confirmed this diagnosis. Chest x-rays disclosed bilateral pneumonia. The patient's progress was uneventful on penicillin therapy. Final diagnosis for this hospitalization was bronchopneumonia.

This third hospitalization presented opportunity to re-examine the drainage site of the liver abscess. This was probed, but there was no evidence of pus-pocket formation, and at termination of hospitalization the drainage site was completely healed. Roentgenograms made March 29, 1949, showed clearing of pneumonitis; those made April 5, 1949, showed a symmetrical chest with a clear right costophrenic angle and no evidence of elevation or fixation of the right diaphragm.

Case 5, a pyogenic liver abscess, presumably secondary to urethral instrumentation, presented the "acute pulmonary syndrome." The patient was treated as a case of empyema thoracis for the first five days of his first hospitalization. The final chest x-ray shows how completely the right diaphragm returned to normal after surgical evacuation of a huge intra-hepatic, pyogenic abscess.

Case 6.—Mrs. E. F., a white person aged seventy-four, a bedridden, obese, arthritic invalid, was hospitalized with a diagnosis of pneumonia of the right lung on January 12, 1948. Roentgenograms on that day showed marked elevation of the right diaphragm, plus a pneumonia of the right upper lobe.

Roentgenograms made January 20, 1947, showed a "tremendous elevation" of the right diaphragm to the



Fig. 10.—Case 6. Roentgenogram showing very marked elevation of the right diaphragm (secondary to bodybuild, obese belly, and prolonged supine posture).

level of the third rib anteriorly. The patient's temperature had hovered between 100°F. and 101°F. for nine days when the writer first saw her on January 21, 1948. Examination at that time showed persistent rales throughout the right lung, good pulmonary descent on inspiration, and no palpable liver. The patient had an unusually broad and deep lower thoracic cage and a remarkably firm, tense, rotund, and obese belly. Fluoroscopy the following day revealed: "the excursion of the diaphragm was equal on the two sides, and it is apparent that the right diaphragm is elevated due to a subdiaphragmatic mass." The patient's erythrocyte count had dropped from 3.4 million to 2.9 million, and her leukocyte count had risen from 14 thousand to 19.4 thousand. Penicillin was being administered. The diagnosis of the attending physician, supported by radiological findings, was subdiaphragmatic abscess.

However, the consulting surgeon tendered the opinion that there was no liver or subdiaphragmatic abscess. The patient's fever was thought to be most probably the effect of the residual pulmonary inflammation. The elevation of the right diaphragm was believed to be explained by: a wide lower thoracic cage; the patient's supine position; a relatively small subjacent liver; the pressure of the rotund and obese belly; and increased intra-abdominal pressure due to some gaseous distention of the bowel. Without surgical intervention, the patient recovered a normal temperature on January 26 and went home fully recovered on February 1, 1948. She remained well until death from unrelated causes two years later.

Case 6 is reported because it presented the roentgenologic findings for liver or subdiaphragmatic abscess plus many of the clinical findings to substantiate either diagnosis. This case demonstrates the importance of evaluation of the clinical situation. The wide, funnel-shaped flaring of the patient's lower thoracic cage plus her orange-shaped, very tense belly crowded with fat and bloated with gas were deemed to be sufficient, in view of her constant horizontal position, to have pushed her liver and diaphragm higher in her chest than they would have normally lain. This explanation for the x-ray findings gave reason for avoiding surgery and for believing that in spite of the x-ray findings, the picture of infection was all pulmonary. The soundness of this judgment was confirmed by the fact that she recovered spontaneously and remained free of further symptoms referable to any subdiaphragmatic or liver lesion.

Case 7.—Mr. E. L., a Negro aged fifty-one, was admitted to Hackley Hospital, January 10, 1948, with a diagnosis of pneumonia of the right lung base. He had become ill with chills and fever, dyspnea, profuse perspiration, cough, and severe general malaise while driving home from the South. Upon admission his respirations were 30, but his pulse and temperature were normal throughout his twenty-day stay in the hospital. There was pain in his right chest and shoulder. Chest expansion was bilaterally equal, and there were moist rales and decreased breath sounds at the right base. The abdomen was negative. Urinalysis was negative except for albumin grade 1-plus and the presence of 15 to 20 leukocytes per high-power field. Erythrocytes numbered 4.96 million; there were 17.5 grams of hemoglobin; leukocytes numbered 16 thousand with 65 per cent segmented forms and 13 per cent stab-forms. Two warm stool examinations were negative for pus, parasites, or ova, but were strongly positive for occult blood.

The roentgenologist's report of the chest x-ray taken January 10 stated, "Extensive pneumonitis, right base, but a subdiaphragmatic lesion would produce the same picture." Ten days later roentgenograms showed "a marked elevation of the right diaphragm with some atelectasis of the right lower lobe, apparently due to compression due to elevation of the right diaphragm. This suggests a subdiaphragmatic lesion, possibly a liver abscess." Fluoroscopy on January 23 showed "excursion of the right diaphragm equal to that on the left. Impression: subdiaphragmatic tumor."

Surgical consultation was obtained January 28. The liver was neither enlarged nor pushed downward. The area of elevated diaphragm by x-ray corresponded with a triangular area at the right lateral base which was flat to percussion and was devoid of breath sounds. The laterally elevated diaphragm was therefore thought to be due to pleural adhesions, pulmonary in origin. In



Fig. 11.—Case 7. Roentgenogram of chest showing elevation of right diaphragm with local pulmonary involvement.



Fig. 12.—Case 7. Lateral roentgenogram of chest showing angular elevation of right diaphragm.

ew of the normal temperature, pulse, and respirations, nd the apparent pleural adhesion to the diphragm, the evation of the right diaphragm could be satisfactorily plained without reference to the liver or the subiaphragm. The patient was therefore dismissed without rgery, January 30, 1948. He has been well since cept for another episode of pneumonia in 1951 at hich time both costo-phrenic angles appeared normal the roentgenograms of his chest.

Case 7 presents adequate x-ray and physical ndings to suggest a diagnosis of liver or subiaphragmatic lesion. This case also presents the acute pulmonary syndrome." But the absence fever militated against the presence of any liver subdiaphragmatic lesion adequate to induce as uch right lower lung pathologic change as was ident in the x-rays. Virus pneumonia frequently ms an afebrile course. For this reason, the ggestion of a primary, subdiaphragmatic lesion as discounted, and the diagnosis of virus pneuonia, only, was made. The wisdom of this dgment was substantiated by the patient's favorle progress without surgery.

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Notes on New Sex Offender Legislation

By Donald M. D. Thurber

Detroit, Michigan

LATE IN 1949 Governor Williams appointed a twenty-two member Commission to study the problems presented by the sex deviate and the sex offender and to make recommendations for appropriate reforms. The Commission, under the chairmanship of Reverend Father Ralph M. Richards, of Saginaw, contained four members of the Michigan State Medical Society. They were Dr. Raymond W. Waggoner and Dr. Ralph D. Rabinovitch, both of Ann Arbor, Dr. P. C. Robertson, of Ionia, and the late Dr. Samuel W. Hartwell, of Lansing. In addition, Dr. Thomas J. Heldt, of Detroit, served as the liaison representative of the Society to the Commission. The Commission issued a lengthy report of its findings, which became the basis for several important enactments in the 1952 session of the State Legislature. The Commission has now been discharged by the Governor.

An amendment to the Hospital Act for Mentally Diseased Persons permits for the first time petitions to be filed in probate court for the commitment to mental hospitals of persons whose sexual behavior conforms with the definition written into the law. Petitions "may include persons whose sexual behavior is characterized by repetitive or compulsive acts which indicate a disregard of consequences or the recognized rights of others, or by the use of force upon another person in attempting sex relations of either a heterosexual or homosexual nature, or by the commission of sexual aggressions against children under the age of sixteen." Medical testimony must be heard, just as in petitions for the commitment of the mentally ill. Such a petition for commitment may not be considered if any criminal proceeding based on sexual behavior is pending against the person named in the petition. Furthermore, the petitioners are limited to the person himself, the prosecuting attorney, the next of kin over twenty-one years of age, the legal guardian, or the person's counsel. The intent of the law is to encourage the voluntary commitment of persons who may not have committed any actual crimes, but of whose ability to behave acceptably there is serious doubt. As worded, the law is not intended to provide a substitute for ordinary criminal proceedings. The limitations placed upon the petitioners are for the purpose of discouraging captious and vengeful petitions by persons not having a true knowledge of the facts. The new language will also permit the transfer of selected sexually deviated prisoners from the State prisons to the Ionia State Hospital. Such transfers have hitherto not been possible unless prisoners were suffering from psychosis or feeble-mindedness. This law has been given immediate effect.

Another bill amends Michigan's existing Criminal Sexual Psychopath Act, the so-called "Goodrich Act." There has been some confusion whether the law might be invoked in Recorder's Court, Detroit, when a person is charged with a misdemeanor. One of the amendments now clarifies the procedure by specifically including misdemeanors. The former insistence upon full and permanent recovery as the criterion for discharge after commitment has been modified by the use of the words, "has recovered from such psychopathy to a degree that he will not be a menace to others." Furthermore, the words, "reasonable grounds to believe that such person has recovered," have now been inserted in other sections of the Act. The new wording is helpful and realistic in that it conforms with what is, in fact, the practice at the present time.

Three additional bills which, together with the amendment to the "Goodrich Act" become effective in September, provide the State with new machinery for the processing of convicted sex offenders. A sexually delinquent person is defined the definition being the same as that given above in the Hospital Act for Mentally Diseased Persons The definition is so worded that the commission of sex crimes involving force or perpetrated against children is prima facie evidence of sexual delinquency. The prosecutor elects whether to charge sexual delinquency as an additional count If a finding of sexual delinquency is returned by the court or jury, together with a conviction of the substantive crime, the sentencing judge may in his discretion impose any sentence now provided by law for the particular sex crime or he may impose an indeterminate sentence which shall have

Mr. Thurber is recent Executive Director of the Governor's Study Commission on the Deviated Criminal Sex Offender.

a minimum of one day and a maximum of life. The crimes which are made subject to the new option are the various assaults with sex intent, sodomy, incest, indecent exposure, sexual assaults and attempts against children, gross indecency, and rape. Provision is made for expert examination and testimony in the court proceedings. A psychiatric clinic is set up in the Department of Corrections, which must provide treatment for and periodic review of all sex offenders sentenced indeterminately. It may also extend treatment services, to the limit of its ability, to other types of prisoners. Authority to parole or discharge indeterminately sentenced prisoners is vested in the Parole Board, which must review the status of each such prisoner and the data presented by the psychiatric clinic not less than once every six months. A satisfactory parole period must precede the outright discharge of an indeterminately sentenced prisoner. If such a prisoner has not been paroled or discharged within three years after the beginning of his imprisonment, he may petition the sentencing court for a hearing at which he may introduce evidence tending to show his recovery. He may make such a petition every five years thereafter so long as he remains in custody. The sentencing court or jury may determine from the evidence available to it and from the testimony of expert examiners whether the prisoner has been sufficiently rehabilitated so that he may be released without danger to himself or to society. The objective of the optional indeterminate sentence and its accompanying features is to make easier the selection by the courts of individuals who will benefit from treatment of indeterminate length or whose removal from society is indicated for an indefinite period because of their dangerous condition. Release then depends upon the prisoner's rehabilitation, not upon the automatic passage of a fixed period of time. Incentive to co-operate in a treatment program is thus increased, while at the same time authority is conferred to hold the prisoner for the rest of his life if his condition remains dangerous in the opinion of the Parole Board, acting upon the advice of the psychiatric clinic.

Aside from the main provisions which have been given above, the new laws contain other language which accomplishes minor reforms, additions, and changes too detailed to list in these notes.

The new legislation was introduced by Representatives Howard R. Carroll, of Mt. Clemens, Herb Clements, of Deckerville, and Lloyd Gibbs, of Portland. Representative Carroll also served as chairman of a committee of the Legislature which examined and studied the legislative recommendations of the Governor's Commission and worked with the Commission in putting into final form the bills which were passed.

BREAST CARCINOMA STUDY

(Continued from Page 1316)

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Early Detection of Cancer

Postgraduate Course

Wayne University College of Medicine offers a Postgraduate course in the early detection of cancer. Three facilities of the College are to be used throughout the year in the presentation of the course: The Yates Memorial Clinic at 4811 John R, Detroit; the Detroit Receiving Hospital; and the Veterans Administration Hospital, Dearborn. The course is scheduled so that it may be taken for the entire year of three quarters, or so that any one quarter may be elected. The course is designed so that doctors of medicine may become acquainted with the means of diagnosis and with the tools of diagnosis which are readily available to them.

The offering for all quarters of the school year is as follows:

First Quarter beginning September 15 and ending December 6, 1952

Monday—Tumor Board Detroit Receiving Hospital	12:30— 2:00 p.m.
Tuesday—Cancer Control Clinic (men) Yates Memorial Clinic	7:00— 9:00 p.m.
Wednesday—Review of Biopsy Slides and Papanicolaou Smears Yates Memorial Clinic	10:30—11:30 a.m.
Friday—Consultation Clinic Yates Memorial Clinic	10:00—12:00 a.m.

Second Quarter beginning December 8, 1952, and ending March 14, 1953

Monday—Cancer Control Clinic (women) Yates Memorial Clinic	3:00— 5:00 p.m.
Wednesday—Review of Biopsy Slides and Papanicolaou Smears Yates Memorial Clinic	10:30—11:30 a.m.
Friday—Consultation Clinic Yates Memorial Clinic	10:00—12:00 a.m.
Friday—Tumor Board Veterans Administration Hospital, Dearborn	3:00— 5:00 p.m.

Third Quarter beginning March 16 and ending June 13, 1953

Wednesday—Review of Biopsy Slides and Papanicolaou Smears Yates Memorial Clinic	10:30—11:30 a.m.
Wednesday—Tumor Clinic Detroit Receiving Hospital	12:30— 2:00 p.m.
Thursday—Cancer Clinic (women) Yates Memorial Clinic	3:00— 5:00 p.m.
Friday—Consultation Clinic Yates Memorial Clinic	10:00—12:00 a.m.

Registration for this course can be made in the office of Postgraduate Medical Education at the College of Medicine, 1512 St. Antoine, Detroit 26. Those wishing to be enrolled for the fall quarter of 1952 must register *before September 13.* Tuition is $50.00 per quarter, and the class is limited to fifteen.

President's Message



We Serve

I wish to avail myself of the just opportunity on the printed page to thank the members of the Michigan State Medical Society for the honor bestowed upon me, and the confidence shown in me, by my elevation to the presidency of your organization. You, of course, are aware that our Society holds an enviable position in the national organization, and there are good reasons for this circumstance. Primarily, and for this we should express our appreciation, we have had many predecessors in our membership of high character and practical vision who could see the possibilities for constructive work by the Society and furthermore were unstinted in their devotion to duty in order to achieve those goals. We still number among our membership many men of the same calibre, and for this I am especially grateful because necessarily the officers of any society cannot take credit alone for the many things accomplished.

In addition, we have been especially fortunate in being able to attract capable men and women to assist us in an excellent capacity, all very loyal employes.

And so during the coming year, I solicit the same interest by and co-operation of the membership, always being mindful of the fact that this is a large organization attempting to serve varying types of communities ranging from densely populated industrial cities to those areas that are sparsely populated and rural in type.

Thank you

R. J. Hubbell

President, Michigan
State Medical Society

Editorial

ACKNOWLEDGMENT

THE EDITOR takes pleasure in rendering credit and commendation to Wm. M. LaFevre, M.D., of Muskegon, Chairman of the Committee on Diabetes Detection of the Michigan State Medical Society, for his splendid work in helping to prepare this edition of THE JOURNAL, the Diabetes Number. Dr. LaFevre has worked for several months, and has selected some good papers covering the disease. He has also contributed an editorial on the subject. We have enjoyed working with him.

DIABETES IN MICHIGAN

FROM THE figures obtained in surveys made in various parts of the country, it is apparent that there are about 42,000 diabetic persons in the state of Michigan, and another 42,000 people are mildly diabetic but as yet have not been discovered.

In order to stimulate interest among the profession in the problem of diabetes, this issue of THE JOURNAL of the Michigan State Medical Society has been devoted to that subject. The education of the diabetic patient and the control of the disease takes a lot of time on the part of the physician, but there is probably no other disease in which the reward for good care is so great.

The early recognition of the condition gives us an opportunity to institute control at a time when serious complications can be prevented. The American Diabetes Association, the Michigan Diabetes Association, the Subcommittee on Diabetes Control, and the various county medical society committees on diabetes have all worked together for the past several years to produce Diabetes Week. This week is devoted to the encouragement of more diligence in the early recognition of diabetes, and its early control. The program goes on all year and, as a result, each year more and more early cases are discovered. School, pre-employment, life insurance, routine factory, and many other required examinations are continually turning up previously undiscovered cases.

Of utmost importance in this program is the office of the family physician. It is there that the best work can be done in finding the uncontrolled cases. Nearly everyone sees a doctor at least once a year, and making a urinalysis a routine part of the examination of each patient who consults him will do much to aid this program.

It is the duty of each of us in the profession to do our part in the prevention of the complications which so often result from lack of early control of the disease.

WM. M. LEFEVRE, M.D.
Chairman, Sub-committee on Diabetes Control
Michigan State Medical Society.

TO A BETTER LIFE—SOCIAL PROGRESS, NOT SOCIALISM

EVERY MOVE toward the betterment of the conditions of the people as a whole is an advance in social progress. The fundamental needs of people are, first and foremost—food, clothing and housing. These are the bare essentials. To them must of necessity be added health, for without health no present good would come of the other three.

Another item is material to all progress—skills. Without skills no progress worthwhile would redound to the benefit of persons who make up any community. These five attributes, food, clothing, shelter, health, skills, are accepted and enjoyed. They are the result of individual and independent action. They are the foundation of our civilized life.

From this beginning, all progress must come. Government through its directors, dictators or bureaucrats has seized upon these basic needs of people and directed their distribution in its own fashion. Sometimes this has been good, sometimes it has seemed to favor certain special groups. There is one fact, however, to remember—individual skills—not Government—create these basic needs of the human race. Government took what was already there, modified it, divided it, or wasted it, and added its own parasitic costs to the whole, then gave back what was already the perquisite of the people.

It is unfortunate that the terms "socialism" and

"social progress" have become of common use. We confuse and misunderstand them. Socialism is the picture we have just given in which government looks after its people's needs with their own goods, which it has taken. Social progress is that situation where, by their own efforts, and their neighbor's help, the people spontaneously build to a better life.

TO A BETTER LIFE

NOT SO LONG ago the great masses of people lived in want. If employed, they worked long hours for little pay. They were able to furnish the bare necessities for their families. Some of our recent forebears lived when the world was just beginning to appreciate the value of individual effort. People were learning that by voluntary work and industry they could procure the necessities and some of the luxuries which their families had known only vicariously for ages.

Our ancestors and our immediate forebears strove diligently for every advantage and to provide better food, clothing, shelter and health. Most houses had absolutely no facilities; toilets, plumbing, central heat, running water, electric power, gas, telephones have all come to us within the memory of our elder doctors of medicine. Our people worked, sacrificed, and finally accomplished a social revolution of living that is absolutely incomprehensible to the younger generation.

In those days, doctors of medicine were few and far between. They had some education, but a world of understanding and a willingness to do what they could to relieve suffering. They traveled long distances by horseback, or as best they could, and carried with them whatever might be needed for the patient.

The desire for a more abundant and satisfactory living stimulated the world to improve what it had, to seek for newer methods and conditions. Better housing, conveniences, food and clothing were the ambition of each household. The growth in social and economic stature was slow at first, but steady. Our fathers and grandfathers were self-sufficient, determined, independent and proud to see their families constantly striving for better and more abundant living conditions. This was social advance, a step to a better life.

Early members of the medical profession took stock of their capabilities and shortcomings. They recognized the utter inadequacy of the medical schools and were instrumental in improving the old, starting new, doing away with the frank diploma mills, and finally, early in this century, succeeded in setting up a set of standards and ratings which made the medical colleges of the United States the best in the world. This produced a tremendous advance in the general level of medical knowledge and skill.

Pioneer families were now able to have reasonably good food, clothing, housing, and health security. It was vastly better than in the old feudal days when only the master, the overlord or the wealthy were secure in their health needs or even able to employ doctors. The costs of better living, including health care, were high for the times, and getting higher. Socially minded persons began doing something tangible.

A committee was appointed to study the costs of medical care. This committee made a report that the costs were high, and some of its members began suggesting the idea that the solution could be for federal control. Great Britain adopted the scheme for a limited, but rather large, segment of her people.

For the past few years, the urge to take over the health services of our nation by the bureaucrats of the federal government has been a never-ceasing threat to the natural and orderly progress of national betterment in every essential need of the people. Bill after bill, plan after plan, speeches and accusations, and vilifications of the medical profession—we have had them all.

The social planners kept proposing one new federal scheme after another. The grass roots of the profession from Texas, Oregon, Washington, Michigan, California, the men in contact with the suffering public, whose patients wanted health care and were willing to pay for it to the best of their ability, these medical men began toying with the insurance principle. Could some plan be provided whereby those persons willing to do so could contribute to a fund which would care for the costs of serious catastrophic illness? The Blue Cross and Blue Shield evolved.

The success of these movements has been so overwhelming that the advantages of good health care need not be foregone by anyone who wishes to use them. The Blue Cross and Blue Shield plans are now available to everyone with an income. The very best possible medical and hospital care is on call now to over eighty-five million persons,

well over half of the total population of the United States. This is another long step in the social progress of the nation to—a better life.

At the present time there seems to be a lull in the planned program. Both political party platforms have clauses against "Socialization of Medicine" and both party nominees have expressed themselves as against "Socialized Medicine."

One would think we might have a rest and be allowed to iron out some of the unintentional and unmistakable inadequacies which have become manifest in our voluntary health plans due to the necessity of development in a new and untried field.

But, no. No time is given to readjust, to resurvey, and to work for safety and security. The President appointed a commission to study the whole field of medical and hospital service plans, the furnishing of adequate health care to the whole population with orders to bring in a report with definite recommendations. He hoped by this move to remove the question of socialized medicine from the political campaign. The American Medical Association promptly branded this commission a political move.

The President's commission has held regional meetings with interested groups allowed to make statements. Notice to some interested medical groups for some reason failed to come or came late. In his broadcast of September 9, Gun Nunn ("Labor Views the News") said that Labor's representative at the meeting in Minneapolis, September 2, 1952, proposed that the Federal Government administer all health services, with the doctors on salary, because every time labor gets an increase in wages they lose their advantage on account of prompt increases in fees by the doctors. This socialized medicine problem is not dead.

There has also been appointed a Commission on Financing of Hospital Care. Due to many causes, the costs of hospital care have advanced alarmingly to the point of grave emergency, causing a spontaneous protest of hospitals and hospital patients and their families. This commission is an independent non-government organization originally sponsored by the American Hospital Association, to report directly to the public. It is financed in its $500,000 budget by The Health Information Foundation, Milbank Memorial Fund, National Foundation for Infantile Paralysis, Rockefeller Foundation, W. K. Kellogg Foundation, and John Hancock Mutual Life Insurance Company. Others have been invited to contribute: The Michigan State Medical Society, the Blue Cross and Blue Shield plans.

All progress in the medical, scientific and economic field has been a growth of the natural urge and desire of our doctors of medicine and our people to provide and to receive the very best, the needful, and the obtainable benefits of the unprecedented advances of science during the last half century. This is another step in the gradual advance to a better life.

MICHIGAN IN LEADERSHIP

MICHIGAN has two members of the Commission on Financing of Hospital Care: Robin C. Buerki, M.D., Detroit, Executive Director, Henry Ford Hospital; and William S. McNary, Detroit, Executive Vice-President of Michigan Hospital Service. The staff Director is Graham Davis of Battle Creek, Past President of the American Hospital Association, on loan from the W. K. Kellogg Foundation, who is at present supervising the study in North Carolina. Mr. Davis, trained in hospital management, spent ten years with the Duke Endowment, and ten years with the W. K. Kellogg Foundation. The Assistant Director is Harry Becker, of Detroit, a member of the Board of Trustees of Michigan Hospital Service and the Board of Directors of Michigan Medical Service. Mr. Becker graduated as M.A. in public administration, University of Nebraska, Post Graduate Yale School of Public Health, Columbia University, and the New York School of Social Work. He was Director of Child Welfare and Services to Crippled Children, Nebraska, 1935-41; Technical Advisor, USPHS, 1941-48, and Director of the Social Security Department UAW-CIO, 1948 to 1951. The Technical Advisory Committee includes E. Dwight Barnett, M.D., Director of Columbia University Institute of Administrative Medicine, formerly President of Michigan Hospital Service, and Andrew T. Court, Detroit, Economist General Motors Corporation.

At the national level, the study is directed mainly to these four items:

1. What are the elements of hospital costs? Can hospital costs be reduced?

2. How can prepayment plans more effectively serve the public and the hospital?

3. What can we do to provide more adequate financing of hospital care for persons receiving

ublic assistance and social security benefits? How an we meet more satisfactorily the problems of inancing hospital care for the low income and ural families?

4. What can physicians and hospitals do, working together, to bring higher standards of care to he public, and, at the same time, keep costs as low s possible?

There are some 1,800 or more government agencies buying hospital care and no consistent pattern f payment. In general, tax-supported agencies uying care tend to pay the hospital less than "cost f service" which means an added cost to other atrons, including the Blue Cross.

This study is independent, not government sponored or stimulated, and we may hope for a fair nd unbiased report. We can only wait and see.

ED FEATHER AND TORCH

AMERICANS, wherever they are found, are public spirited, public minded, interested in he bettering of the circumstances of their neighors, as well as of themselves. Relief agencies of very description, agencies for boys' work, girls' ork, children's aid, family service, Red Cross, March of Dimes, Cancer Societies, Tuberculosis ocieties, to mention just a few, have been active or many years throughout the land. Each of these ad a campaign for funds.

These numerous "drives" became not only a natter of constant duty, but also of irritation. hey took too much time and interfered too much ith ordinary affairs. A little over thirty years ago few far-sighted and public spirited citizens conceived the idea of consolidating all these drives n one grand effort, a Welfare Fund, or Comunity Fund, or Associated Charities. Whatever ne name, the whole community joined, appointed permanent board, selected a method of raising large sum of money, and the modern Community Chest was born. This has been known as the ed Feather Agencies. The annual drive will be eld in Michigan this fall. We had intended to st the Community Chests in Michigan but find here are one hundred twenty, conducting one undred sixteen campaigns for operating funds.

Of late years, a large number of societies for the udy of various diseases have developed. In Michigan there are the Michigan Heart Society, he Michigan Cancer Society, the Crippled Children, the Polio, the Sister Kenny, Arthritis and Rheumatism, Cerebral Palsy, Tuberculosis and many others. Most of these societies did not belong to the various Community Chests, so necessarily had to conduct their own individual fund-raising campaigns.

In 1947, many social and industrial leaders, stimulated by certain of our medical men, formed the United Health and Welfare Fund, with its consolidated campaign. This is the Torch Fund, which started in Michigan. The campaign will be consolidated with the Community Chests in most of the state areas.

We salute the Red Feather and the Torch. They are a distinct advance in our social evolution to—a better life.

ARE YOU REGISTERED— WILL YOU VOTE???

THE RIGHT of voting is precious. Literally hundreds of thousands of Americans have fought for that privilege. Research has shown that medical men in the past have been lax in taking advantage of the boon. Hopefully, that situation is in the forgotten past.

We hope and trust that every MSMS member and his family have registered and will vote. How you vote is important, but *that you vote* is more important. An election decided by a minority is not "Majority Rule."

It has been suggested that we, the medical profession, make election day, Tuesday, November 4, 1952, a MEDICAL HOLIDAY—that we make no appointments, have a free schedule, and that we spend a sufficient time getting our friends or patients to the voting places. That's a good way to preserve our present type of medical freedom.

Let us have a real election with no absentees on November 4.

Let us make it a medical holiday.

Let us vote—and help many others to vote!

MSMS

Today the Federal government comprises over 2,055 executive agencies, employs more than 46,000 propaganda agents, gives direct orders to the largest peace-time army in its history and also to 2½ million Federal employes who don't wear uniforms.

Beyond that, exactly 27,000,000 Americans look to local and Federal treasuries for checks.

Frederick Grant Banting, M. D.

By William M. LeFevre, M.D.
and John C. Farmer

Muskegon, Michigan

IT SEEMS only fair that we should accord to Frederick Grant Banting a place among the most honored in the world's long history; even more so because his was a positive contribution to his fellow man. He was a shy fellow, actually disdainful of the praises heaped upon him, and eager only to hasten ahead in this short life and continue his work. His tragic death in 1941 was a great loss to the medical world, yet he willed to future millions of people a life far more comfortable and happy than they otherwise could have enjoyed.

He was born on a farm near Alliston, Ontario, in 1891. Here he spent his early youth, attending the local schools and working on the farm. Surprisingly, he was not a particularly brilliant student at the time and often was worried whether he would pass into the next school year. He took great interest in athletics and was a valuable member of his school baseball and soccer teams. After graduation he was sent to Victoria College by his father who hoped to interest his son in the ministry. The boy, however, decided to enter the field of medicine. At the University of Toronto, Banting proved to be an average student in medicine. Here his greatest asset, which he carried with him through life, was the ability to work hard.

Graduating in 1917, he immediately entered the Medical Service and was soon in France. It was not long before he proved himself a hero. During the battle of Cambrai his Battalion Medical Officer was killed and Banting, a young and inexperienced Captain, replaced him. He remained in the front line aid station under constant fire operating and dressing the wounded. His right forearm was torn by shrapnel but he refused to leave. The next morning, seriously ill, he was evacuated to the rear where he steadfastly refused to have his arm amputated. His superiors finally allowed him to treat his own arm which completely healed. He was awarded the Military Cross of Honor by the British Army for bravery in action.

Doctor Banting's photograph appears on the front cover of this number of THE JOURNAL.

After the war, Banting spent a year as intern in the Children's Hospital in Toronto. Interested in orthopedic surgery he set up an office in London, Ontario, but it became such a struggle to meet his financial requirements that he was forced to accept a position as instructor in physiology at the University of Western Ontario. Concentrating on the physiology of the pancreas, he became convinced that it would be possible to isolate hormones from the pancreas of cattle which would be useful in treating diabetes mellitus in man. In May, 1921, he finally persuaded Dr. J. J. R. Macleod to lend him a laboratory to conduct his experiments at the University of Toronto.

The story of his discovery of insulin with the help of Charles Best is well known.

Of course, the world owes him a great debt; but he would have been the first to deny it. After discovering insulin he shyly accepted the honors bestowed upon him but continued his work. He won the Nobel Prize in 1923 and in 1933 was made a Knight of the British Empire. As chairman of the Banting and Best Department of Medical Research at the University of Toronto, he made significant contributions to the study of cancer, silicosis, coronary disease and electro-encephalography. When World War II began, he returned to uniform and as a Major was liaison officer between the Canadian and United States National Councils on Research. He died, February, 1941, in a plane crash in Newfoundland while en route to England to demonstrate a new aviation suit.

Perhaps, in his own words, there is an answer to many of our remaining medical problems: "I am a firm believer in the theory that you can do or be anything that you wish in this world, within reason, if you are prepared to make the sacrifices I think, and work hard enough and long enough."

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Diabetic Enjoys Normal Life Twenty-Five Years

Carl Lundgren became diabetic when he was sixteen years old. That was in 1927. Carl has been on a well-regulated, accurately measured diet ever since. He has taken insulin each day as directed by his doctor. He finished high school and later studied to be a draftsman. He went to work in a manufacturing plant and has been promoted at regular intervals. He is married, has two children, and his hobby is boating. This summer he and his wife had a delightful trip to Mackinac Island in their cruiser.

At the present time he has a normal blood pressure, normal kidney function, no evidence of peripheral vascular disease, and normal-appearing occular fundi.

All this was possible *only* by carefully following his diabetic routine of diet and insulin. This routine does not interfere with his normal activities. He eats well and can follow his diet at home, at play, or on his boat. This happy life is possible for any diabetic person if he is properly instructed by his doctor of medicine and follows the instructions.



Diabetic Retinitis

Relationship Between Retinal Degenerative Changes and the Degree of Diabetic Control

Visual disturbances in the diabetic are preventable for an indefinite number of years, depending upon the degree of dietary control. Loss of vision is devastating and the physician who accepts the diabetic as a patient assumes the trust and the responsibility of giving that person the advantages of all the factual scientific, experimental, and clinical knowledge which has been amassed over the years.

One reason for poor results in the treatment of diabetes is the fact that the disorder is a painless one, and therefore patients feel well until complications intervene. Another reason is the fact that proper control requires vigilance twenty-four hours every day, and its own monotony is a cause of laxity.

In 1943, Ballantyne called attention to capillary telangiectases or aneurysms which he thought might be specific in diabetes. Further work by him, Friedenwald, Ashton, and others convinces us that the lesions are abundant in uncontrolled diabetes. Similar lesions are also found in reparative processes following obstruction of the central retinal veins.

Peculiarly the lesions are confined to the eye. The aneurysms are round and uniform in size in contradistinction to the elongated and irregular hemorrhage of hypertensive and renal disease, the lesions of which are found in the middle layers of the retina.

If the aneurysms are watched closely they may be found to disappear when the disease is brought under control.

The author has also seen other instances in which aneurysms disappear when good control is restored for a sufficient period of time in patients with severe uncontrolled diabetes of long duration. O'Brien and Allen showed that retinopathy disappeared after two months of good control in six diabetic individuals, all of whom were under thirty-one years of age. On close observation some of the lesions may disappear spontaneously, so evaluation of treatment requires some caution.

Diabetic retinitis and Kimmelstiel-Wilson disease are frequently considered as allied. In all probability time and further experience will show that both are the result of insulin inadequacy, or untreated diabetes, and that they are simply stages of the same process. We find diabetic retinitis in the absence of Kimmelstiel-Wilson disease, but not vice versa.

From the standpoint of microscopic pathology, diabetic retinitis and Kimmelstiel-Wilson disease have several things in common. Capillary dilation is present in both, and there is localized degeneration and proliferation of the vessel walls. There is hyaline deposition in the intercapillary connective tissue of the kidney on the one hand and waxy exudates in the retina on the other.

The best results have been obtained in those patients who have avoided glycosuria and hyperglycemia most consistently, and that is the goal. Reactions must be avoided. Hyperglycemia and glycosuria are non-physio-

(Continued on Page 1366)

Michigan's Department of Health

Albert E. Heustis, M.D., Commissioner

DEMAND FOR BIRTH CERTIFICATES TAXES DEPARTMENT FACILITIES

The demand for birth certificates is creating in the Department a situation rapidly approaching that of the early days of World War II. An average of fifty persons a day are coming to the Department for copies of birth certificates, a volume of desk service greater than the Department is staffed to maintain continuously. As a result, the backlog of unprocessed mail requests has passed 1,000 and is increasing daily.

One of the reasons for the unusual demand is the crowded conditions of the schools. In some areas school officials are requiring a birth certificate for enrollment. Another reason is the resumption of hiring by heavy industry following the steel strike.

RENEWED EMPHASIS PLACED ON BOOSTER SHOTS FOR DIPHTHERIA PREVENTION

With diphtheria at its lowest point in the history of the state, the Department is undertaking the difficult task of stimulating interest of parents in continued protection by booster shots. Unless immunization levels are kept high, the state is in constant danger of an epidemic of this disease.

As diphtheria continues to go down, the need for booster shots to replace the stimulus no longer provided by the diphtheria carrier is becoming increasingly urgent. Parents need to be reminded that when children are not being constantly exposed to the diphtheria bacillus they lose their artifically induced immunity and must, therefore, be given additional protection.

The Department recommends boosters at three, five and ten years of age to maintain maximum protection. This is in contrast to the former recommendation of booster shots at three and five. The additional shots is the answer to the present lack of routine exposure to the diphtheria bacillus.

Once before, from 1940 to 1943, diphtheria showed a sharp downward trend, with an average of about 240 cases per year. In 1944 this trend was reversed and cases had shot up to 630 by 1945. A statewide immunization campaign was launched and the disease declined sharply, going below 100 cases a year in 1950, for the first time in Michigan history. In that year only eighty-four cases were reported. Only forty-eight were reported in 1951 and twenty-eight have been recorded so far this year.

IODIZED SALT EDUCATIONAL CAMPAIGN UNDER WAY

The story of goiter control in Michigan will be featured in the October issue of *Michigan's Health*, monthly bulletin of the Department, following publication of the report on "Goiter Prevention in Michigan" by Brock E. Brush, M.D., and J. K. Altland, M.D., in The Journal of the Michigan State Medical Society. The bulletin article will launch an intensive educational campaign urging use of iodized salt, to include news releases, radio broadcasts, exhibits, posters and pamphlets.

FILM LOAN LIBRARY READY FOR YEAR'S DEMANDS

There are now a total of 240 films, eighty-eight film strips, and seven sets of slides in the film library. Films intended for professional use are Breast Cancer: The Problem of Early Diagnosis; Gastrointestinal Cancer: The Problem of Early Diagnosis; Uterine Cancer: The Problem of Early Diagnosis; Routine Admission Chest X-Ray in General Hospitals; Techniques of Group Chest X-Ray Services; Penicillin and Venereal Disease and Syphilis.

Film strips for professional groups are: Hookworm Disease and Hookworm Infection; Laboratory Diagnosis of Rabies; Laboratory Diagnosis of Tuberculosis (Part I); Life Cycle of a Malaria Parasite; Medical Certification of Causes of Death; Worms in Your Muscles: Spread and Prevention of Trichinosis and Taking Care of Diabetes (Kit includes 11 sound film strips, wall charts, and a teaching guide manual).

HEALTH OFFICER CHANGES

M. R. French, M.D., became director of the Kalamazoo City-County Health Department on September 8, resigning as director of the Branch-Hillsdale District Health Department.

Donald M. Harris, M.D., was appointed Director of the Branch-Hillsdale Health Department, effective August 8. Dr. Harris was in Michigan from 1946-48, first as director of the Chippewa County Health Department and later as head of the Chippewa-Luce-Mackinac District Health Department.

R. L. Loftin, M.D., resigned as director of the Bay City and Bay County Health Departments effective September 1, 1952.

Benton V. D. Scott, M.D., resigned as director of the Jackson City Health Department effective September 5, 1952.

Roelof Lanting, M.D., was appointed director of the Shiawassee County Health Department September 1, having resigned as director of the Lansing-Ingham County Health Department as of the same date.

Ernest Cook, M.D., has resigned as director of the St. Joseph County Health Department effective August 31.

J. C. Slaybaugh, M.D., has resigned as acting director of the Mason County Health Department and Mr. William Hasenbank, Chairman of the Mason County Board of Health, was appointed acting director to serve until a full-time director is appointed.

Mr. Ivan Miller, Chairman of the Mecosta-Osceola Board of Health, has been appointed acting director of the Mecosta-Osceola District Health Department to serve until a full-time director is chosen.

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RESEARCH IN THE SERVICE OF MEDICINE

In Memoriam

ANDREW L. HOENIG, M.D., of Cherokee, Iowa, died August 21, 1952, at the age of sixty-one. Dr. Hoenig became a member of the staff at the Iowa State Hospital ten months ago. Previous to that he had practiced medicine in Detroit for twenty years and earlier had practiced for five years in Mancelona, Michigan.

He is survived by his wife, Eve.

LEO G. JENTGEN, M.D., of Detroit, died August 10, 1952, at the age of sixty.

Dr. Jentgen was a surgeon and senior staff physician at Providence Hospital, Detroit. He joined the staff of Providence Hospital following his graduation from the University of Michigan Medical School in 1919.

He was a member of the American College of Surgeons.

Dr. Jentgen is survived by his wife, Madge; a daughter, Mary Margaret; one sister, Loretta, and two brothers, Frank Jentgen and C. J. Jentgen, M.D., of Detroit.

CHARLES H. O'NEIL, M.D., of Port Sanilac, died August 7, 1952, at the age of eighty-six.

Following his graduation from the Detroit College of Medicine in 1895, he began his practice at Deer River on Lake Superior, a lumbering center. Later he moved across the state to Black River on Lake Huron, another lumbering community. Following that he moved to Frederick, north of Grayling, where he spent ten years. In 1910, he came to Flint and continued the practice of medicine until his retirement in 1941.

Dr. O'Neil was a member of the Flint Board of Health from 1919 to 1928 and served as a member of the Hurley Hospital Advisory Board as well as becoming Chief of Staff. In 1922 he served as acting city health officer and was a member of the State Board of Registration in Medicine in 1925.

He is survived by his wife, Maude; two brothers, Edward, of Port Huron, and Dennis, of Detroit, and a sister, Mrs. David Sweet, of Port Huron.

WALTON K. REXFORD, M.D., of Detroit, died August 6, 1952, at the age of sixty-nine.

He had practiced medicine in Detroit since 1915. Dr. Rexford was graduated from the University of Michigan Medical School in 1908.

He was a member of the staff of Children's Hospital of Michigan and a consulting surgeon for Harper and Receiving Hospitals. Dr. Rexford was also an associate professor of urology at the Wayne University College of Medicine.

During World War I, Dr. Rexford served with the Medical Corps in France.

He was a Fellow of the American College of Surgeons and a diplomate of the American Board of Urological Surgery.

Dr. Rexford is survived by his wife, Hannah, a son, John, of Bay Village, Ohio, a daughter, Mrs. Charles Hawley of Pleasant Ridge, and four grandchildren.

LAWRENCE C. TOWNE, M.D., of Lansing, died August 16, 1952, at the age of sixty-eight.

For the past forty-three years he has served the community of Lansing, devoting his practice to internal medicine. He was graduated from the Northwestern Medical School in 1909.

He was a diplomate of the American Board of Internal Medicine and a Fellow of the American College of Physicians.

Dr. Towne is survived by his wife, Bess; two sons, William B. Towne, of Niles, and James B. Towne, of Wilmette, Ill.; and one daughter, Miss Mary R. Towne, of Chicago.

FRANK N. WILSON, M.D., professor of internal medicine at the University of Michigan, Ann Arbor, died September 11, 1952, at the age of sixty-one.

Dr. Wilson was known throughout the medical world for his development of the electrocardiograph.

He was graduated from the University of Michigan Medical School in 1913 and became an instructor there in 1914.

During World War I he served in the U. S. Army Medical Corps as a captain.

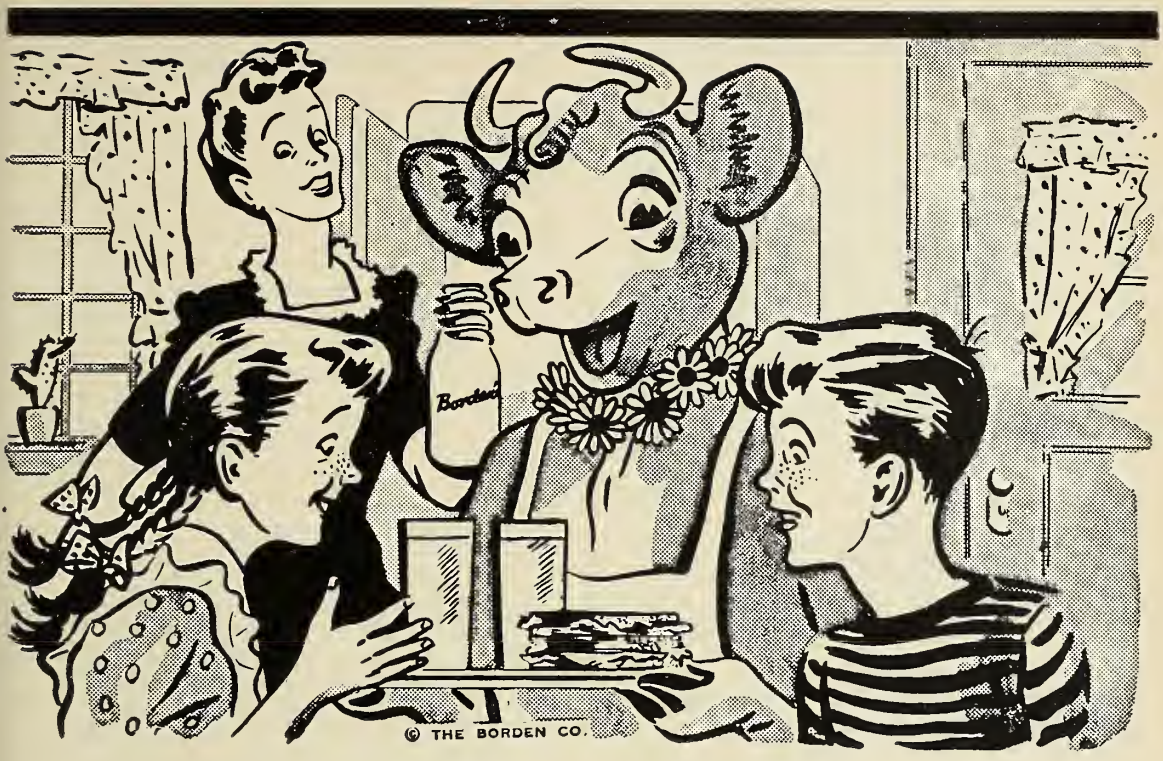
In 1922 he returned to the University of Michigan as a teacher and became a full professor in 1924.

During his career he received many honors from medical organizations throughout the world.

A special number of *Circulation*, the Journal of the American Heart Association, issued in July, 1950, was dedicated to him, and similar recognition was given him by the *American Heart Journal* in the November, 1950 issue. At the annual meeting of the American Heart Association in June, 1951, the highest honor which can be conferred by the organization, the Gold Heart Award was given Dr. Wilson in recognition of his scientific achievements.

Dr. Wilson was a diplomate of the American Board of Internal Medicine, and a member of the American and Michigan Heart Association, the Central Society for Clinical Research, the Association of American Physicians, the American College of Surgeons, the American Society for Clinical Investigation, and the American Society for Experimental Pathology.

He is survived by his wife, Julia, and a daughter, Mrs. Eugene Lepeschkis, of Vermont.



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obviates guesswork; you *know* which lead is recorded.

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Correspondence

Mr. Hugh W. Brenneman
Michigan State Medical Society
606 Townsend Street
Lansing 15, Michigan
Dear Mr. Brenneman:

Thank you for sending the copies of your excellent Medical Associates Brochure. This will be of tremendous help to us in formulating a similar plan for the North Carolina area and we believe the whole program pointed out in this brochure is very worthwhile.

Sincerely yours,

KENNETH E. PENROD, Ph.D.
Assistant Dean, Duke University, Durham, North Carolina

September 8, 1952

Dear Dr. Burns:

I am herewith enclosing a summary of the pertinent recommendations of the North Central States Conference on Brucellosis in Animals and Man, as relates to human brucellosis. Perhaps it would be desirable to convey this message to the members of the Society by publishing it in THE JOURNAL.

Please be assured of my appreciation in being asked to serve as representative of the Society at this conference.

Sincerely yours,

S. E. GOULD, M.D.
Wayne County Board of Institutions

Approved by:
R. M. ATHAY, M.D.
Superintendent
July 14, 1952

NORTH CENTRAL STATES CONFERENCE ON BRUCELLOSIS IN ANIMALS AND MAN

Herewith is submitted a report of the North Centra States Conference on Brucellosis in Animals and Man The Conference which was held in St. Paul, Minnesota at the Lowry Hotel, July 7, 8 and 9, 1952, was attende by approximately 150 representatives of interested organi zations from 14 states. Those attending included repre sentatives from U. S. Public Health, U. S. Bureau Animal Industry, state departments of health, stat veterinarians, veterinary and agricultural colleges, far organizations, cattle and hog raisers, farm publication live stock dealers, dairy producers and representativ from the state medical societies of Wisconsin, South D kota and Michigan. Only three representatives attend from Michigan: The Michigan State director of t Bureau of Animal Industry, the Chief Veterinarian the State Department of Health and the representati of the Michigan State Medical Society.

The program of the first day consisted of presentati of formal papers and a summary of each state's activiti on the control of brucellosis. On the second day ea representative was assigned to one of 10 task forc Each task force was given a specific subject for discussi and formulation of recommendations. The reports w read at the conclusion of the day. On the third day t recommendations of each task force were discussed the general assembly and final recommendations adopt

Specific points of special interest to medical men may be listed here.

The principal sources of human infection in order of importance in the U. S. are: first, cattle; second, hogs; and third, goats. Inasmuch as the disease in man is spread almost always from infected animals and their products, the eradication of human brucellosis depends on eradication of brucellosis in animals. As a result of the control measures now in force, there is definite evidence of decrease of the disease among animals in the U. S. and there is evidence that the disease can and will be eradicated both in animals and man. The chief methods of control and eradication among cattle at present are: (1) herd testing by means of abortus ring test of pooled specimens (from 1 to 3 cans) of milk; (2) blood agglutination of all cattle in herds having positive ring tests; isolation and eventual disposal, preferably by slaughtering, of reacting animals (those with positive agglutination test of 1:100 and over); vaccination, with standard vaccine, of calves between ages 4 and 8 months.

Approximately 75 per cent of all human infections are the result of occupational exposure and hence the disease acquires great importance as an occupational hazard, particularly among farm workers, live stock workers, veterinarians and dairymen. Approximately 25 per cent of human infection is the result of ingestion of non-pasteurized infected milk and milk products.

The disease in man cannot be diagnosed with certainty without the aid of the laboratory. For this reason it is exceedingly important to define clearly the tests that are of value and to indicate those that are not.

The only absolute confirmation of the diagnosis is a positive culture *(Br. abortus, Br. suis* or *Br. melitensis).* A culture may be positive in the absence of fever and even during or after antibiotic therapy. (Aureomycin is the drug of choice; penicillin has no value whatever in this disease.) If the blood culture is negative, cultures may be made of the sternal bone marrow, other infected tissue or secretion, a lymph node that has recently enlarged, the urine, cerebrospinal fluid or synovial fluid.

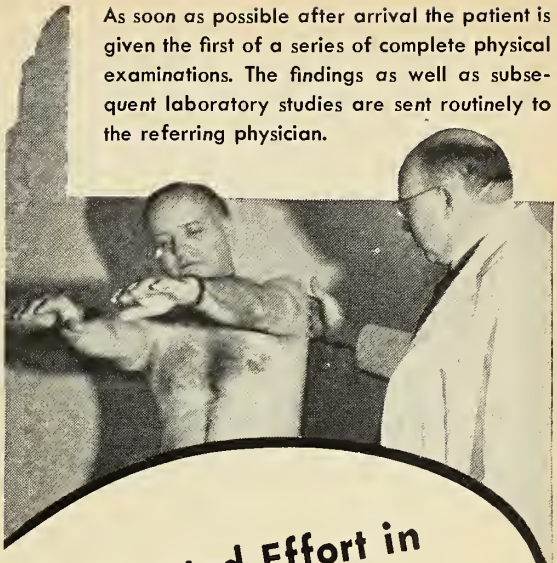
The skin test has about the same importance as the tuberculin test, a positive test indicating skin immunization, usually as a result of past exposure. It does not indicate that the patient has the specific infection at the time of the test. Consequently *the skin test should not be relied upon* for diagnosis. Likewise the opsonic test is unreliable and it is recommended that it *not be used.* The complement-fixation test is difficult to perform and *not* recommended as a routine procedure.

The agglutination test is of great value, a titer of 1:160 or over having diagnostic value, and especially a rising titer during the period of observation of the patient. The two most important points in performance of the agglutination test are the reliability of the antigen and the proper technique in conducting the test. The Conference recommended that the antigen prepared by the Bureau of Animal Industry be recognized as the standard antigen and that this antigen be made available to all laboratories. The Conference also recommended that the test be carried out according to criteria adopted by the National Research Council (see Diagnostic Criteria for Human Brucellosis, W. W. Spink et al., J.A.M.A., 149: 805-808, June 28, 1952).

Dear Doctor:

Your letter of enquiry to Dr. Wilfrid Haughey, Editor of the *State Journal* has been referred to us for reply.

The latest information we have concerning the reclassification of Priority III physicians by the Selective Service System, is that Priority I and II will be exhausted before calling Priority III. When they start calling Priority III they will be called by age bracket starting with the youngest in that group.



As soon as possible after arrival the patient is given the first of a series of complete physical examinations. The findings as well as subsequent laboratory studies are sent routinely to the referring physician.

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At all times the regimen of treatment is well coordinated under the direction of a staff of experienced full-time physicians who are members of the American Medical Association.

When you refer a patient to The Keeley Institute, you know that he will be taken care of as your patient and you are continually informed of his progress.

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Complete information, including rates, will be furnished to physicians on request.

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Migraine In Children

"Migraine may appear during the first years of life. The presence of subjective signs, such as headache and flimmer scotoma, is often difficult to determine in young children. The true nature of the symptoms frequently remains obscure for years."

Vahlquist, B. and Hackzell, G.: Acta Paediatrica *38:* 622 (1949).

NO. OF CASES	SEX	AGE AT ONSET	CYCLIC VOMITING	DURATION OF ATTACK	INTENSITY
31	8 ♀ 23 ♂	3 yrs. (mean)	3 out of 31	2½ hrs.	severe in all cases

TABLE CONT'D

NO. OF CASES	UNILATERAL HEADACHE	NAUSEA	FLIMMER SCOTOMA	VERTIGO	HEREDITY
31	18 out of 31	31 out of 31	12 out of 31	6 out of 31	20 out of 31

(reference given above)

In a study of 400 adult migraine patients, it was revealed that 34% had suffered attacks before the age of 15.* These investigators concluded that childhood migraine was a much greater clinical problem than was previously believed and that psychodynamic mechanisms played an important part in the disease.

These criteria are useful in diagnosis:

Headache attacks with symptom-free intervals plus (at least two of the following) nausea, scintillating scotoma, hemicrania, and hereditary predisposition.

For symptomatic relief in these cases, Cafergot®, N.N.R. (ergotamine with caffeine) may be administered orally. For best results, give adequate dosage promptly.

For children within the age range 7 to 12 years—Cafergot® is administered, one tablet when the attack appears imminent followed by one additional tablet within 30 minutes. Not more than two Cafergot tablets should be administered to children within this age range.

In the adolescent age group, 12 to 18 years of age, the dosage may gradually be increased as necessary up to the usual adult dose, i.e., two tablets when the attack appears imminent followed by one tablet doses at half hour intervals until the attack is aborted. *(Total maximum dose for adults: six tablets for each attack.)*

*Katz, J., Friedman, A.P., and Gisolfi, A.: New York State J. Med. *50:* 2269 (Oct.) 1950.

Sandoz Pharmaceuticals
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68 CHARLTON STREET, NEW YORK 14, N. Y.

Being classified 1-A and ordered for a pre-induction physical does not necessarily mean that orders to report for induction will follow immediately. It is very possible that the physical examination will disqualify a number in the older age bracket.

If this does not fully cover your questions, do not hesitate to call on us again.

Sincerely yours,
GROVER C. PENBERTHY, M.D.
Chairman, Michigan Volunteer Advisory Committee

Aug. 22, 1952

Dear Doctor Haughey:

This is to acknowledge your very good letter of August 25, 1952.

It is indeed gratifying to learn that the October issue of your JOURNAL will be devoted to the subject of diabetes, and we are most appreciative of your fine cooperation.

The material which you have outlined, including an editorial on diabetes by my good friend Doctor LeFevre will, I am sure, cover the subject adequately.

On behalf of the American Diabetes Association, I would like to take this opportunity to express our sincere appreciation for your interest and splendid assistance.

Very cordially yours,
JOHN A. REED, M.D., *Chairman*
Committee on Detection and Education
American Diabetes Association

Sept. 4, 1952

LUXURY PLACED BEFORE HEALTH

A spokesman for the U. S. Chamber of Commerce said today a "psychological law" keeps the average American from putting as much money into medical care as in an automobile or television set.

Emerson P. Schmidt, the organization's economic director, said the "low priority" the public gives to medical expenditures is responsible for some of the shortcomings of present medical services.

In testimony prepared for President Truman's commission on the nation's health needs, Schmidt made a spirited defense of voluntary health insurance programs and condemned proposals for compulsory insurance.

He said that if the public in the last 25 years had been as eager for "deluxe medicine" as for other items, the nation "would at present have an abundance of medical practitioners and facilities, just as in the case of automobiles."

"The normal person," he said, "buys a $2,500 automobile on the installment plan because he wants it. But a $2,500 operation he may regard as a violation of social justice."

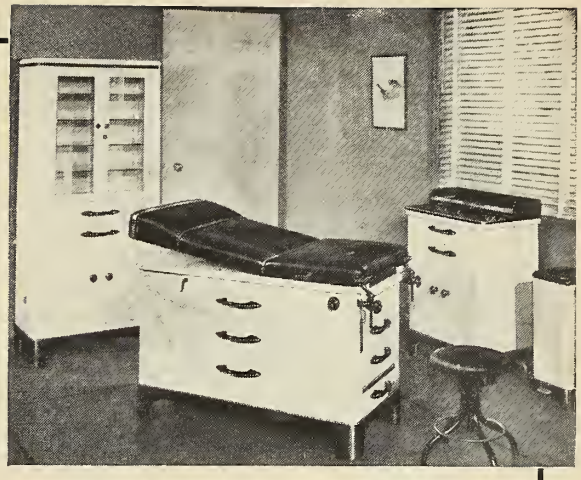
Schmidt was one of a series of witnesses to appear before the commission at public hearings on the hotly disputed question of how the nation can best pay for adequate health care.—*Lansing State Journal,* October 9, 1952.

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Hamilton Steeltone examining room equipment embodies many exclusive features that make your office more productive. Counterbalanced top—Fit-All disappearing stirrups and built-in Glide-A-Roll, Ster-O-Sheet table cover attachment are all patented and available only in Hamilton equipment.

Steeltone—conservative in appearance, professional in design, and constructed of heavy, electrically welded furniture steel is a wise choice in modern examining tables and treatment and instrument cabinets. Finish is chip-proof, acid-resistant Du Pont Dulux. Available in white or five colors that harmonize with modern room decorating schemes. Come in and see our display of Steeltone and the complete line of Hamilton examining tables and cabinets soon, won't you?



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$10,000 accidental death Quarterly $16.00 **$50 weekly indemnity, accident and sickness**	**$20,000 accidental death Quarterly $32.00** **$100 weekly indemnity, accident and sickness**

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60 days in Hospital	5.00 per day	10.00 per day	15.00 per day	20.00 per day
30 days of Nurse at Home	5.00 per day	10.00 per day	15.00 per day	20.00 per day
Laboratory Fees in Hospital	5.00	10.00	15.00	20.00
Operating Room in Hospital	10.00	20.00	30.00	40.00
Anesthetic in Hospital	10.00	20.00	30.00	40.00
X-Ray in Hospital	10.00	20.00	30.00	40.00
Medicines in Hospital	10.00	20.00	30.00	40.00
Ambulance to or from Hospital	10.00	20.00	30.00	40.00
COSTS (Quarterly)				
Adult	2.50	5.00	7.50	10.00
Child to age 19	1.50	3.00	4.50	6.00
Child over age 19	2.50	5.00	7.50	10.00

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NEWS MEDICAL

MICHIGAN AUTHORS

D. Emerick Szilagyi, M.D.; R. Ralph Margulis, M.D., and **Gilbert D. Jay, III, M.D.,** of Detroit, are the authors of an article, "Observations on Effects of Corticotropin (ACTH) and Cortisone in Management of Some Postoperative Surgical Problems," published in the *Archives Of Surgery,* August, 1952.

Franklin H. Top, M.D., of Minneapolis, Minnesota, formerly of Detroit, is the author of an article, "Ammunition Against Infections," published in *The American Academy of General Practice,* September, 1952.

Reed M. Nesbit, M.D., of Ann Arbor, read a paper, "Problems Relating to the Recognition of Hydronephrosis in Everyday Medical Practice," October 1, 1952, at the annual meeting of the Medical Society of the State of Pennsylvania.

V. Everett Kinsey, M.D., and **Charles E. Frohm, M.D.,** of Detroit, are the authors of an article, "The Aqueous Plasma Steady-State-Ratio of XYLOSE," published in the *American Journal of Ophthalmology,* August, 1952.

* * *

Official estimate of tuberculosis cases reduced.—Public Health Service and National Tuberculosis Association have revised downward by 20 per cent their estimate of the total number of active tuberculosis cases in the country. The new figure of 400,000 replaces the half-million estimate used during the past ten years. Of the total, it is estimated that 150,000 cases are undiscovered. PHS notes that the older estimate was based on mortality data, while the present estimate was arrived at through an inventory of tuberculosis cases registered with local health departments and on findings of chest x-ray programs.

* * *

Survey Research Projects.—The Committee on Research of the AMA Council on Pharmacy and Chemistry will soon mail questionnaires to determine what medical research projects are in progress in the U. S. at the present time. The survey has a three-fold purpose: to establish an up-to-date file of medical research projects; to evaluate the premise that certain fields of medical research are suffering from lack of financial support, and to consider the actual contributions of individual scientists in terms of free time and personal expenditure of funds. A random sample of 15,000 physicians from all parts of the country and selected personnel from medical schools, public health services, and pharmaceutical firms will be asked to participate in the survey.

New Office Opens September 1.—The new office of the Joint Commission on Accreditation of Hospitals, at 660 Rush Street, Chicago, opened on September 1. Dr. Edwin L. Crosby, former superintendent of Johns Hopkins Hospital, Baltimore, is director of the Commission, which will assume responsibility for the hospital standardization program formerly carried out by the American College of Surgeons.

* * *

Free Advice for Doctors.—Timothy Turner, columnist for the *Los Angeles Times,* wrote an article recently about the reading material usually found in doctors' offices. He studied the subject in detail and then came up with some ideas.

He said magazines for doctors' offices should be the ones that have short stories or articles. Continuing, he said:

"This leaves out such publications as the *Saturday Evening Post* and *Collier's,* for they have full-length articles and long short stories. One may have to wait for the doctor an hour or more, but hope springs eternal that he will not have to wait long, so he does not want to start a long story, for he may not be able to finish it.

"Here is my list: *Newsweek, Reader's Digest, Life, Holiday, National Geographic, Harper's Bazaar, Vogue, Seventeen, Business Week, New Yorker, Esquire,* and *Today's Health* (formerly *Hygeia*), an American Medical Association magazine."

* * *

Doctors and Drug Companies.—In his Sunday evening, September 14, TV broadcast, Drew Pearson predicted that the Federal Government will dissolve five New York drug companies, because 700 doctors own stock in the companies, and there is a suspicion that they might prescribe drugs for their personal profit rather than the benefit of the patients. This was given in a tone far from friendly.

* * *

Louis H. Bauer, M.D., President of the American Medical Association, addressing the national convention of the American Legion in New York, said it was heartening in this critical year of 1952 "to see that both of our major political parties—one of them directly and the other by implication—have recognized that great upsurge of public opinion on the issue of socialized medicine."

"The health plank in the Republican party platform," he continued, "includes the outright statement that 'We are opposed to Federal Compulsory Health Insurance with its crushing cost, wasteful inefficiency, bureaucratic dead weight, and debased standards of medical care.'

"The Democratic party platform—adopted by a convention representing the views of the party rank-and-file, in contrast to the views of a handful of planners in the executive department of the federal government—contains no endorsement of Compulsory Health Insurance, as has been the case with previous platforms, but simply urges a resolute attack against the financial problems involved in serious illness.

"In view of what has been happening during the last three or four years, both party actions confirm the validity of the medical profession's case against socialized medicine. The two party platforms also give reason for hope that never again will the people's health be used as a football in the political arena. Above all, however, they constitute a timely tribute to the forces of an aroused public opinion."

Dr. Bauer covered a wide range of subjects in his Legion talk, including constitutional rights, bureaucracy in government, corruption, confiscatory taxes, socialism, propaganda and the Federal Security Agency, states' rights, the tremendous growth of voluntary health insurance plans, and the International Labor Organization.

"The American Medical Association and the American Legion have much in common," he said. "Not only are they jointly interested in the health and welfare of the veteran, but they also have provided the main leadership in the drive against the socialism which is steadily creeping over this country."

Dr. Bauer said that American physicians will be forever grateful to the Legion for its early, vigorous and continued support against socialized medicine.

* * *

Michigan Medical Service, as of July 31, 1952, had 548,742 persons covered by its voluntary surgical or medical-surgical plans. At the same time, Michigan Hospital Service had 2,688,248. Of these, Federal, State and local government employes amounted to 84,870; school units amounted to 58,218.

Since its inception until July 31, 1952, Michigan Medical Service has paid out to doctors for medical services $7,328,000 at an average overhead of 10.86 per cent. Michigan Medical Service owns an office building in Detroit which it will occupy in 1953, the Burnham-Brople Building.

There is a reserve for contingencies of $5,126,039.42.

* * *

Max Karl Newman, M.D., served as chairman of the national meeting of the American Federation of the Physically Handicapped, at the Statler Hotel, Detroit, Michigan, August 10-12, 1952. He moderated a medical panel on medical rehabilitation, of which Dr. Michael Hanchook, M.D., medical director of the Detroit Transmission Company, was a participant.

* * *

Health Plans Gain Widely in Nation.—85,991,000 persons in the United States had hospital insurance in 1951, a rise of 12 per cent. More persons in this country are protected through voluntary plans against sickness and accident in 1951 than ever before, according to the results of a survey released by the Health Insurance Council of the Institute of Life Insurance in its annual report on accident and health coverage in the United States.

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After allowing for duplication of coverage, there were 85,991,000 persons with protection against hospital expense when 1951 ended, an increase of 12 per cent over the 76,961,000 persons covered a year earlier. Compared with ten years earlier, coverage had increased by nearly 70,000,000 persons. This type of protection, the council explained, provides benefits toward payment of hospital charges for room, board, et cetera.

* * *

Postgraduate Courses in Vienna.—One of the brightest spots in the University of Vienna's fame as a medical center has always been its postgraduate courses and, if the current plans of a group of Viennese physicians are brought to fruition, these courses will begin once again to play an important role in the training of American doctors.

During the years preceding World War II, thousands of American doctors attended the courses given by the University's famous Academy of Medicine. Most of these American medical men came to Vienna under programs arranged by the American Medical Association of Vienna.

The Association became defunct in 1938, but a number of Viennese and American professors formerly associated with it have—for some time—felt that a similar organization would be a valuable means of facilitating study in Vienna by American doctors.

Many of Vienna's greatest specialists are still teaching in the Academy and contrary to popular belief, many of the clinical facilities in Vienna are actually on a higher level than they were in prewar times.

A complete course registry listing over 515 English language courses has been prepared, together with other materials. Registrations for courses can be made at any time throughout the year. Applications should be sent directly to the Vienna Academy of Medicine, Allgemeines Krankenhaus, Wien IX, Alserstrasse 4, Austria.

* * *

The American Society of Physical Medicine and Rehabilitation at its annual session in New York, August 28, 1952, elected Max Karl Newman, M.D., of Detroit, secretary-treasurer.

* * *

The 8,055 Mobile Army Surgical Hospital (MASH), the first of its kind in Korea, has just treated and evacuated its 50,000th battle casualty.

The 200-bed MASH, organized two weeks after the outbreak of the Korean war, has been at its present location, just behind the front lines since last October.

Helicopters and ambulances have brought in wounded troops from American, Korean, British, Canadian, Australian, New Zealand, Filipino, Turkish, Colombian, Ethiopian, Thai, French, Netherland, Belgian, Luxembourg and Greek units. Hospital personnel take pride in the amazing patient recovery rate of 99.8 per cent.

Maj. Jeremiah Holleman, MC, Columbus, Miss., heads the staff of 15 American and Canadian doctors, one American dentist, 16 nurses and 181 other officers and enlisted men assigned to administrative and technical duties. The nursing staff, under Capt. Lorena M Goodell, ANC, Syracuse, N. Y., includes nurses from the Netherlands, France, Greece, and the United States.



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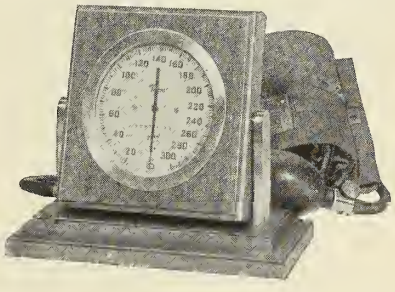
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Priority III Physicians Classified.—Local draft boards on July 31 had processed 2,038 of the 32,636 physicians in Priority III. However, no call-ups from Priority III are anticipated until March at least. The plan is to call the younger men first. Priority III physicians are those who have had no military service, but were neither educated by the government nor deferred from World War II service to continue their education.

* * *

The Wayne County Academy of General Practice and the Michigan Academy of General Practice will sponsor a two-day Postgraduate Clinic at the Kellogg Center, East Lansing, November 17-18, 1952. This will be the sixth annual clinic co-sponsored by the two GP academies.

The host of subjects—from pediatrics to geriatrics—will feature the following guest lecturers: C. E. Dutchess, M.D., New York, on Geriatric subject; R. B. Greenblatt, M.D., Augusta, Ga., on "Functional Uterine Bleeding"; Gene H. Stollerman, M.D., New York, on "Rheumatic Fever"; D. L. Show, Jr., M.D., Philadelphia, on "Infant Nutrition"; G. S. Bates, M.D., Detroit, on "Blood and Blood Substitutes"; D. A. Cameron, M.D., Detroit, on "Trauma"; R. T. Costello, M.D., Detroit, on "Management of Degenerative Neurological Diseases"; G. S. Fisher, M.D., L. E. Bauer, M.D., and J. H. Curhan, M.D., all of Detroit, on panel covering "Abnormal States During Pregnancy"; A. S. Friedlaender, M.D., Detroit, on "The Antihistamines in Allergy"; S. W. Hoobler, M.D., Ann Arbor, Moderator of a Heart Panel by Grand Rapids, Ann Arbor and Detroit cardiologists; S. D. Jacobson, M.D., Detroit, on "Treatment of Obesity"; H. J. Kullman, M.D., Dearborn, on "Peptic Ulcer"; K. J. McMorrow, M.D., Detroit, on "What Does Modern Rehabilitation Offer?"; D. B. Marcus, M.D., Detroit, on "The Office Management of Diabetes"; D. W. Myers, M.D., on "Common Non-Tuberculous Pulmonary Diseases"; A. E. Schiller, M.D., Detroit, on "The Pruritides"; E. D. Spalding, M.D., Detroit, on "Differential Diagnosis of Coma"; P. V. Woolley, Jr., M.D., Detroit, on "Physiologic Treatment of Infant Diarrhea."

The annual meeting of the Michigan Academy of General Practice will be held on Monday, November 17, after luncheon. Plans to form a Congress of Delegates will be presented at this meeting.

The annual banquet will be held Monday, November 17, with Mr. Russell Barnes of the *Detroit News* as guest speaker.

Special entertainment for the ladies is being arranged.

The slogan of the 1952 Postgraduate Clinic is "Every GP a PG."

* * *

The Upjohn Company announces that Robert W. Heinle, M.D., has joined its Medical Division as of September 1, 1952. Dr. Heinle, a recognized authority on hematology, will be in the Department of Clinical Investigation, being concerned chiefly with studies in nutrition.

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The pathologist in direction is recognized by the Council on Medical Education and Hospitals of the A. M. A.

Blue Cross-Blue Shield Commission, Chicago, recently announced the appointment of J. Walter Thompson Company of Chicago as advertising counsel. These two Commissions co-ordinate the activities of the eighty-one Blue Cross and the seventy Blue Shield plans located throughout the United States.

* * *

Mrs. Robert S. Breakey, Lansing, President of the Woman's Auxiliary to the Michigan State Medical Society during the past year, was featured as "Personality of the Week" in the August 17 *State Journal,* Lansing, Michigan. The eulogistic article was entitled "Local, National Improvements Are Her Aims." A subtitle stated "Mrs. Breakey will really work if she believes the cause is just."

Congratulations, President Breakey, on a well-deserved orchid from your home-town newspaper!

* * *

The Psychiatry and Neurology Division of the Veterans Administration is providing a four-months in-service training course in psychiatry and neurology for physicians who are interested in this field and in employment by the Veterans Administration. These courses start January 15, 1953.

Vacancies exist throughout the country and there are many opportunities for advancement.

For full information, those interested should address the Manager of the Veterans Administration Hospital, Fort Custer, Michigan, or the Veterans Administration Central Office, Washington 25, D.C., Attention, Psychiatry and Neurology Division.

* * *

Louis K. Diamond, M.D., of Boston, addressed the Flint Academy of Internal Medicine on October 7 in Flint. His subject was: "Natural History and Management of Purpura Hemorrhagica." John Parks, M.D., of Washington, D. C., also spoke to the Flint Academy on "Ovarian Tumors."

* * *

The fourth annual Michigan Industrial Health Day is scheduled for Tuesday, March 10, 1953, in the Sheraton-Cadillac Hotel, Detroit.

All members of the Michigan State Medical Society are cordially invited to attend and hear an interesting program devoted to subjects of industrial medicine and surgery.

E. A. Irvin, M.D., President of the national Industrial Medicine Association, will be honored at a banquet in the Sheraton-Cadillac Hotel which will follow the day's clinic, sponsored jointly by the Michigan Industrial Medicine Association and the Michigan State Medical Society.

T. I. Boileau, M.D., of Detroit, is President and Edwin De Jongh, M.D., of Detroit, is Secretary of the Michigan Industrial Medicine Association. For program, write Dr. Edwin DeJongh, 12400 W. Outer Drive, Detroit, Michigan.

The Industrial Health Day will immediately precede the 1953 Michigan Clinical Institute (scheduled for March 11-12-13.)

* * *

The Texas Medical Association dedicated its new

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Memorial Library Building, located at 1801 Lamar Boulevard, Austin, Texas, on September 21.

Congratulations, physicians of Texas!

* * *

The Toledo Academy of Medicine moved into its new T.A.M. office and library building, located at 3103 Collingwood Avenue, Toledo, on September 19. The formal dedication ceremony was attended by many notables, with the chief address being given by the President-elect of the American Medical Association, E. J. McCormick, M.D., Toledo.

Congratulations, physicians of Toledo, Ohio!

* * *

The 1952 Michigan Welfare League Conference will be held at the Fort Shelby Hotel, Detroit, Monday-Tuesday-Wednesday, November 10-11-12, 1952. The theme for this year's Conference will be "Human Values in Democracy."

* * *

M. H. Hoffmann, M.D., Detroit, was awarded the honorary degree of Doctor of Laws by his alma mater, Loras College of Dubuque, Iowa, at its summer convocation, August 1, 1952.

Congratulations, twice-Doctor Hoffmann!

* * *

Urology Award.—The American Urological Association offers an annual award of $1000.00 (first prize of 500.00, second prize $300.00 and third prize $200.00) for essays on the result of some clinical or laboratory research in Urology. .Competition shall be limited to urologists who have been in such specific practice for not more than five years and to men in training to become urologists.

The first prize essay will appear on the program of the forthcoming meeting of the American Urological Association, to be held at the Hotel Jefferson, St. Louis, Missouri, May 11-14, 1953.

For full particulars write the Executive Secretary, William P. Didusch, 1120 North Charles Street, Baltimore, Maryland. Essays must be in his hands before January 15, 1953.

* * *

Cost of Living—Cost of Medical Care.—During the last decade the cost of living went up 69 per cent. The total hospital bills went up 67 per cent. Many of these, of course, depend upon the cost of food and wages. The cost of prescriptions only went up 37 per cent and cost of doctors' fees only went up 38 per cent. These figures are from the Department of Labor.

In ten years the cost of medical care has not risen nearly as much as the cost of living:

Cost of living	Up 69%
Hospital bills	Up 67%
Cost of prescriptions	Up 37%
Doctor's bills	Up 38%

—*Michigan Health Council Bulletin,* August, 1952.

* * *

The Veterans Administration is instituting a four-month intensive training course in psychiatry and neurology to fit the needs of physicians without such pre-

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vious training who are assigned to duty in 22 predominantly psychiatric hospitals. Physicians who have been engaged in general practice may request this training upon applying for a position at one of these hospitals.

The course will be held at the VA Hospitals in Coatesville, Pennsylvania; Palo Alto, California; and at Downey-Hines, Illinois, near Chicago. Physicians will be employed at salaries commensurate with their training and experience (salary range: $5,500 to $11,800 per annum) and assigned to the course with travel and per diem for the four-month period.

Information and applications may be obtained from your nearest VA Hospital or Regional Office, or by writing to the Chief Medical Director, Veterans Administration Central Office, Washington 25, D. C.

* * *

What a Joke!—A pamphlet entitled "Platform for You and Your Family" came across my desk recently. It was published by the Public Affairs Institute, 312 Pennsylvania Avenue S.E., Washington, D. C., which calls itself "a nonpartisan, nonprofit research and educational organization." Yet the one-sided health section in the pamphlet was prepared by the Committee for the Nation's Health, which has been fighting in behalf of socialized medicine for years.

An introductory page in the pamphlet, written by Dewey Anderson, the executive director, states that the Public Affairs Institute "does not participate in political action nor suggest partisan solutions of problems of child welfare, education, health, housing and social security."—George F. Lull, M.D., AMA Secretary and General Manager.

* * *

The average doctor of medicine last year earned $12,518.00, or $980 more than in 1950, according to the Office of Business Economics of the Department of Commerce, based on a mail survey. As in the past, the independent physician did better ($13,378) than his salaried colleague ($9,522). Of an estimated 750,000 physicians in the United States, 38,500 hold salaried positions.—*Newsweek*, August 4, 1952.

It is estimated that Michigan has 16,500 active cases of tuberculosis. Of these, 10,300 are known to health departments and 6,200 are unknown. Of the known cases, 4,740 are under supervision in homes or diagnosed active but not checked within the past year.

These are estimates derived by applying national estimates to Michigan's population.

Michigan has 5,566 cases hospitalized, including tuberculosis cases in mental and penal institutions. There were 6,144 new cases reported in 1951, about two thirds of them active.

These are actual records. But neither of these figures is the full measure of tuberculosis cases requiring isolation and treatment.

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HARACTERISTICS OF A SUCCESSFUL DMINISTRATOR

A successful "administrator" must delegate work. To hom do you delegate work? whom do you promote? hom do you support for promotion? Such a person ıust show emphatic evidence of a capacity to:

1. **Laugh at one's self.** (Important.) See how funny you are and accept it. Those that can't laugh at themselves laugh at other people.
2. **To live in the present.** Look out for those that keep talking about the good old days. Usually they don't know what's going on now. So much going on now there is no time for the past.
3. **To demonstrate a chronic propensity to give more than he takes.** Put more in than you expect to get out. It must be chronic, not just some temporary thing to take care of a particular situation.
4. **Suffer a present frustration in order to accomplish a larger future goal.**
5. **Never make the same error twice.** This seems innocuous. However, it implies that the individual recognizes the error—must see it himself—and admits it. It's necessary to admit errors when made in order to prevent repetition.
6. **To direct antagonism toward suitable targets.**
 (a) Poverty
 (b) Mosquitoes
 (c) Golf balls
 (d) Et cetera

Need to direct antagonism where it will do no harm. Humans are very fragile persons. Words hurt. Most people have to learn to control antagonism.

PROF. CHARLES GRAGG, Harvard University

* * *

E. J. Brunette was named Convention Manager of Grand Rapids as of September 1. He succeeds Frank H. Whitwam who is ill.

Mr. Brunette was a long-time Assistant Manager of the Pantlind Hotel in Grand Rapids.

* * *

Physician needed at local federal agency.—A qualified doctor of medicine interested in a newly established position is urgently needed to provide part-time medical assistance for employes at a local federal agency, it was announced recently by Lieutenant Colonel Thomas A. Rice, Public Information Officer for Army Ordnance in Detroit. Working conditions can be arranged so as not to interfere with the existing medical practice of accepted applicant.

Mail inquiries may be addressed to the Public Information Office, Army Ordnance, 574 East Woodbridge, Detroit 31, Michigan.

* * *

Trauma Meeting.—On Wednesday, November 12, 1952, the Michigan Regional Committee on Trauma of the American College of Surgeons is presenting the First Annual Symposium on Trauma under the auspices of the College of Medicine of Wayne University. There will be twenty-two illustrated ten-minute talks on a wide

Say you saw it in the Journal of the Michigan State Medical Society

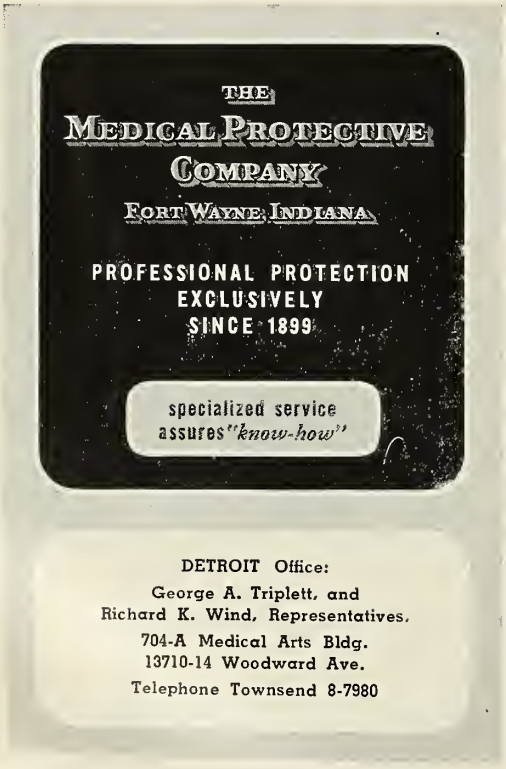
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Surgical Technic, Surgical Anatomy and Clinical Surgery, four weeks, starting October 20.
Surgical Anatomy and Clinical Surgery, two weeks, starting November 3.
Surgery of Colon and Rectum, one week, starting October 20, November 17.
Gallbladder Surgery, ten hours, starting October 20.
Bronchoscopy, one week, by appointment.
General Surgery, one week, starting October 6.
General Surgery, two weeks, starting October 6.
Breast and Thyroid Surgery, one week, starting October 6.
Esophageal Surgery, one week, starting October 13.
Thoracic Surgery, one week, starting October 20.
Fractures and Traumatic Surgery, two weeks, starting October 6.
GYNECOLOGY—Intensive Course, two weeks, starting October 20.
Vaginal Approach to Pelvic Surgery, one week, starting November 3.
OBSTETRICS—Intensive Course, two weeks, starting September 29, November 3.
MEDICINE—Intensive General Course, two weeks, starting October 13.
Gastroenterology, two weeks, starting October 27.
Gastroscopy and Gastroenterology, two weeks, starting November 3.
CYSTOSCOPY—Ten-day Practical Course starting every two weeks.
DERMATOLOGY—Intensive Course, two weeks, starting October 13.

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variety of subjects given by a faculty drawn from eleven departments of the College of Medicine and the profession at large. Provision has been made during a morning and afternoon intermission for actual demonstration of the surgical care of patients on the wards of Receiving Hospital. In these demonstrations, the speakers will be assisted by the surgical staff and residents of the Department of Surgery. A buffet luncheon will be served in the Auditorium through the courtesy of the Chrysler Corporation.

PROGRAM

Morning Session—9:00 A.M.

1—"The Problem of the Severed Tendon,"
JOSEPH L. POSCH, M.D., Detroit
2—"Fractures of the Shaft of the Tibia,"
A. JACKSON DAY, M.D., Detroit
3—"Principles of Treatment of Wounds of the Face,"
J. HARDEE BETHEA, M.D., Detroit
4—"Principles of Wound Healing in Trauma,"
CHARLES G. JOHNSTON, M.D., Detroit

WARD WALK—Receiving Hospital—10:00 A.M.

Morning Session—11:00 A.M.

1—"Control of Bleeding and Treatment of Shock,"
ALFRED M. LARGE, M.D., Detroit
2—"Important Anatomical Considerations in Trauma,"
ERNEST D. GARDNER, M.D., Detroit
3—"Fracture of the Ribs,"
PAUL V. O'ROURKE, M.D., Detroit
4—"Treatment of Fractures of the Forearm, Practical Aspects,"
ANGUS G. GOETZ, M.D., Detroit
5—"Basic Principles of Vascular Surgery,"
EUGENE A. OSIUS, M.D., Detroit

Buffet Luncheon—12:00-1:30 P.M.

Afternoon Session—1:30 P.M.

1—"Bacteriology in the Surgery of Trauma,"
CLYDE S. RIGHTS, M.D., New Haven, Conn.
2—"Thoraco-Abdominal Wounds,"
WILLIAM M. TUTTLE, M.D., Detroit
3—"Penetrating Wounds of the Adomen,"
LAWRENCE FALLIS, M.D., Detroit
4—"Principles of the Treatment of Skull Fractures,"
E. S. GURDJIAN, M.D., Detroit
5—"The Open Method for Treatment of Burns,"
MERLE M. MUSSELMAN, M.D.
6—"Fractures of the Surgical Neck of the Femur,"
HERBERT E. PEDERSEN, M.D.

WARD WALK—Receiving Hospital—2:30 P.M.

Afternoon Session—3:00 P.M.

1—"The Hazards of Blood Transfusion,"
CHAS. G. JENNINGS, M.D., Detroit
2—"Neurological Aspects of Injury to the Spinal Column,"
JOHN E. WEBSTER, M.D., Detroit
3—"Nutrition of the Post-operative Patient,"
GAYLORD S. BATES, M.D., Detroit
4—"Transportation of the Injured,"
HAROLD W. WOUGHTER, M.D., Detroit
5—"Trauma to the Eye,"
ALBERT D. RUEDEMANN, M.D., Detroit
6—"Fracture of the Tibial Plateau,"
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SENHOWER OPPOSES)CIALIZED MEDICINE

Dwight D. Eisenhower spoke out emphatically against)cialized medicine" Sunday as leading toward "assembly e treatment" of patients.

The Republican presidential nominee said the Ameri- ı people received the world's best medical care now. cautioned against "any foolish experiment" that uld "nullify what our present system already achieved."

:n a statement issued shortly before starting on his ıpaign tour, Eisenhower said:

'Any move toward socialized medicine is sure to have result: instead of the patient getting more and better lical care for less, he will get less and poorer medical e for more."

he General declared a patient under Federally oper- l medical care would suffer as a taxpayer, too, "be- se it would require a whole new army of Government ks to handle the records that would be an essential of a compulsory system."

isenhower said he recognized that local, state and eral Government had a responsibility "to assist the)rtunate, but it must not be in ways that will :n or weaken the benefit already available to the vast)rity."

am opposed," he said, "to a Federally operated and rolled system of medical care which is what the inistration's compulsory health insurance scheme is, ıct."

Eisenshower said the progress of American medicine has been no accident.

He said "it was achieved because doctors and scientists had their hearts in their work, doing what they wanted to do and not what they were compelled to do."

But the General said the effect of compulsory methods on patients was "still more important." He declared:

"The patient may fear—and no doubt correctly in many cases—that he would receive regimented, assembly line treatment instead of care that is tailored to his individual needs."—*Detroit Free Press,* September 15, 1952.

HOXSEY RULING STRENGTHENS FEDERAL PROSECUTION AUTHORITY, FDA SAYS

A U. S. Court of Appeals decision in the Hoxsey Clinic of Texas case has greatly strengthened the hand of the government in its fight against worthless cancer remedies, according to Food and Drug Commissioner Charles W. Crawford. The decision was handed down at New Orleans, reversing a District Court ruling.

Of importance in future federal actions, according to FDA, is the Appeals Court's decision that testimony of lay witnesses that they had cancer, or were cured of cancer, has no value in the eyes of the court.

The lower trial court judge had refused to issue an injunction against the Hoxsey Clinic. After reviewing the testimony of the fifty medical witnesses and cancer experts who testified for the government, and the twenty-five defense witnesses, the Appeals court ordered an injunction against Harry M. Hoxsey and the Hoxsey Cancer Clinic (Dallas), prohibiting shipment of their products across state lines to cancer patients.

THE DOCTOR'S LIBRARY

Acknowledgment of all books received will be made in this column, and this will be deemed by us as full compensation to those sending them. A selection will be made for review, as expedient.

THE UNIPOLAR ELECTROCARDIOGRAM. A Clinical Interpretation. By Joseph M. Barker, M.D., F.A.C.P., Cardiologist, Yater Clinic; Associate Professor of Clinical Medicine and Special Lecturer in Physiology, Georgetown University School of Medicine; Director of the Heart Station and Visiting Physician, Georgetown University Hospital; Chief of Cardiology, Providence Hospital; Visiting Physician, Gallinger Municipal Hospital; Consulting Cardiologist, Arlington Hospital, Arlington, Virginia. Assisted by Joseph J. Wallace, M.D., F.A.C.P.; Advised by Wallace M. Yater, M.D., F.A.C.P. Foreword by Frank N. Wilson, M.D., F.A.C.P. New York: Appleton-Century-Crofts, Inc., 1952.

As Dr. Wilson has so aptly stated in his foreword; "There are a great number of electrocardiographic books ranging in scope from the briefest introduction to the PQRST's of the subject to treatises in the "Handbuch" class. There is a vast and mostly indigestible periodical literature. All of these are of value."

One, therefore, is pleased to have access to a new comprehensive, yet simple, book dealing with the unipolar electrocardiogram. The author has maintained simplicity by translating mathematical formulae and terminology into prose form and by the use of detailed descriptions. These latter are of such length as not to be boresome. Numerous original line drawings supplement the text, and although unipolar electrocardiography deals primarily with considerations of the ventricular complex, a section on the cardiac arrhythmias is included.

Almost all of the material is from personal observation on patients of the Yater Clinic and Georgetown University Hospital. Among the original observations the following seem worthy of note: indications for the exercise test in the diagnosis of angina pectoris; indications for leads from higher levels upon the precordium in high antero-lateral infarction; demonstration of diffuse intraventricular block and criteria for diagnosis; more precise criteria for the diagnosis of right ventricular hypertrophy complicated by complete and incomplete right bundle branch block, and the relationship between the transitional zone of the precordial electrocardiogram and cardiac position in left ventricular hypertrophy.

The format of this book is very good. Parts to be emphasized are in heavier print and the illustrations, drawings and tables are excellently presented. The author is to be congratulated on producing such a fine book. It achieves its primary purpose of furnishing guidance in unipolar electrocardiography to students and physicians.

G.W.S.

COWDRY'S PROBLEMS OF AGEING BIOLOGICAL AND MEDICAL ASPECTS. Third Edition edited by Albert I. Lansing, Ph.D. Washington University, St. Louis. Baltimore: The Williams & Wilkins Co., 1952. Price $15.00.

This third edition of a widely known book covers what has transpired in gerontology since 1942 and reports the opinions of a group of gerontologists as to significant trends and profitable areas for further work on ageing. Lansing's forty-eight contributors thoroughly cover both normal and pathological aspects of ageing. Throughout the book there is expressed a need for clarification of the relation between degenerative disease and ageing. Some say that the process of ageing begins with the fetus; others have designated almost every age from thirty-five on as the start of the "declining years." To most physicians, the calendar year at which the "ageing problems" becomes important is not the chief problem. The problem is the need to distinguish between, on the one hand, the changes that are natural and only to be expected in the ageing body and on the other hand, the chronic and degenerative conditions that appear most frequently in the later years of life.

In this most excellent treatise on these problems, some chapters discuss the body from the biological and cellular angle, some treat of specific clinical or organic problems and still others consider the social and economic adjustment of older people. Each chapter is actually a monograph on the specific subject. It treats and hence makes for easier and more interesting reading for the busy practitioner. The continuity is good, however, and each chapter presents information that is vital to every

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ysician in practice today—since the average age of patients will continue to reflect the fact that ours an ageing population.

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G.W.S.

. Russian wolf-hound came over to this country and an American dog.

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DIABETES RETINITIS

(Continued from Page 1343)

logic to say the least, so it is logical to believe that those patients who avoid these factors for the greatest portion of each twenty-four hours are the ones who will be freest from active diabetes. Equally as important as the avoidance of glycosuria and hyperglycemia is the insistence upon freedom from obesity.

Rapid progression, however, is not so much a matter of individual variation as it is a matter of failure of control over long periods of each day or night.

The fact that the early retinal aneurysms, as described by Ballantyne, occur in untreated diabetes and may be seen to disappear when diabetes is controlled should be sufficiently encouraging to impress us with the importance and the efficacy of caloric regulation.

Summary

Among the earliest organic changes found in diabetes is the appearance of capillary micro-aneurysms in the perimacular area of the retinae. Vision may remain normal for many years in spite of the existence of aneurysms. Retinal changes in diabetes can be retarded for an indeterminate number of years when treatment conforms to the known experimental and clinical laws which regulate diabetes.

Causes of failures: Considering diabetes as a disease of carbohydrate metabolism rather than a disease of total metabolism. Prescribing insulin for an obviously obese diabetic. Failure to reduce the weight of obese diabetics. The belief that the minimum amount of insulin should be used rather than an adequate amount to control diabetes over the maximum portion of each twenty-four-hour day.—James W. Sherrill, M.D., in *Bulletin of The Scripps Metabolic Clinic,* October, 1951.

THE WRITING BETWEEN THE LINES

Take a look at your handwriting. The length of your stroke, where you dot your i—these things are not a matter of chance. According to graphanalysts (often called graphologists), the characteristics of your handwriting are products of the law of your personality. As such, they tell a lot about you. No two handwritings are ever alike. They are as individual as fingerprints. In the hands of an expert, handwriting gives a precise clear picture of the personality which produced it. That's why handwriting analysts like Cleveland's Hazel Hutchison are being called on frequently these days to help industrial personnel and placement men find out more about the people they must fit to jobs. Graphanalysis can reveal important personality traits. Is the individual honest? Is he emotionally stable? Is he intelligent enough to follow instructions on a given job? Can he endure monotony, present on some tasks? How will he react in an emergency? Is he liable to have trouble getting along with other employes? Does he have leadership qualities? These are some of the things you can find out by handwriting analysis. And while it doesn't suggest that you forget about thorough pre-placement physical examination, graphanalysis can tell you important facts about an individual's health particularly those concerned with blood pressure and metabolism. Even more surprising is the graphanalyst's ability to identify tendencies before they become physically apparent. Addiction to drugs and alcohol is evident in handwriting. So are suicidal tendencies. So are incipient brain diseases and paralysis.—From "Graphanalysis: A New Placement Tool?" in *Occupational Hazards,* 14:10 (Aug.) 1952.

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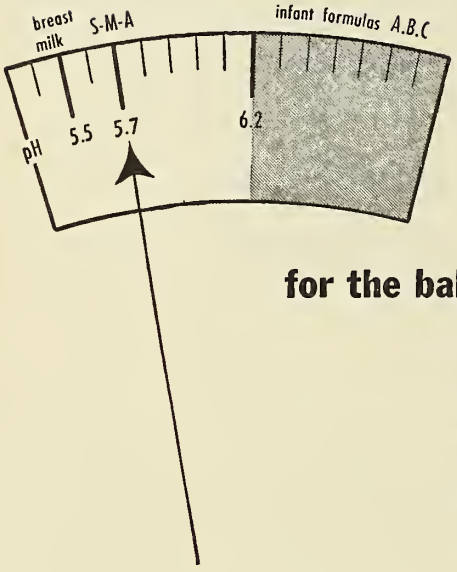
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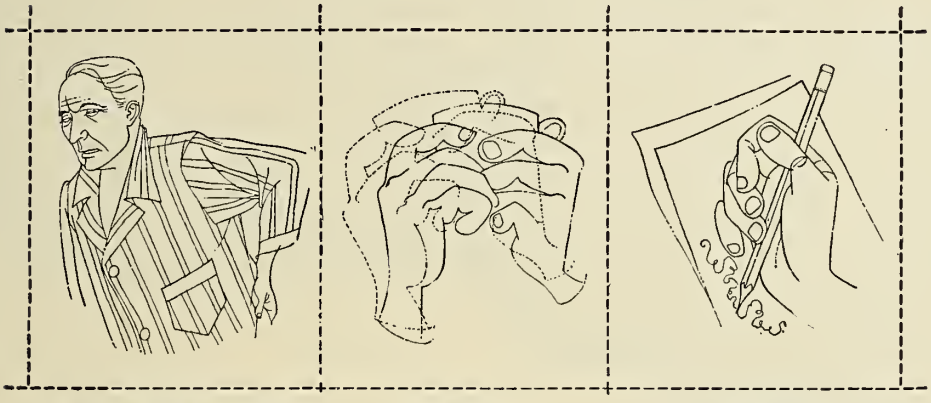
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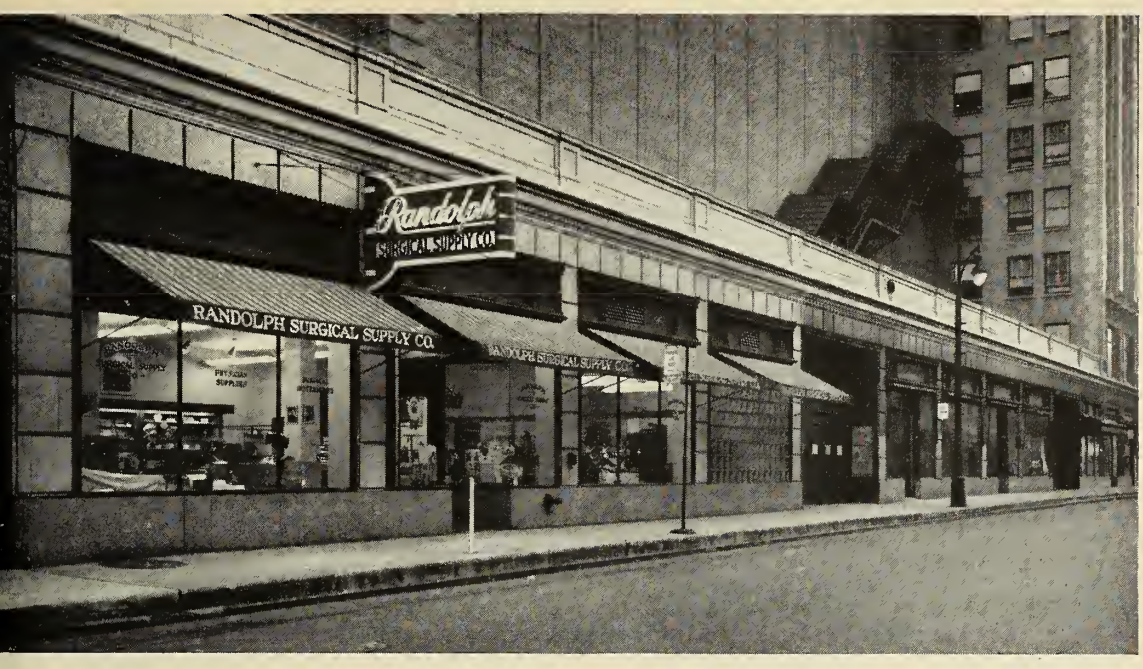
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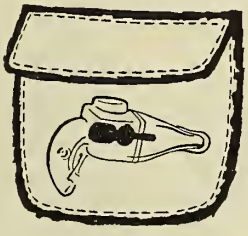
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*Hyman, H. T., "An Integrated Practice of Medicine," page 3082, W. B. Saunders 1946

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1. Kaufman, R., and Farmer, L. (1951), Norisodrine by Aerohalor in Asthma, Ann. Allergy, 9:89, January-February.
2. Swartz, H. (1950), Norisodrine Sulphate (25 Per Cent) Dust Inhalation in Severe Asthma, Ann. Allergy, 8:488, July-August.
3. Krasno, L., Grossman, M., and Ivy, A. (1949), The Inhalation of 1-(3',4'-Dihydroxyphenyl)-2-Isopropylaminoethanol (Norisodrine Sulfate Dust), J. Allergy, 20:111, March.

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HIGHLIGHTS OF SEPTEMBER SESSION OF THE COUNCIL,

September 21 and 26, 1952

Three meetings of The Council were held during the 87th Annual Session of the Michigan State Medical Society in Detroit. One hundred four items were presented and discussed by the twenty-five members (eighteen Councilors, the Speaker and the Vice Speaker of the House of Delegates, the President, President-Elect, Immediate Past President, Secretary and Treasurer). A total of 219 cumulative hours was contributed by these members of The Council to weigh and decide upon the problems facing the entire medical profession of Michigan.



The Council, Michigan State Medical Society, 1952-53

Front row *(left to right):* W. D. Barrett, M.D., Detroit; R. H. Baker, M.D., Pontiac; R. J. Hubbell, M.D., Kalamazoo; Chairman William Bromme, M.D., Detroit; L. W. Hull, M.D., Detroit; W. S. Jones, M.D., Menominee; L. Fernald Foster, M.D., Bay City.

Standing (left to right): J. D. Miller, M.D., Grand Rapids; Wilfrid Haughey, M.D., Battle Creek; G. B. Saltonstall, M.D., Charlevoix; D. B. Wiley, M.D., Utica; R. S. Breakey, M.D., Lansing; C. A. Paukstis, M.D., Ludington; Ralph W. Shook, M.D., Kalamazoo; J. E. Livesay, M.D., Flint; H. H. Hiscock, M.D., Flint; F. H. Drummond, M.D., Kawkawlin; A. H. Miller, M.D., Gladstone; Arch Walls, M.D., Detroit; H. B. Zemmer, M.D., Lapeer; G. W. Slagle, M.D., Battle Creek; W. B. Harm, M.D., Detroit; L. C. Harvie, M.D., Saginaw; B. M. Harris, M.D., Ypsilanti.

Absent on MSMS business: Otto O. Beck, M.D., Birmingham, and Wm. A. Hyland, M.D., Grand Rapids.

- **Reorganization of The Council: William Bromme, M.D., Detroit, was re-elected chairman; H. B. Zemmer, M.D., Lapeer, was chosen as vice chairman; W. S. Jones, M.D., of Menominee, was again made head of the Finance Committee; D. Bruce Wiley, M.D., Utica, was re-elected chairman of the County Societies Committee; and C. A. Paukstis, M.D., of Ludington, was given the post of chairman of the Publication Committee.**
- **The monthly financial reports** were studied and approved. **Bills payable** were reviewed **and ordered paid.**
- **The following Committee reports were considered: (a) Finance Committee,** meeting of September 20; **(b) Rheumatic Fever Control Co mittee,** September 10; **(c) Medical Advis Committee to Michigan Hospital Service,** m ing of August 21.

Co-ordinating Committee re President's C mission on Health Needs of the Nation, meeti of August 27 and September 10.

A special vote of thanks was extended to C **Umphrey, M.D.,** chairman of this committee, his splendid work in co-ordinating the effort all health, hospital and medical agencies in

(Continued on Page 1382)

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*Adams, C. H., and Cecil, R. L.: Ann. Int. Med. *33*:163, 1950.

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HIGHLIGHTS OF THE COUNCIL

(Continued from Page 1380)

nection with the September 23 Detroit Hearing.

A letter of congratulation and commendation also was authorized to be sent to Co-Chairman **K. B. Babcock, M.D.,** Detroit, for making it possible for individuals who have a basic understanding of the health, hospital and medical needs of the people of this area to be heard at the September 23 Detroit hearing.

• **Beaumont Breakfast of September 25.** The Council felt that the responsibility for the Beaumont Memorial was now on the local level, to be stimulated by members of the MSMS Council. The chairman of The Council was authorized to contact each member of The Council to urge him to visit every component county society in his district and see if he can obtain 100 per cent (or as near 100 per cent as possible) in contributions to the Beaumont Memorial—and to report his work and success to The Council at its Annual Session of January 30-31, 1953.

President Beck reported that contributions, to September 20, 1952, amounted to $21,190, and that approximately $2,000 had been added by MSMS members who attended the Annual Session in Detroit. The Council expressed sincere thanks to all M.D.'s who have been generous in their contributions to the Beaumont Memorial.

Prison Report.—President Beck offered to The Council a report on the 1951 survey of the hospital and medical facilities of the State Prison of Southern Michigan at Jackson. This re-survey—the first being made four years ago—indicated a great improvement in health facilities at the Jackson Prison—but the Committee recommended additional betterments and advancement in the service. President Beck called the report "one of the finest accomplishments of the Michigan State Medical Society."

• A letter of congratulations and thanks to **R. L. Finch, M.D.** (Chief Physician of the State Prison of Southern Michigan) was authorized.

• **A. D. Allen, M.D.,** of Bay City, and **John R. Rodger, M.D.,** of Bellaire, were recommended to the Governor to succeed themselves as members of the Hospital Advisory Council (Hill-Burton Act) as MSMS representatives.

• A Special Committee to study the need for a revision of the Model Constitution and By-Laws for County Medical Societies was authorized. The present model is dated 1937.

• **Goldie B. Corneliuson, M.D.,** was reappointed to serve as an MSMS representative to the Committee for Improvement of Nursing Services, a committee of the Michigan Nursing Center Association.

• **At the MSMS booth at the State Fair** (September 2-5, 1952), 77,520 pieces of literature were distributed and 217 showings of medical films were made. Thanks were extended to the 10 members of the Woman's Auxiliary and to representatives of the Michigan Health Council who covered the booth in behalf of the State Society.

• **A report on Housing the Aging,** meeting in Ann Arbor on July 24-26, as drafted by A. Hazen Price, M.D., Detroit, was accepted with a vote of thanks.

• **The Special Committee to study a health and accident insurance program for MSMS members** reported on a meeting with representatives of insurance brokers from Chicago. The Committee felt that the proffered contract did not meet the needs of the doctors of Michigan and could not be accepted. The Council instructed that such a report be given to the House of Delegates. Subsequently, the House of Delegates instructed that the Committee, enlarged to five, continue its study. The current committee is composed of: W. Jones, M.D., Menominee, Chairman; L. Fernald Foster, M.D., Bay City; J. Duane Miller, M.D., Grand Rapids; Arch Walls, M.D., Detroit; and Mr. J. Joseph Herbert, Manistique, MSMS Legal Counsel.

• **The monthly report of the Public Relations Counsel** included: (a) **9 television shows, 6 radio shows and 3 service club talks** have been arranged during the 1952 MSMS Annual Session in Detroit, including the WWJ dramatic radio show on "The Strange Case of Dr. Beaumont." All time used over the air was contributed by the Detroit radio and television stations at no cost to the Michigan State Medical Society; (b) **the revision of the Medical Associates brochure** has resulted in a great demand for same in Michigan and throughout other states; (c) **the Good Citizenship Campaign** is continuing with success: it is expected that the highest percentage ever achieved in the medical profession will be registered at the voting booths on November 4, 1952.

(Continued on Page 1384)



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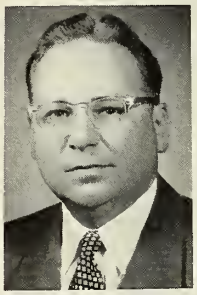


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MICHIGAN INDUSTRIAL HEALTH PROGRAM TO BE PRESENTED IN MARCH

The fourth annual Michigan Industrial Health Day will be held Tuesday, March 10, 1953, at the Sheraton-Cadillac Hotel, Detroit—the date preceding the 1953 Michigan Clinical Institute. A full program of scientific papers beamed to industrial medicine and surgery will feature the day.



E. A. Irvin, M.D.

A reception and testimonial banquet in honor of E. A. Irvin, M.D., Detroit, President of the national Industrial Medical Association, will follow at the Sheraton-Cadillac Hotel.

The complete program will be published as a special feature of the December Number of The Journal.

All members of the Michigan State Medical Society are cordially invited to attend the Michigan Industrial Health Day and the banquet of March 10, 1953, in Detroit.

HIGHLIGHTS OF THE COUNCIL

(Continued from Page 1382)

• **Three nominees for the Michigan Foremost Family Physician Award** were selected for presentation to the House of Delegates on September 22: S. L. Loupee, M.D., Dowagiac; D. J. McColl, M.D., Port Huron, and E. L. Thirlby, M.D., Traverse City.

• **The Supplemental Report of The Council,** for submission to the House of Delegates on September 22, was developed and the thirteen items were approved.

• **Matters referred to The Council by the 1952 MSMS House of Delegates** were discussed and action taken on several; the balance was referred to the meeting of October 23, pending receipt of transcript of the House of Delegates Proceedings.

• **B. M. Harris, M.D., was chosen as chairman of the Study Committee on Inclusion of Assistant's** Fees in Blue Shield, in insurance companies, and in Uniform Fee Schedule for Governmental Agencies—with power to nominate the members of his Committee.

• **Appointment of members to the 1952-53 MSMS Committees** was announced by President R. J. Hubbell, M.D., Kalamazoo.

• **Two matters of mutual interest** were discussed with State Health Commissioner A. E. Heustis, M.D., Lansing.

• **A vote of official thanks to all who helped make the 1952 Annual Session an outstanding** success (registration of 3,605, an all-time record, despite conflicts with the American College of Surgeons and the American Roentgen Ray conventions) was placed on the minutes of The Council.

• **A vote of thanks was extended to Wyeth, Inc., of Philadelphia** and to its officers Stuart V. Smith D. J. Withington and R. G. Wilder, for presentation to the Michigan State Medical Society of the Dean Cornwell painting "Beaumont and St. Martin" on September 23 in Detroit. This famous and valuable painting is to be housed in the MSMS home in Lansing until July, 1954, when it is to be moved to the completed Beaumont Memorial on Mackinac Island.

• **A vote of thanks was extended to the State Journal Advertising Bureau** and its Director A. Jackson for their printed recognition of the Journal of the Michigan State Medical Society as a model of good publishing.

• **Request was granted to house the archives of the Woman's Auxiliary** to the Michigan State Medical Society at 606 Townsend, Lansing.

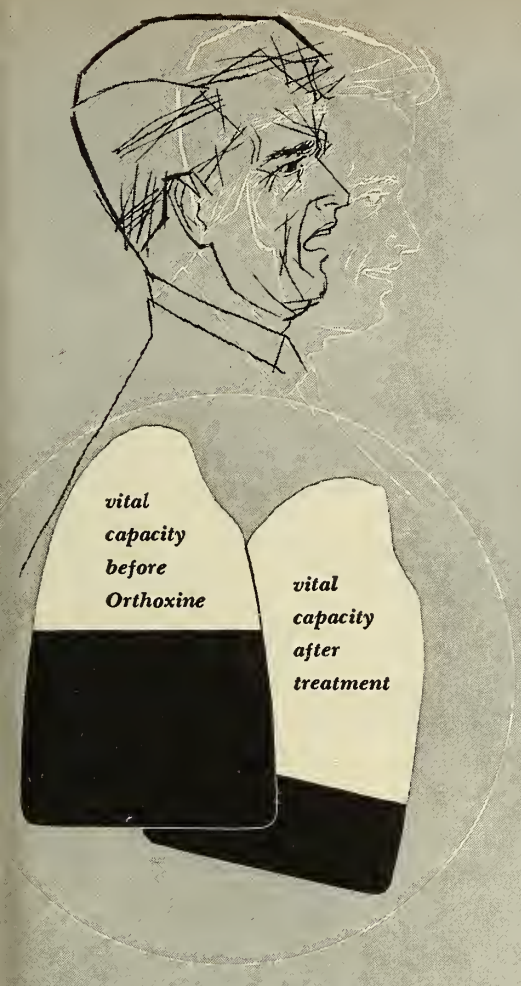
• **A resolution from the Michigan Pathologic Society** offering all co-operation in the passage a medical examiners system bill through the Michigan Legislature was read. C. Allen Payne, M.D. of Grand Rapids, was selected as MSMS representative to attend an October 13 meeting in Chicago of the College of American Pathologists to discuss the medical examiner system bill and other important and related matters of law and forensic medicine.

PROBLEM OF THE AGING

The Research Council for Economic Security, in a July report, asks and answers the question: Why should not retirement be handled selectively? Clarence B. Randall, in his book A Creed for Free Enterprise, makes this statement:

"Since all men are different, and individual characteristics vary widely in later years, why should not retirement be handled selectively, keeping those who are up in their prime and releasing only those as to whom

(Continued on Page 1388)



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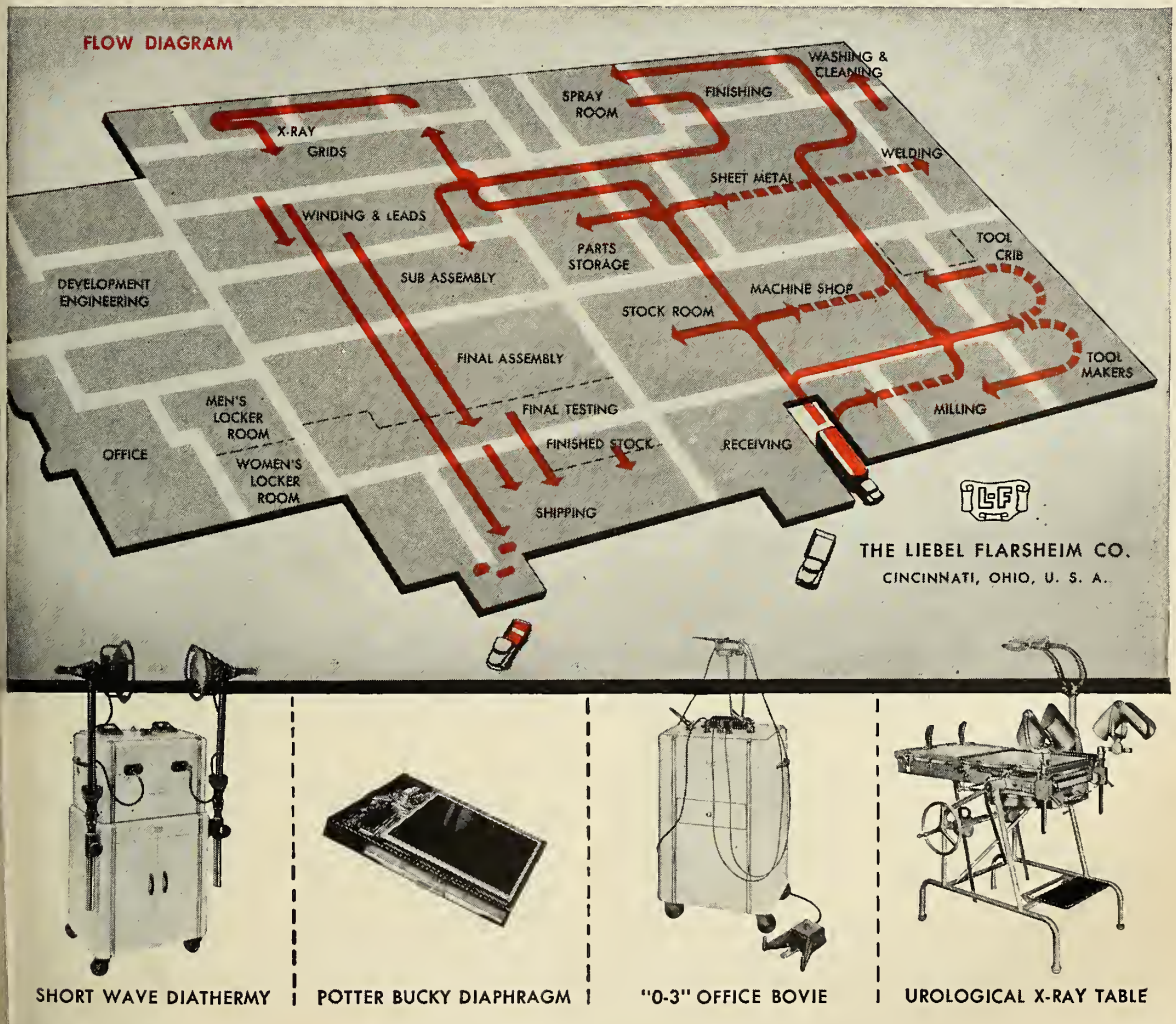
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PROBLEM OF THE AGING

(Continued from Page 1384)

there is doubt? This is a plausible suggestion, often urged by those who have a particular man in mind who looks for all the world as good at sixty-five as he did at fifty. There are many such. . . . Among junior executives at about the age of forty there is never any doubt but that there should be compulsory and complete retirement for older men at not later than the age of sixty-five. The doubts come to those who have passed sixty, and the subtle self-hypnosis of indispensability seems to be associated with thinning hair, bifocals, dentures, and longer belts. It is the occupational disease of seniors."

Randall concludes, "I am convinced that for purposes of sound administration there must be a fixed age limit with compulsory retirement from active day-to-day responsibility, as distinguished from wisdom duties such as membership on a board of directors." Preferential retirement, whereby one executive is retained upon reaching a certain age while another is retired, is poor personnel practice. Randall feels that it can only give rise to suspicions of favoritism, and result in lowered company morale. He notes also that while medical science may some day outdate the sixty-five-year limit, this time has not yet arrived.

* * *

Public and private funds for housing aged persons are being considered in Detroit, Boston, Los Angeles, and New York. New York already reserves 5 per cent of all state-aided public housing for the aged. In Florida, the State University as well as the state administration have been studying for three years the possibility of erecting entire villages for retired persons and their families. The Massachusetts legislature is considering a $5 million fund to build 400 to 500 special housing units. All the plans envisage special kitchens, recreation, and other facilities to serve the specific needs of elderly persons.

Recently enacted increases in social security benefits provide: (1) increases of $5 a month or 12½ per cent, whichever is greater, in old age and survivor insurance benefits representing an average increase of $60 per month; (2) commensurate increases in Railroad Retirement System benefits; (3) an increase in the maximum limit of outside earnings for annuitants from $50 per month to $75; (4) an OASI monthly employment credit of $160 for members of the armed forces during 1947-1953; (5) an increase of $250 million in federal funds for grants to the states for public assistance which permits an increase in benefits of $3 a month for dependent children and $5 a month for the aged, the blind, and the disabled.

Nearly three out of every five males aged sixty-five to sixty-nine are still in the labor force, reports the Statistical Bureau of the Metropolitan Life Insurance Company. Of all older males, aged seventy to seventy-four, two out of every five are employed or seeking employment. Occupation seems to have something to do with the aged remaining in the labor force. Thus, older men tend to remain at work longer in agricultural, managerial, and self-employed positions than those in hazardous jobs.

Economic security, pre-retirement preparation, and post-retirement adjustment are the three legs of the security stool, say Lawrence J. Ackerman and Walter C. McKain, Jr., in "Retirement Programs for Industrial Workers," *Harvard Business Review* (July-August, 1952). Basing their observations of the current scene on their poll of 403 companies, they acknowledge rapid advances in retirement programs, but point to many uncharted fields.

Of the firms polled, 15 per cent had no pensions, no pre-retirement health or education programs, and no post-retirement contracts. Nearly one-quarter of the companies had nothing more than a pension plan. The authors note, however, that many existing plans and programs are being revised. Overall, Ackerman and McKain feel that "industry, aided by government and the community, each in its respective sphere, is in the progress of formulating a highly humane and civilized approach to the older person in industry."—*Insurance Economics Survey.*

State Commissions on Aging Decide to Continue Under FSA Guidance.—For a time at least, the federal government will continue to furnish central guidance for states attempting to set up medical and other programs for the aged. Decision to remain under the wing of Federal Security Agency's Committee on Aging and Geriatrics (Clark Tibbitts, director) was reached at the conclusion of a three-day conference of state commissions on aging and federal officials. The question was whether to set up an interim national organization with no ties to the federal government. During discussion, it was argued that a new non-federal association wouldn't be practical because as yet so few states (14) have commissions on aging, and the responsibilities and authority of many of these are uncertain.

John L. Thurston, deputy administrator of Federal Security Agency, told the delegates that they were welcome to return to Washington and the FSA with their problems. He said he thought it was fitting for the federal government to serve as a catalyst or stimulator in such a new and expanding area.

Conference work groups brought out that the public generally is unaware of the growng problem of caring for the aged and that agencies and facilities for them are lacking in many areas. There was agreement that the problems can best be handled at the state and community level. Panel speakers also emphasized that (a) the trend is toward committees authorized by state legislatures, with citizen's advisory committees or lay members participating, (b) subcommittees of commissions generally fall into four groups: employment, health, personal adjustment and housing-living arrangement and (c) major function of commissions is formulation of plans for action programs.—AMA *Capitol Clinic.*

* * *

A hygiene of aging program is being established in the public health service of the Federal Security Agency. The purpose of the program, according to Surgeon General Leonard A. Scheele, is to advise health departments on the development of these activities. It is also designed to help health departments consider the needs and problems of the aging group in all their programs.

(Continued on Page 1390)

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PROBLEM OF THE AGING

(Continued from Page 1388)

"More health services will be needed for older persons," Dr. Scheele said. "Increased emphasis will have to be placed on preventing and alleviating the ills of older adults and on helping them play a more active role in the community." The hygiene of aging program will be operated by the Division of Chronic Disease and Tuberculosis of the Bureau of State Services.

UTILIZATION OF PREPAID MEDICAL PLANS

The Heller Committee in California recently published the results of a study of the utilization of medical care plans. The study covered 455 families residing in the San Francisco Bay region. The family incomes ranged from $1,553 to $21,690 per year, with the mean $4,147, the median income, $3,823. In 60 per cent of the families some member was covered by some form of medical prepaid insurance for some period during 1947-1948. Less than 20 per cent had all members of the family covered. Less than half of the 1,504 individuals making up these families were covered by any plan during any part of the year. Two-thirds were covered by hospital insurance only. About one fourth of those members of the plans who received some type of medical care received care through a prepaid plan. Ninety per cent of the patients who received care through a plan paid some additional costs. (In California some of the plans specify additional costs for certain services.) In most cases this additional charge was less than $25.

MEMBERSHIP IN HEALTH PLANS

A survey by the Health Insurance Council of memberships as of 1951 found that 85.9 million persons were protected against hospital expense, 65.4 million had surgical expense coverage, 27.7 million had medical expense protection, and 39.7 million had protection against loss of income resulting from disability. This does not include persons covered under state disability compensation plans. The organizations covered by this survey included insurance companies, Blue Cross, Blue Shield, local medical societies, and other independent plans adopted by industry, employe benefit associations, and private clinics.

HOSPITAL OPERATING COSTS

The cost of operating a hospital has been rising at the rate of one per cent a month for the last ten years. Ellis Walker, in *Hospital Management* (June, 1952) quotes Harry Becker, associate director of the Commission on Financing of Hospital Care, as saying, "This cost may be as much as 20 per cent higher in 1954 and 1955 than it is today." In a panel discussion at the Annual Convention of Western Hospitals, where this statement was made, one of the recommendations called for an expansion of prepaid plans to cover diagnostic services in advance of actual hospitalization. This would tend to cut costs since periodic check-ups would catch many illnesses in their early stages before hospitalization became necessary. The panel is reported also to have stated that "one of the chief faults of present insurance plans is their failure to cushion the financial blow of a long-term illness."

VETERANS AFFAIRS

The American Legion's Medical Advisory Board, fearful that economies are pulling the Veterans Administration's medical program from the "high plateau" of recent years, is appealing to U. S. Budget Bureau and Congress. Following a meeting of the board, Chairman Leonard G. Rowntree said the members hoped that the Budget Bureau would come up with a "realistic" budget for fiscal 1954. The bureau is now working on that budget. In addition, Dr. Rowntree said the board was counting on the next Congress passing a deficiency appropriation to restore VA beds eliminated by budget cuts voted by the last Congress. The best that could be expected, he said, would be funds in time for the last three months of fiscal 1953 (next April, May, June).

Dr. Rowntree said the Board felt the "gradual whittling away" of VA budgets both by the Budget Bureau and by Congress is lowering the quality of medical service and spreading a "sense of insecurity" among VA medical personnel.

The immediate problem is the $31 million (or 5 per cent) cut Congress made in the funds the Budget Bureau had approved for VA medical programs during the current year. VA already has announced it would have to reduce its average hospital patient load from 102,000 to 99,200.

VA has an acute problem. It is attempting to absorb its $31 million budget cut without laying off medical personnel—physicians, nurses and dentists. To get expenses of the Medical Department under the limitation set by Congress, about 3,000 hospital beds are being closed out and 6,000 positions eliminated. However, all professional personnel, according to VA, are being offered assignments elsewhere.

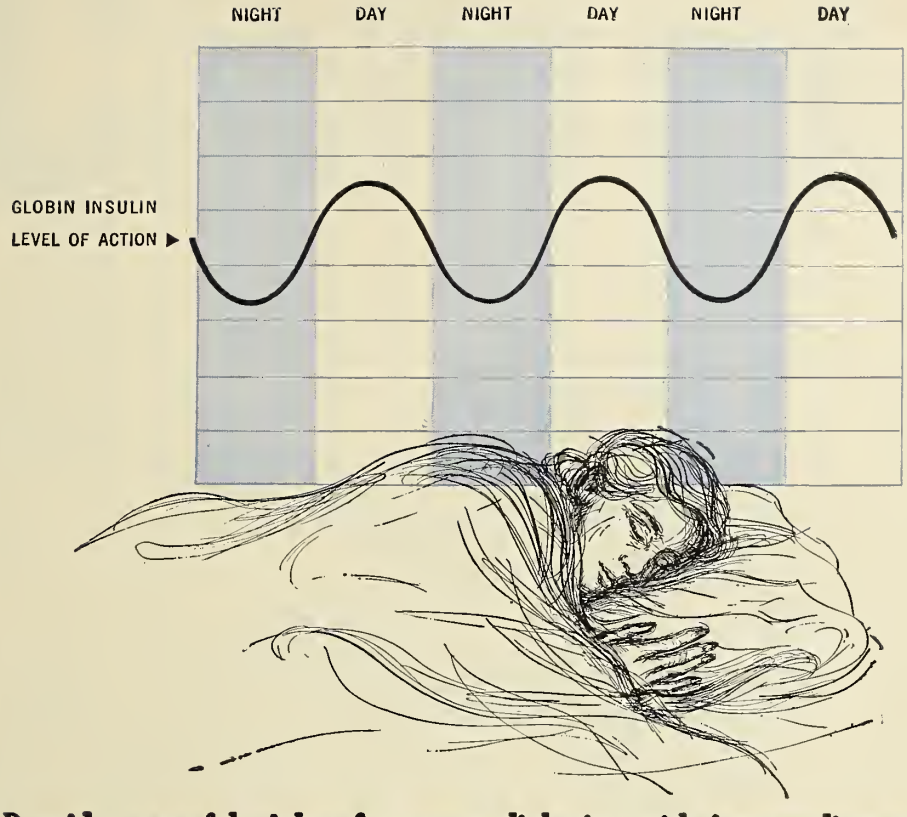
AMA *Washington News Letter*

HOW MANY HANDS ARE IN YOUR POCKET?

In these times, the salary check received by the average citizen is committed almost 100 per cent by the time he gets it—in some instances, of course, it is overspent. The mortgage on the house, the company that financed the automobile, the store that put in the TV set, the grocer who sends a bill once a month; all of these and others have their hands in the citizen's pocket. He doesn't see or handle any substantial sums of money any more; it is all paper work. As Clifford B. Reeves of Mutual Life says, there are only $268 of hard-earned money in the world—all the rest of it is accounting.

The net effect is that the average citizen is never much farther than three months from bankruptcy. He is in a financial position where a serious uninsured loss would ruin him. He is well aware of this. Conse-

(Continued on Page 1392)



Provide peaceful nights for many diabetics with intermediate-acting

Globin Insulin 'B. W. & Co.'®

Globin Insulin 'B.W. & Co.', given in one injection in the morning, acts promptly, sustains action during the day when it is needed most, tapers off during the night when hypoglycemic reactions might otherwise occur.

For many diagnosed diabetics think of Globin Insulin because it possesses the highly desirable intermediate-timing of action; furthermore accurate measurement of doses is uncomplicated since it is a clear solution.

40 units in 1 cc.	vials of 10 cc.
80 units in 1 cc.	vials of 10 cc.

'Wellcome'® brand Globin Insulin with Zinc

Burroughs Wellcome & Co. (U.S.A.) Inc., *Tuckahoe 7, N.Y.*

HOW MANY HANDS ARE IN YOUR POCKET?

(Continued from Page 1390)

quently he has turned to all forms of protection—prepaid hospitalization, life insurance, fire and casualty, inland marine, and anything else that he believes he needs to provide the security that he no longer is able to furnish out of his own situation. He achieves security as he purchases property, on the installment plan.

And it is not only the average citizen that has been infected by the amortization principle which makes it so easy to create property by spending futures—by borrowing money. At the other end of the economic scale the big corporations borrow huge sums to expand their operations, and they amortize their debt in the same manner, if not in the same size, as the average citizen. They also do not wait until they have saved up the money before spending it.

Many of us today live close to the brink of financial disaster. We have our jobs which are contingent upon our being able to perform satisfactorily in them. The salary checks that we get for doing the work are pretty well committed in advance. Taxes hamper the accumulation of money. These are some of the reasons why so many forms of insurance have ceased to be a matter of choice and have become things of necessity.—*The National Underwriter,* June 26, 1952.

FUTURE DATES FOR YOU

The **Michigan Clinical Institute** is scheduled for Detroit five years in advance as follows:

1953.....March 11-12-13
1954.....March 10-11-12
1955.....March 9-10-11
1956.....March 8- 9-10
1957.....March 13-14-15

The Annual Sessions of the **Michigan State Medical Society** are scheduled six years in advance, as follows:

1953.....September 23-24-25—Grand Rapids
1954.....September 29-30-October 1—Detroit
1955.....September 28-29-30—Grand Rapids
1956.....September 26-27-28—Detroit
1957.....September 25-26-27—Grand Rapids
1958.....Week of September 22—Detroit

* * *

The **Annual MSMS Public Relations Conference** will be held at the Sheraton-Cadillac Hotel on Sunday, February 1, 1953, following the three-day Annual Session of the MSMS Council.

The Annual **County Secretaries Conference** will be held at the Porter Hotel and at the MSMS headquarters in Lansing on Wednesday, February 25, 1953, following the one-day meeting in Lansing of Michigan's County Society Executive Secretaries.

MEDICAL MEETINGS AND CLINIC DAYS

A list of known medical meetings and clinic days, sponsored by county medical societies and other physicians' groups in Michigan, follows:

1953

Jan. 16-17 Sixth Annual Michigan Rural Health Conference Kellogg Center, East Lansing

Jan. 28 Mt. Carmel Mercy Hospital Clinic Day Detroit

Feb. 1 MSMS Public Relations Conference Sheraton-Cadillac Hotel, Detroit

Feb. 25 MSMS Annual County Secretaries' Conference Porter Hotel, Lansing

Mar. 10 MICHIGAN INDUSTRIAL HEALTH DAY Sheraton-Cadillac Hotel, Detroit

Mar. 11-13 MICHIGAN CLINICAL INSTITUTE Sheraton-Cadillac Hotel, Detroit

Mar. 13 Fourth MICHIGAN HEART DAY (part of MCI) Detroit

Spring MSMS Postgraduate Extramural Courses Statewide

April 8 Genesee County Medical Society 9th Annual Cancer Day Flint

April Jackson County Medical Society's Clinic Day Jackson

April Highland Park Physicians Club Clinic Highland Park

May 7 Ingham County Medical Society's Clinic Day Lansing

May 13 Wayne University Medical Alumni Clinic Day and Reunion Hotel Fort Shelby, Detroit

May 21 The American College of Surgeons Annual Symposium on Trauma and Nutrition Detroit

June 1-5 AMA Annual Session New York

June 2 Annual Clinic Day, Bon Secours Hospital Detroit

June Upper Peninsula Medical Society Annual Meeting Escanaba

July 30-31 Annual Coller-Penberthy Medical Surgical Conference Traverse City

August Third Annual Clinic, Central Michigan Committee, ACS Michigan Committee on Trauma, plus Michigan National Guard Medical Personnel, and Michigan Society of North Central Counties Grayling

Sept. 22 Michigan Chapter, American College of Surgeons Grand Rapid

Sept. 23-25 MSMS ANNUAL SESSION Grand Rapid

October Michigan Cancer Conference East Lansing

Autumn MSMS Postgraduate Extramural Courses Statewid

Additions to this list of meetings are invited b the Editor of JMSMS, in order to make thi monthly announcement complete and accurate.

CAMELS

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pack after pack!

Famous Beaumont Painting Presented to MSMS by Wyeth, Inc.



WYETH EXECUTIVE PRESENTS CORNWELL WORK
Stuart V. Smith *(left)*, Vice President of Wyeth, Inc., Philadelphia, points out a detail of the Dean Cornwell painting, "Beaumont and St. Martin," to Otto O. Beck, M.D. *(center)*, Birmingham, 1951-52 MSMS President, and to Harry J. Loynd *(right)*, Detroit, President of Parke, Davis & Company. Wyeth, Inc., presented the valuable painting to MSMS on September 23, 1952. It will hang in the Beaumont Memorial building on Mackinac Island.

The beautiful Dean Cornwell painting "Beaumont and St. Martin" depicting a highlight in the history of medicine—which had its beginnings in Michigan—was presented to the Michigan State Medical Society by Wyeth, Incorporated, the Philadelphia pharmaceutical house, on September 23, during the 1952 MSMS Annual Session in Detroit.

The presentation was made by Stuart V. Smith, Senior Vice President of Wyeth, Inc., and was accepted by President Otto O. Beck, M.D., Birmingham, in behalf of the State Medical Society (See page 1417).

A great-grandniece of Dr. William Beaumont, Mrs. George L. Stokes of Flint, unveiled the Beaumont painting.

Assisting in the ceremonies were D. J. Withington, Vice President, and Robert G. Wilder, Public Relations Counsel of Wyeth. Aiding President Beck were A. H. Whittaker, M.D., Detroit, Chairman of the MSMS Beaumont Memorial Restorations Committee, and J. E. Livesay, M.D., Flint, a long-time friend of the historically important Stokes family.

The "Beaumont and St. Martin" painting temporarily will hang in the MSMS headquarters at 606 Townsend, Lansing, until its permanent "home," the Beaumont Memorial to be erected by Michigan doctors of medicine on Mackinac Island, is completed. The dedication ceremonies are tentatively set for July, 1954.

The Beaumont Memorial will be carefully erected on the site of the American Fur Company store

(Continued on Page 1396)



DON'T MISS 

APPEARING REGULARLY IN THE J. A. M. A.

(Continued from Page 1394)

on Mackinac Island where the blast of a musket saved a million lives. This restoration, to cost the medical doctors of Michigan some $40,000, will be given to the people of the State of Michigan as an historical memorial.

In this original American Fur Company store, the French-Canadian voyageur, Alexis St. Martin, accidentally was wounded in his side in 1822. The wound left an opening in the man's stomach through which William Beaumont, M.D., a surgeon at nearby Fort Mackinac, could observe the action of the gastric juices.

The story of Dr. Beaumont and Alexis St. Martin is an historical tale of drama and medical discovery in an age when the science of medicine was as primitive as the locale of Mackinac Island.

Dr. Beaumont's important medical discovery began on June 19, 1822, when an accidentally discharged musket caused a gaping wound in St. Martin's side; Beaumont was certain the young voyageur could not live through the day. But St. Martin lived with a hole in his side; he lived with a gastric fistula through which Dr. Beaumont studied the actions of the stomach's digestive process; with this human test tube, Dr. Beaumont was able to determine the role of emotion in digestion.

His experiments on the gastric juices are monumental in the history of medicine; until that time, little was known of how food was digested. Dr. Beaumont's contributions to medical science rank with Harvey's discovery of the circulation of the blood and are rated above the famed experiments of Ivan Petrovich Pavolov which contributed to the knowledge of the physiology of digestion.

Parke, Davis & Co. Purchase Land for Memorial

The initial contributions for the purchase of the land for the Beaumont Memorial was made by Parke, Davis & Co. of Detroit through the interest and dynamic co-operation of W. F. Doyle, Lansing, Chairman of the Mackinac Island State Park Commission. The Park Commission has agreed to maintain the Memorial in perpetuity.

The Michigan State Medical Society already has commissioned the famous Professor Emil Lorch of Ann Arbor to be the architect in the erection of the Beaumont Memorial. Members of the Consultative Committee and of the Working Committee to aid with the details of construction, include: Otto O. Beck, M.D., Birmingham; F. A. Coller, M.D., Ann Arbor; Prentiss M. Brown, Detroit; L. J. Hirschman, M.D., Traverse City; Professor Emil Lorch, Ann Arbor; Harry J. Loynd, Detroit; A. H. Whittaker, M.D., Detroit; W. S. Jones, M.D., Menominee; D. Hale Brake, Lansing; J. Joseph Herbert, Manistique; A. N. Langius, Lansing; G. B. Saltonstall, M.D., Charlevoix; William Bromme, M.D., Detroit; W. F. Doyle, Lansing, and L. Fernald Foster, M.D., Bay City.

The work of bringing the Beaumont Memorial to a reality for the people of the State of Michigan has been and is being done by members of the Michigan State Medical Society. It is a project that will inure permanently to the credit of Michigan's medical men. The public by the hundreds of thousands who visit Mackinac Island in future endless summers will read a plaque that gives credit to the M.D.'s of Michigan for their tangible efforts in extending credit to one of their own immortal men of science.

Proposed

BEAUMONT MEMORIAL



"A little from many will build the Beaumont Memorial—a monument to the generosity of Michigan's medical men."—Otto O. Beck, M.D.

Beaumont Memorial Restoration Committee
Box 539, Lansing 3, Michigan

I attach my check in the amount of: $.....
OR
I pledge the amount of: $.....

payable on or before
to assist my fellow doctors of medicine of Michigan in building the Beaumont Memorial on Mackinac Island, Michigan.

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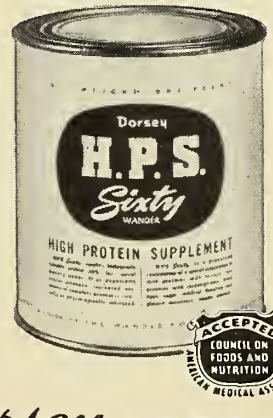
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Prepared with water according to directions (6 oz. water, 1½ oz. **H.P.S.** *Sixty*), three servings daily furnish 77 Gm. of biologically complete protein. When skim milk or whole milk is used instead of water, three servings provide 96 Gm. or 95 Gm. of protein respectively.

H.P.S. *Sixty* is processed from milk protein concentrate, soy protein, whole egg powder, powdered sugar and flavoring. Its proteins are intact; hence it is not burdened by objectionable odor. Valuable for use when whole protein can be utilized, **H.P.S.** *Sixty* may be indicated in the dietary management of undernutrition, peptic ulcer, hepatitis, chronic diarrheal states, pregnancy and lactation, and following burns and other injuries which raise the protein needs. Caloric equivalent, 3.6 per Gm., 102 per ounce.

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Cancer Comment

MSMS CANCER CONFERENCE ATTENDANCE RECORDS BROKEN



F. L. Rector, M.D.

The Fourth Michigan Cancer Conference, primarily sponsored by the MSMS Cancer Control Committee, was held at the Kellogg Center for Continuing Education, East Lansing, on October 9, and drew an attendance of more than 300. This was an increase of over 100 more than attended any previous session.

The Conference was held in co-operation with the Annual Training School of the Michigan Division, American Cancer Society; it also was sponsored by the Michigan Department of Health.

L. E. Holly, M.D., of Muskegon, presided.

R. J. Hubbell, M.D., President, Michigan State Medical Society, welcomed the delegates and discussed "Some Aspects of the Cancer Problem in Michigan." C. Allen Payne, M.D., Grand Rapids, spoke on the question: "Is Progress Being Made in Cancer Control?" Freddy Homburger, M.D., of Boston, Massachussetts, reviewed "Cancer Diagnostic Tests." Otto K. Engelke, M.D., of Ann Arbor, gave his views on "The Local Health Department's Responsibility in Cancer Control." Miss E. Margaret Siebert of Lansing discussed "Cancer Control—The Price and the Payoff"—with a plea for individual interest in the cancer control problem.

A luncheon was held immediately following the morning program at which Horace Wray Porter, M.D., of Jackson, presided. Questions from the audience were answered by the morning speakers.

Dr. Rector Honored

Frank L. Rector, M.D., Lansing, long-time active in cancer education and Secretary of the MSMS Cancer Control Committee, was signally honored at the luncheon. A leather, gold engraved briefcase was presented to him by Horace Wray Porter, M.D., Jackson, who had served as Chairman of the MSMS Cancer Control Committee for the past two years. The following eulogistic statement was read by MSMS President Hubbell:

> GREETINGS and congratulations to Frank L. Rector, M.D., from the undersigned on the publishing of the "Cancer Manual for High School Students" and in sincere appreciation of twenty-two consecutive years in cancer education in Michigan, the last six of which have been spent as the never failing secretary of the Cancer Control Committee of the Michigan State Medical Society.
>
> We recognize your outstanding record in cancer education in the United States, particularly in Michigan, and your exceptional ability as a secretary whose meticulous attention to detail, continuous rhetorical perfection and unexcelled memory for names, faces, facts and figures makes you the invaluable asset that you have been to the Cancer Control Committee.
>
> On this premier publication day of your Cancer Manual, on which you spent years in careful and painstaking editorial preparation, we salute you. It has been a pleasure and a privilege to have served on this committee under your secretarial service.

The scroll was signed by members of the MSMS Cancer Control Committee and other friends of Dr. Rector.

TREATMENT OF CANCER

The increasing emphasis being placed on cancer research is producing therapeutic measures that give promise of value in the cancer field. It must be emphasized, however, that in no case has an agent effective against all forms of cancer been discovered. Those now known and worked with usually are confined in their activities to one or two types of the disease and on these they exert only a palliative effect and then often only in one sex.

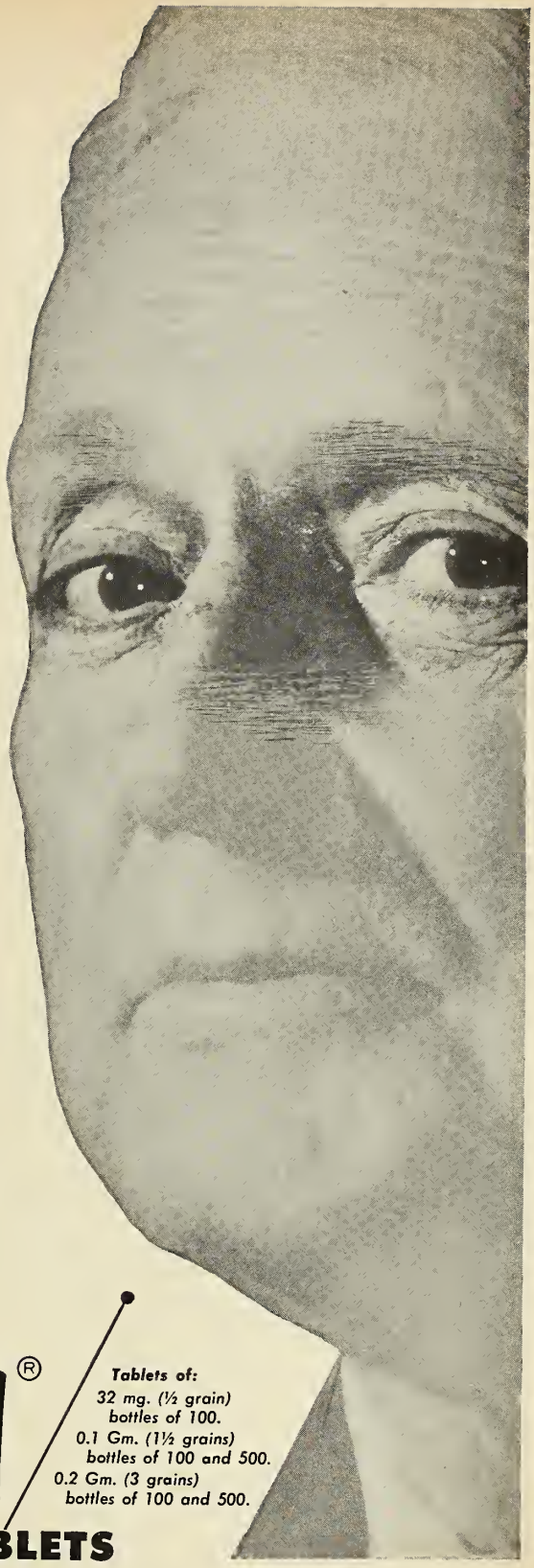
In surgical treatment the area of operability has been extended by blood and electrolyte transfusions, by better control of infections and safer anesthetics. Mutilation is sometimes extensive and postoperative activities of the individual markedly curtailed.

In the radiological therapy of cancer, much progress has been made in two directions: (1) in

(Continued on Page 1400)



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Mebaral is also a reliable anticonvulsant.

INDICATIONS:

Because of its high degree of sedative effectiveness, Mebaral finds a great field of usefulness in the regulation of agitated, depressed or anxiety states, as well as in convulsive disturbances. Specific disorders in which the calming influence of Mebaral is indicated include neuroses, mild psychoses, nervous symptoms of the menopause, hypertension, hyperthyroidism and epilepsy.

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Say you saw it in the Journal of the Michigan State Medical Society

TREATMENT OF CANCER

(Continued from Page 1398)

enabling a heavier dosage of radiation to be delivered to the cancerous growth through improved methods of focusing the radiation on the malignant growth; and (2) the use of radioactive chemicals with a special selectivity for certain tissues; viz.:—radioactive phosphorus for bone lesions and radioactive iodine for cancer of the thyroid gland. Radioactive cobalt also is assuming increasing importance in cancer therapy.

The recent installation of a 50-gram radium "bomb" in an eastern hospital has brought into use a greater amount of radium than has ever before been assembled for cancer therapy. Reports of its use will be watched for with keen interest by all radiologists.

The search for effective anti-cancer chemicals is being pursued with great intensity. A few, like the nitrogen mustards, have caused temporary remissions in lymphoblastomas and leukemia. Folic acid antagonists, ethyl carbamate and stilbamidine are among the chemicals that have given encouraging results when used on certain types of cancer. Cortisone is without permanent benefit although in certain phases of chronic leukemia it gives helpful palliation. The list of such chemicals being investigated is an extensive one.

No blood or other body fluid test for cancer has any reliability for general use. Such "tests" are the stock in trade of the average cancer quack and charlatan, who often claims that by such tests he can not only diagnose cancer but also can determine precancerous conditions.

In spite of all the publicity about new cancer "cures" coming from the research laboratories via the pages of newspapers and lay magazines, the only *curative* methods generally available to the clinician are surgery and irradiation, used either together or separately.

Many stories have been printed in which claims are made that a new "cure" has been found. All too often these reports are based on laboratory animal tests or, at the most, on one or a very few human patients. Often the reported results are but one step or phase of a larger research program and have little significance when additional information comes to light about the problem as a whole. The fact that no subsequent report ever is made on many of these "tests" and "cures" establishes their worthlessness as reliable therapeutic measures.

The unwarranted premature publicity about cancer diagnostic measures and curative procedures, as well as the false propaganda of the unprincipled quack and charlatan, lead many cancer patients to refuse accepted scientific methods of treatment or delay treatment in the hope of impossible cures through propagandized methods. Both situations work incalculable harm to the public and the cancer patient. They also aggravate public criticism of the medical profession for refusing to utilize such methods in treatment of their cancer patients. Physicians should not hesitate to point out to their patients and to the public the inconclusive results on which premature claims are based and the harm that would result from their indiscriminate use in cancer therapy.

An aspiration or needle biopsy is not a satisfactory method for obtaining a biopsy of a breast lesion.

* * *

Actual surgical biopsy with immediate frozen section followed by radical mastectomy is the proven method of management of cancer of the breast.

* * *

Observation of of a breast tumor should be limited to a period of two to four weeks to observe effect of cyclic changes or to observe a possible inflammation.

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Heart Beats

MEMBERSHIP IN THE MICHIGAN HEART ASSOCIATION

The Michigan Heart Association, which was formed by a committee of the Michigan State Medical Society, extends a cordial invitation to all medical doctors to become active members in the Association. Membership is open to any medical doctor who is interested in the objectives and work of the organization. For those who may not be familiar with these objectives, the Association's Articles of Incorporation state that it was formed for the following purpose: ". . . the acquisition, dissemination and application of knowledge concerning the normal heart and circulation, and the causes, diagnosis, prevention and treatment of disorders of the circulation and diseases of the heart, blood vessels and lymph vessels . . ."

How well the Michigan Heart Association has adhered to these objectives is accurately recorded in the more than $185,000.00 which has been allocated by the Association during the past three years for thirty-five research studies into diseases of the cardiovascular system. This money has been provided to medical schools, hospitals and other institutions in Michigan and represents more than one-half of the total amount of monies received by the Heart Association to date from United campaigns throughout the State.

In addition to its comprehensive program of research, the Michigan Heart Association has provided funds for several education and community service projects including: major financial support of the Michigan State Medical Society's Rheumatic Fever Control Program; expansion of a professional education program designed to keep the Doctor of Medicine in Michigan informed of the latest scientific advances in diagnosing, treating and controlling heart disease; development of an effective public education program; development of a program of time and energy conservation for the homemaker whose work capacity is limited by heart disease; intensified studies in industry to increase job opportunities for heart patients; participation in Michigan Health Council projects, and many others.

One of the major activities of the Association's professional education program is the Annual Heart Day Program, which is held each year in conjunction with the Michigan State Medical Society's Clinical Institute. The 1953 Heart Day has been scheduled for Friday, March 13, and will feature the presentation of papers concerned with the latest information on heart research work.

In addition to these projects, the Michigan Heart Association provides financial aid to the American Heart Association for heart research and education throughout the nation.

Active membership in the Association entitles you to subscriptions to a total of four different publications dealing with cardiovascular diseases, depending upon the type of membership which you choose. The latest addition to this list of publications is a bi-monthly journal entitled *Circulation-Research.* This journal will deal mainly with basic science reports in the cardiovascular field, and the monthly Journal, *Circulation,* will be devoted exclusively to work of clinical usefulness. *Modern Concepts of Cardiovascular Disease* is a monthly publication, and is a condensed review of the latest thinking on specific topics within the cardiovascular field. The fourth publication is *The American Heart Quarterly* which carries informative "news article" type of information on heart diseases.

If you are interested in membership in the Michigan Heart Association and if you would like to share in its numerous programs and activities, clip and mail the following coupon today for full information on all types of membership.

TO: Michigan Heart Association
4421 Woodward
Detroit 1, Michigan

Please send me complete information on membership in the Michigan Heart Association. I am interested in the following publications:

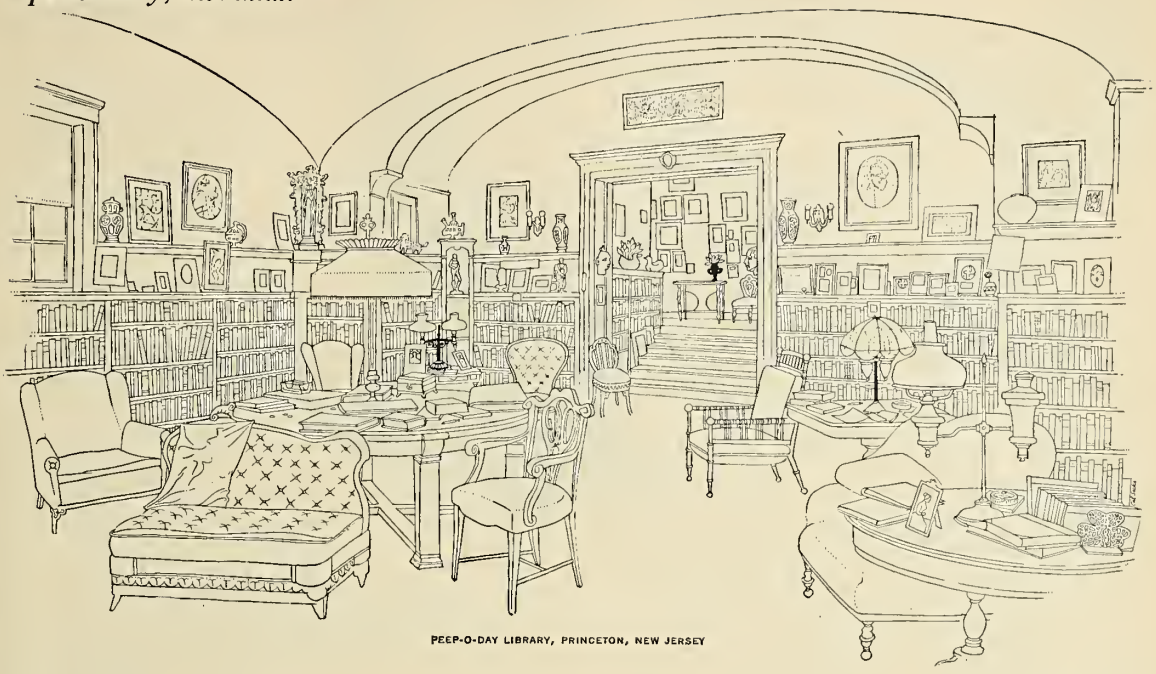
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Small amounts of aureomycin may reduce disability, or hospital stay, to a few days.

Early use of aureomycin may forestall those failures that have been reported in the literature following penicillin and streptomycin.

The proven range of clinical usefulness of aureomycin is so wide that, when clinical diagnosis is established, prolonged and costly laboratory studies are largely unnecessary.

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100 mg.—Vials of 25 and bottles of 100.
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AMA News Notes

TV SHOWS TO HIGHLIGHT DENVER MEETING

Plans are being made to present two half-hour network television shows covering high points of the American Medical Association's sixth annual Clinical Session in December. Originating from Denver, the telecasts will highlight Session activities, including presentations of new surgical and clinical demonstrations, special scientific exhibits and other interesting medical features. The programs will be of interest to physicians who cannot attend the meeting as well as to the general public.

Present plans call for coast-to-coast coverage on two different nights during the meeting, December 2-5. Once again the programs are being sponsored by Smith, Kline and French, Philadelphia pharmaceutical firm.

RURAL HEALTH CONFERENCE SET FOR FEBRUARY 27-28

"Widening the Highway to Health" will be the theme of the eighth national Conference on Rural Health to be held February 27-28, 1953, at the Roanoke Hotel, Roanoke, Virginia. The day preceding the general sessions (February 26) will be devoted to an informal get-together of physicians who are responsible for rural health programs in their respective states, to discuss "Doctor Participation in Community Programs."

The subject of financing rural medical care will be covered at Friday's sessions. An experience-and-accomplishment program to stimulate thought on "What Can I Do When I Get Home?" will be presented the last morning. The final luncheon speaker will tell what medicine is doing, in cooperation with other organizations and groups, to help America solve its health problems.

NEW RADIO SERIES ON SPORTS AND HEALTH

A new series of radio transcriptions dealing with sports and health subjects will be available about December 15, from the AMA's Bureau of Health Education for use by local radio stations. The programs are based upon on-the-scene interviews with Olympic winners in Helsinki, Finland, and with national champions and other outstanding sports figures in this country.

Topics cover personal aspects, athletic accomplishments, team practice and health values of sports. Among those interviewed were Bobby Brown, M.D., of the world's champion New York Yankees; Harrison Dillard, Olympic 100-meter hurdling champion, and Julius Boros, world's national golf champion.

PR CONFERENCE IN DENVER

The AMA's fifth annual National Medical Public Relations Conference will be held Monday, December 1—the day before the opening of the Clinical Session—at the Shirley-Savoy Hotel, Denver. Theme of the one-day meeting will be "Mutual Understanding . . . the Key to Better PR." The Conference program will be geared primarily for physicians. Members of the House of Delegates, officers of state and county medical societies, officers of the Association and executive secretaries and PR personnel are cordially invited.

NATIONAL CONFERENCE ON TRICHINOSIS

The American Medical Association has joined with the U.S. Public Health Service, the U.S. Bureau of Animal Industry, the American Public Health Association and the American Veterinary Medical Association in sponsoring a National Conference on Trichinosis. The meeting is scheduled for December 12, at AMA Headquarters, Chicago.

It is hoped that the Conference will stimulate interest in the need for further public education on the dangers of trichinosis. Doctors Leonard W. Larson, Bismarck, and J. J. Moore, Chicago, were appointed AMA representatives by the Board of Trustees.

RURAL HEALTH RADIO SERIES AVAILABLE

An eight-week radio transcription series on rural health entitled "Help Yourself to Health" was released October 15, by the AMA's Bureau of Health Education to state and county medical societies. The series consists largely of true stories about small American communities which have successfully solved their health problems through

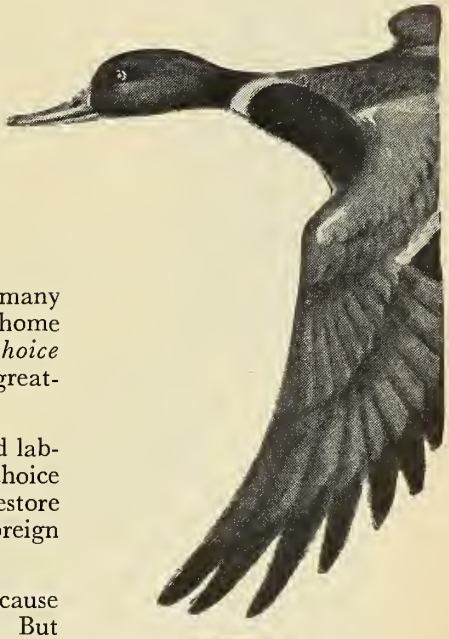
(Continued on Page 1406)





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RURAL HEALTH RADIO SERIES AVAILABLE

(Continued from Page 1404)

local initiative and effort. Citizens from these communities tell the stories in their own words.

Verbatim comments used in the transcriptions were tape-recorded at the National Conference on Rural Health held in Denver. The series was produced by the Rocky Mountain Radio Council. Each program runs fifteen minutes.

Covered in the series are such vital topics as "How Small Towns Can Get a Doctor," "How Small Towns Can Keep a Doctor," "Training Rural Doctors," "Working Together for Health" (health councils) and "Projects for Your Health Council." The theme that "self-help is the American way" runs throughout the programs.

FIRST AID GUIDE NOW AVAILABLE

Useful tips on how to handle common first aid emergencies have been compiled in a pocket-sized manual by the AMA's Council on Industrial Health and the Bureau of Health Education. The booklet outlines adequate first aid instructions for everyday illnesses and injuries in a simple way. It is designed to guide those who have not received formal first aid training as well as to refresh the memories of the experienced. A list of suggested items for a first aid kit also is included.

Single copies are available without charge through either of these AMA departments. Quantity prices will be supplied on request by the Order Department.

STUDENT AMA ANNUAL MEETING

Outstanding leaders in medicine and medical education will be featured on the program of the 1952 annual session of the House of Delegates of the Student American Medical Association December 29-30, at the Sheraton Hotel, Chicago.

Dr. Walter C. Alvarez, Chicago, will speak December 30, on "The Disappearing Art of Diagnosing with the Eyes and Ears." John Van Nuys, M.D., dean, Indiana University School of Medicine, will be the principal luncheon speaker the same day, discussing "A Dean and His Problems."

Also included on the intensive two-day schedule will be a luncheon given by the Blue Shield Medical Care Plans and a buffet supper by Abbott Laboratories of North Chicago.

It is hoped that state and county medical societies will lend enthusiastic support to local chapters of the SAMA by making sure that they are represented again this year.

STATES' MEDIATION COMMITTEES

The AMA Council on Medical Service reported at a recent meeting at AMA headquarters that mediation committees had now been set up in each of the forty-eight states, the District of Columbia, and Hawaii, marking a major milestone in the medical care program for the United States.

This is the result of an intensive four-year campaign on the part of the medical profession for the creation of such patient-physician relations bodies throughout the country.

This fact became known as reports were received from the chairmen of seven committees, each dealing with a specialized field of medical care. Other highlights from these reports, presented at a two-day meeting of the council, were:

(1) Voluntary health coverage continues to gain both in quality and quantity. There are ample reasons to predict that 90 million persons will be covered by some form of protection against the costs of illness, accident and hospitalization in 1953.

(2) Community health councils have increased from forty-eight local health councils in 1943 to 1,190 in 1951, showing a substantial increase during the past year. Twelve indigent medical care studies have been made under the direction of the council, and plans are under way for an additional nine studies. Placement services for physicians have been established in thirty-seven states. Approximately 600 emergency call programs are now in operation throughout the United States.

The committee chairmen making the reports were: Drs. Ralph A. Johnson, Detroit, physician placement services; H. B. Mulholland, Charlottesville, Va., indigent medical care; W. L. Crawford, Rockford, Ill., maternal and child care; W. A. Sawyer, Rochester, N. Y., industrial workers; Percy E. Hopkins, Chicago, prepayment, and F. J. Elias, Duluth, health co-operatives.

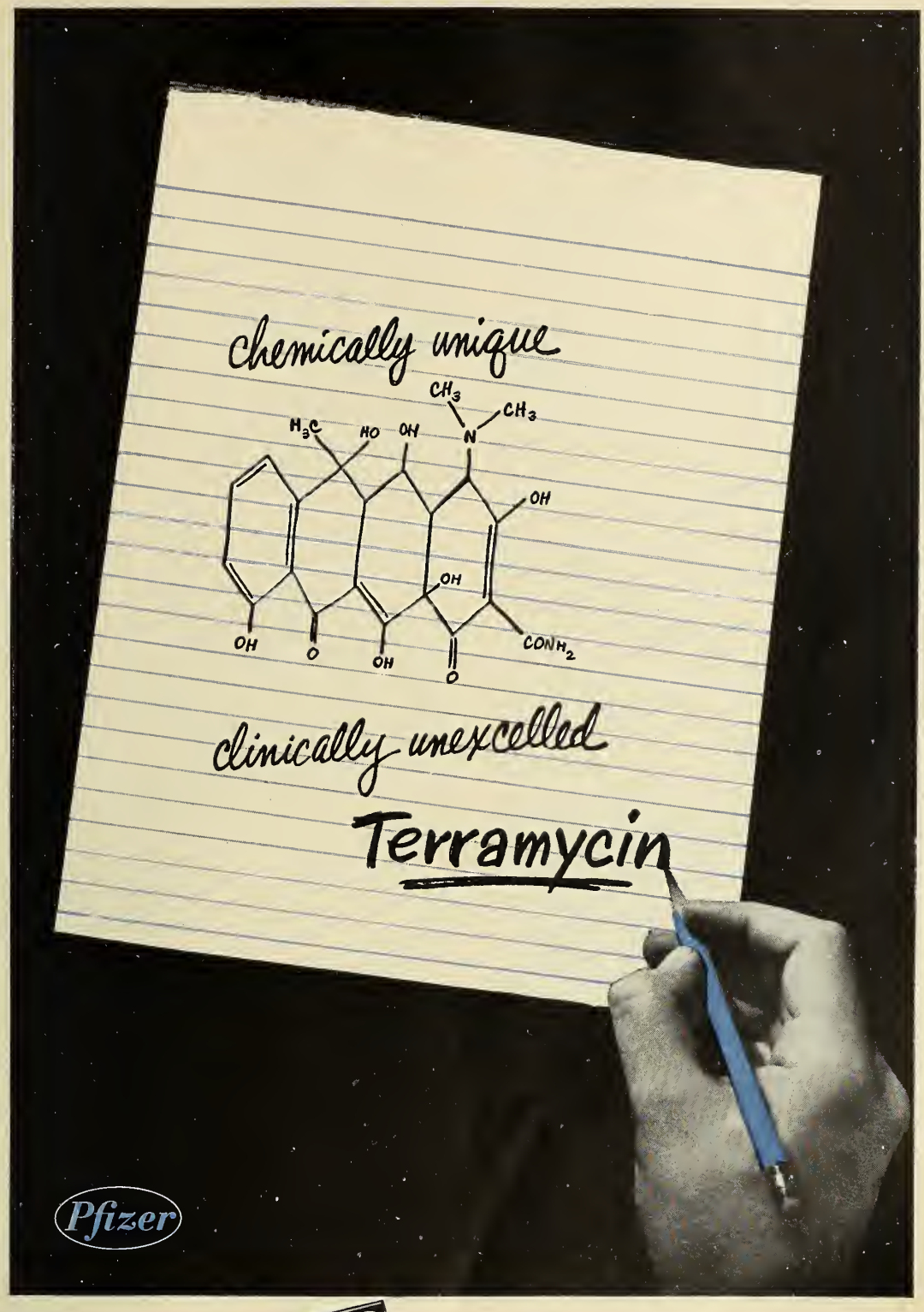
The greatest possibility for improvement of results in the treatment of gastric carcinoma, other than earlier diagnosis, is more aggressive surgical intervention.

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More Contributions to AMEF

Following are the names of the doctors of medicine, alumni of the College of Medicine of Wayne University, who have contributed (up to September 30, 1952) to the Medical Library Fund, for which they receive credit from the American Medical Education Foundation. About $87,000 from about 600 contributors has been received:

Cecil Akroyd, Herman Albrecht, Elvis S. Alford, B. T. Alm, Sam Alpiner, Robert L. Alznauer, George H. Andries, Raymond C. Andries, L. Byron Ashley, Lawrence R. Atler, Don A. Bailey, Louis J. Bailey, W. Claire Baird, Frank T. Balaga, M. A. Balcerski, Radivoj Ray Barber, Benjamin Barenholtz, Morton Barnett, William H. Barron, A. Duane Beam, Donald C. Beaver, C. L. Becklein, Morris C. Beckwitt, W. George Belanger, Roland R. Benson, Frederick E. Bentley, Charles J. Berger, Joseph H. Bergin, Ivan C. Berlien, Gerald J. Bernath, Bernard Bernbaum, Albert E. Bernstein, Montrose M. Bernstein, Robert J. Bernucci, Leonard Birndorf, Alexander W. Blain, Alexander Blain, III, James H. Blain, Jr., Alfred Bleier, Joseph Bleier, Abraham Bloch, Elliss J. Bolan, Ephraim B. Boldyreff, Ralph H. Bookmyer, Robert M. Bookmyer, Sidney Bornstein, Roman E. Boucher, Walter H. Boughner, Edwin G. Bovill, Horace F. Bradfield, Lionel Braun, Viola G. Brekke, William B. Bremer, M. S. Brent, Norman W. Brey, William J. Briggs, Osborne A. Brines, Clark D. Brooks, R. A. Brown, Reeve M. Brown, Earl Brubaker, Edwin L. Bruer, Donald R. Bryant, Henry Burkhardt, D. H. Burley, Robert T. Burns, Perry P. Burnstine, Roswell G. Burroughs, Samuel A. Butler, Edward J. Buttrum.

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Following are the names of the doctors of medicine, *not* alumni of the College of Medicine of Wayne University, who have contributed to the medical library fund, for which they receive credit from the AMEF:

Sidney L. Adelson, E. Bryce Alpern, Charles H. Althuler.
James B. Blodgett, I. V. Botvinick.
Mario S. Cioffari, Harold E. Clark, Charles L. Clarke.
I. Donald Fagin, Samuel Glassman, E. S. Gurdjian, Charles G. Jennings, Charles G. Johnston.
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Carolyn Salisbury, Suzanne Sanderson, Geza Schinagel, Edward D. Spalding, Saul C. Stein, Walter A. Stryker, H. Saul Sugar.
Ivan B. Taylor, Robert C. Thumann, Vincent J. Turcotte.
J. K. Weston.

A list of Michigan doctors of medicine who contributed direct to the University of Michigan Medical School, for which they receive credit from the AMEF, will be published in a forthcoming number of JMSMS.

Kraurosis or leukoplakia may be associated with cancer of the vulva.

* * *

The best treatment for leukoplakia of the vulva is radical excision.

* * *

Primary cancer of the liver may originate from the parenchyma or the biliary system and many are secondary to cirrhosis.

* * *

The outstanding sign of primary liver cancer is progressive liver enlargement frequently accompanied by anemia, weakness, abdominal pain and gastrointestinal disturbances.



Federal Medicine

COMPULSORY HEALTH INSURANCE— AN ECONOMIC ISSUE

In a study reported in the February issue of the *Quarterly Journal of Economics,* Rita and W. Glenn Campbell suggest that money spent for better housing, sanitation and research in preventive medicine for low income groups would be a more economical method of raising the country's health level than by expending the same amount in drugs and physician's fees. The authors feel that families with incomes of less than $2,000 per year—less than the pre-Korean living level —probably cannot pay for their medical expenses. There are 9.6 million such families in the United States. However, some of these are farm families with non-money incomes, and others may be only temporarily at this income level. It is estimated, therefore, that 6 million of the 46 million families in the United States cannot afford medical expenses. The Campbells point out that charity cases will continue to be financed from general tax funds even under a compulsory health program.

IT'S STILL COMPULSORY

Oscar Ewing has finally admitted publicly that any government-sponsored health insurance plan would have to carry the compulsory feature.

Mr. Ewing made the admission in an informal interview with three CBS radio Washington correspondents on the CBS network show, "Capitol Cloakroom," from Washington on September 5. He was a guest on the program; the three correspondents were Griffing Bancroft, Bill Sydell and Ron Cochran.

The interview, as transcribed by Radio Reports, Inc., went like this:

COCHRAN: "Well, do you know how Governor Stevenson stands on the matter of compulsory health insurance?"

EWING: "I think he has some questions in his mind about it. I have not discussed it with him. The only thing that I know about his views was in one of the magazines recently where he said that he was not sure that this suggestion of ours was the best, that he rather —he looked with some favor on a plan that would take care—where the insurance would merely take care of catastrophic illnesses, that is probably that the patient would have to pay the first hundred or 150 or 300 dollars of the sickness and then the insurance would take care of the rest."

COCHRAN: "Like $50 deductible automobile insurance."

EWING: "Exactly."

COCHRAN: "If you get a fender bumped."

EWING: "And such thing is well worth considering."

BANCROFT: "Would it have a compulsory feature in it?"

EWING: "Oh, *you can't have it without the compulsory feature* to my way of thinking because that's the only way that you can get everybody in and get the insurance rates down to a low enough level so that it's a workable thing. Otherwise, all the people that are prone to sickness and the older people, they'll take the benefits of insurance and the young people and the healthy won't do it, and it's very much better to have it just as you do social security, your old age and survivors insurance. It's compulsory and you're building up a fund there during your working years that meets these expenses."

—AMA Secretary's Letter.

SUBVERSIVE CONNECTIONS CITED

The Washington State Medical Association held a most enthusiastic meeting in Seattle and, in addressing the doctors, Ernest B. Howard, M.D., Executive Secretary, AMA, said that one of the strongest forces behind the administration's campaign for compulsory, tax-supported health insurance is the Committee for the Nation's Health, which has its headquarters in New York.

"This group," he said, "is the chief propaganda agency for socialized medicine. It has some imposing names on its letterhead—Eleanor Roosevelt, Philip Murray, William Green and Robert Sherwood.

"But it should also be noted that out of 166 charter members, ninety-two have been cited one or more times because of subversive connections or activities by the House UnAmerican Activities Committee. Over half of the members serving as officers and directors since its organization in 1946 have subversive records and have long been associated with avowed Communists."

THE AMERICAN LEGION AND THE DOCTOR

The AMA Board of Trustees has reiterated its previous stand that doctors everywhere should take a more active interest in the affairs of the American Legion. Physicians who are members of the Legion were urged specifically to attend meetings of their posts, since the policies of the Legion, like those of the AMA, are decided at the grass roots level.

The Board's expression came after it had studied a report on health matters which were discussed at the Legion convention in New York a short time ago.

Legion delegates adopted a resolution opposing I.L.O procedures that would socialize medicine by internationa treaty, and they turned down another resolution whic would have mandated the Legion to urge the Veteran Administration to give special recognition to chiroprac tors. This would have permitted veterans to choos chiropractic treatment at government expense. A sim lar resolution for optometry was also defeated. Th chiropractor resolution, coming from eight state depar ments of the Legion, resulted in one of the bittere battles on the floor of the convention. The fact th

(Continued on Page 1414)

Meat...

and its Wide Clinical Applicability

That meat is an important component of the high protein diet[1] employed in the treatment of many pathologic states is evident from the following dietary suggestions that have been recommended by some authorities in the field of nutrition:

Protein of good quality and in adequate amounts is the most effective dietary agent for protecting the liver from damage and for promoting its repair.[2] In the long-term management of chronic liver disease, a suggested diet includes at least 4 ounces of lean lamb, veal, or beef in both the noon and evening meals.[3]

Among the nutritional needs of patients with chronic ulcerative colitis is protein.[4] For such patients a recommended diet includes 4 ounces of tender meat with luncheon and with dinner.[5a]

In diabetes mellitus, maintenance of protein reserves is important for supporting well-being and vigor, for maintaining resistance to infection, and, in conjunction with good general management, for minimizing many of the degenerative changes commonly seen in this condition.[6,7] One ounce of bacon at breakfast and 2½ ounces of cooked meat at each of the other two meals are valuable in a diabetic diet.[5b]

A program of treatment[8] found useful in atherosclerosis of the coronary vessels includes an adequate diet low in fat (20-25 Gm. daily) and normal or moderately high in protein (60-100 Gm. daily), in conjunction with lipotropic agents. A sample menu of this diet lists 2 ounces of lean meat at both the noon and evening meals.

Underweight or average weight patients with persistent low blood sugar levels are benefited by a high protein diet providing meat two or three times a day.[9] In overweight patients of this type, lean meat is served at luncheon and at dinner.

During convalescence from infectious disease, the importance of "high protein-high calorie" diets including generous servings of meat deserves emphasis.[10] For this purpose, a suggested typical daily menu schedule which results in weight gain, improved vigor, and a restored sense of well-being furnishes ½ ounce of bacon at breakfast and 3 ounces of meat at each of the other meals. Supplementary feedings may include additional amounts of meat.

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2. Patek, A. J., Jr.: Evaluation of Dietary Factors in Treatment of Laennec's Cirrhosis of Liver, J. Mt. Sinai Hosp. *14:*1 (May-June) 1947.
3. Portis, S. A., and Weinberg, S.: Recent Advances in the Medical Treatment of Cirrhosis of the Liver, J.A.M.A. *149:*1265 (Aug. 2) 1952.
4. Welch, C. S.; Adams, M., and Wakefield, E. G.: Metabolic Studies on Chronic Ulcerative Colitis, J. Clin. Investigation *16:*161 (Jan.) 1937.
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Editorial Comment

THE PRESIDENT'S POLITICAL CHESTNUT

The President trotted out another of his political chestnuts Tuesday when, addressing a convention of hospital administrators, he revived his socialistic pet scheme. He called it "a goal of enterprise—American enterprise." Which, fortunately, it is not.

In an off-the-cuff remark, Mr. Truman recalled the furor which the medical profession raised when Mrs. Millard Fillmore installed the first bathtub in the White House about 1850. The reactionary doctors wanted to lynch the good lady, he declared.

In a recent issue of the *Saturday Evening Post*, Beverly Smith exploded the Fillmore bathtub legend. He proved that the story was concocted out of whole cloth by Henry L. Mencken in one of the latter's whimsical moments during World War I. Soon after, Mencken confessed his hoax.

Smith, after careful research, learned that the first bathtub was installed in the White House by Truman's idol, Andy Jackson, somewhere between 1829 and 1833.

But here again, the truth is a minor detail to Andy's successor. He sticks by the Fillmore story as proof of how reactionary the medical profession is. After all, it opposes socialized medicine.

"And now," said Harry, just to make monkeys of the medical fuddyduddies, "there are more bathtubs in the White House than in the Benjamin Franklin Hotel."

The management of that hostelry explained they had one in every room—1,200 to be exact.

If the White House has that many, one wonders why it wasn't easier for Harry to clean up his Administration.—Editorial, *Detroit Free Press*, Sept. 18, 1952.

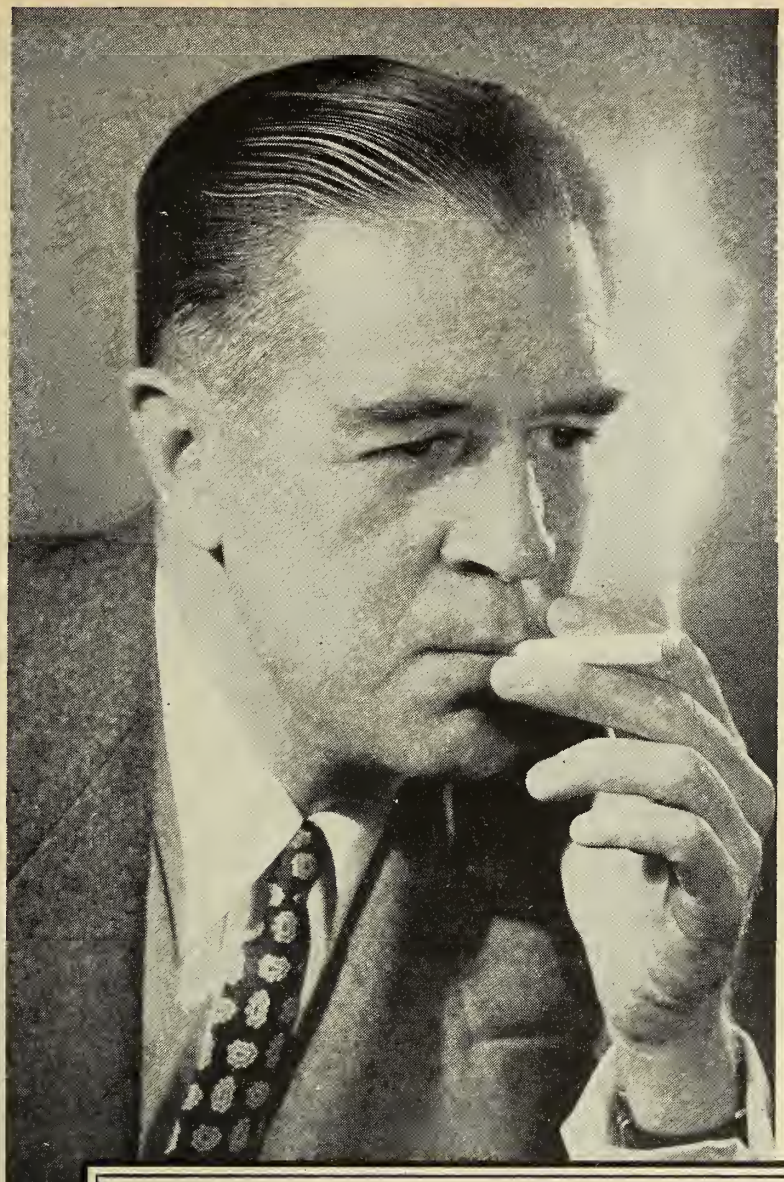
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Payments to student doctors would be unfair to both patients and doctors engaged in private practice. The resources of UMS will not be diverted to the support of hospitals or medical education. The true interests of our public will be served best by such policy.—*United Medical Service Bulletin* (New York).





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PERMANENT RUSK COMMITTEE PROPOSED

The Health Resources Advisory Committee (Rusk Committee) has recommended that it (or a similar group), be continued on a permanent basis. Its summary report says: "It has become increasingly apparent . . . that some mechanism similar to the Committee should be continued not only during this period of mobilization but as a permanent statute of the federal government. The Committee believes it is vital that . . . at a sufficiently high organizational level to make its work effective, there must be a co-ordinating body in the health fields if full utilization for both civilian and military needs is to be made of the health potentials of our nation."

The Committee, organized in 1950, now has three roles, (1) advising Office of Defense Mobilization on all health matters, (2) functioning as the National Advisory Committee to Selective Service, and (3) advising Defense Department on call up of medical reserves by balancing civilian against military needs for physicians and other personnel in the health fields.

The Committee commended the Armed Services for providing the best military medical care in history, while at the same time reducing the physician ratio from the World War II peak of six per 1,000 troops to the current 3.7. This means, the Committee explains, that 5,000 physicians who might be in military service have remained in civilian practice. The Defense Department saving resulting from the lower ratio was estimated at 40-50 million dollars.

SELECTIVE SERVICE

Selective Service's National Advisory Committee is appealing to hospital administrators for help in urging recently-graduated physicians to register under the doctor-draft law. "The only exception," the notice says, "is for those who must complete their internship before receiving their degree and during such internship apply for and accept a commission in the armed forces."

ONCE-DEFERRED 4F'S NOW IN SERVICE

The lowered mental standard for military induction, ordered by Congress, is bringing results. Already 17,000 men once classified 4-F for mental reasons are in uniform and approximately the same number are awaiting induction. Of the 114,000 re-examined so far, 33,000 or slightly less than one third have been found mentally fit for service. Still to be re-examined are 186,000. Congress in June, 1951, directed that the percentile score in the Armed Forces Qualification Test (mental) be lowered from 13 to 10. Re-examinations began the first of this year and are now running at the rate of about 25,000 a month. Congress also ordered that the same physical standards effective in 1945, at the close of World War II, should prevail. The armed forces say, however, that since 1948 physical standards have been no higher than in 1945.

CASUALTIES HANDLED BY NAVAL HOSPITAL SHIPS

For the first twenty-one months of the Korean War, admissions to the three Naval Hospital Ships operating in the theater averaged more than fifty per day, with a peak of almost 100 per day during the hard fighting of late 1950 and 1951. These and other statistics on the three hospital ships—*Consolation, Repose* and *Haven*—were released by the Statistical Division of the Bureau of Medicine and Surgery. Through last March, more than 33,000 casualties were handled by the three ships.—*AMA Capitol Clinic*

"FRINGE BENEFITS"

The United States Chamber of Commerce estimated Saturday that American businesses pay their employes nearly $25,000,000,000 a year in "hidden pay-roll" benefits.

The money goes to the workers under a great variety of programs including pension plans, sickness and death benefits, holidays and Social Security and unemployment insurance payments, the Chamber said.

It based its estimate on a nation-wide survey of 736 companies conducted by Dr. Emerson P. Schmidt, the organization's director of economic research. He said these companies paid out an average of $644 per employe last year in "fringe benefits."

This, he said, was an "all-time high" average cost to the companies.

Schmidt said 138 of the companies were included in two similar surveys by the Chamber. Their "hidden payroll" costs jumped in four years from an average of $410 a year per employe to $681—or 66 per cent—he asserted.—*Detroit Free Press,* Sept. 14, 1952.

THE AMERICAN LEGION AND THE DOCTOR

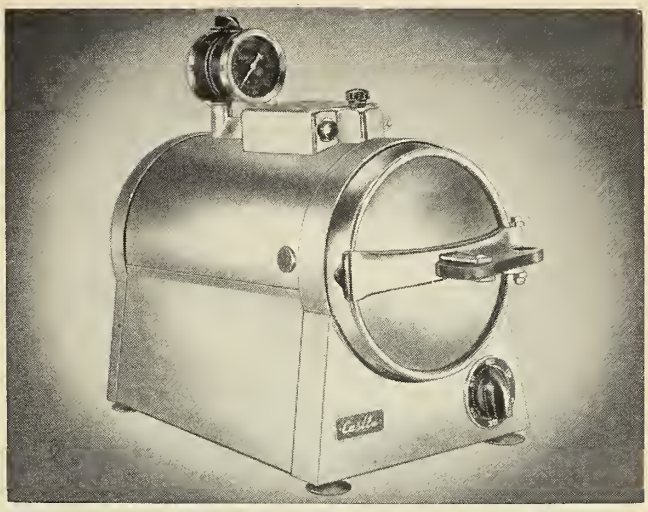
(Continued from Page 1410)

it was defeated was remarkable since such large delegations as Illinois, New York, Pennsylvania and Texas voted solidly for the chiropractor resolution.

Several Legion officers explained that such strength is generated at the local level. That is why more doctors should attend meetings of their local posts where health proposals originate.

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Beaumont and St. Martin

By Stuart V. Smith
Vice President, Wyeth, Incorporated
Philadelphia, Pennsylvania

IT IS fitting, indeed, that we gather in this room tonight to honor the memory of a great man and doctor. Within a few miles of this place, on the Island of Mackinac, in 1822, a medical pioneer made history which has affected the lives of people the world over. Few people, however, know this doctor's name, and fewer still know the significance of his work.

William Beaumont, M.D., is well known to you. His great work, which gave medicine its first reliable information on digestion, has been heralded for decades by the profession, but it has passed almost unnoticed by the people who have reaped the benefits of his study.

Wyeth, who has long been concerned with this problem, undertook a project in 1939 designed to acquaint Americans with their fellow countrymen—physicians and pharmacists who have contributed greatly to the advancement of medicine from which society has benefited.

To accomplish this purpose, a series of original canvases entitled "Pioneers of American Medicine" was conceived. The outstanding American illustrator and muralist, Dean Cornwell, N.A., was commissioned to execute the paintings. Months of painstaking research insured the accuracy of detail that went into each painting.

I recall Dean Cornwell telling me of his experience in gathering background for the canvas that he painted of Major Walter Reed. He spent many weeks in Havana taking photographs and making piles of sketches of furniture and wall details because accuracy is so important. He told me that in order to get sketches of the kind of furniture that likely surrounded Dr. Finlay on the day he received Major Reed he had to visit many of the wealthy homes in Cuba.

"It was a charmng experience," he related, "but also hard work—harder than the kind a door-to-door canvasser does. People don't seem to get used to the idea that an artist works, so each call became a visit with accompanying cocktails. That meant by the time the day had worn on that I had had quite a few. That kind of work takes a lot out of a man."

Well, the canvases were completed and they fulfilled our every wish. They have been and are a great tribute to the doctors who have made such tremendous contributions to American medicine. They have been exhibited throughout the United States and have been seen by thousands of school children and adults alike.

It is my personal opinion that the painting of Beaumont and St. Martin is among Cornwell's greatest. The detail and accuracy; the color and expressions have created a living image in my mind. I hope that you, too, will share this memorable experience when you view the dramatic scene which the artist has recreated.

Major William Beaumont well deserves a prominent place in the history of physiology. His protracted and careful experiments on the French Canadian, Alexis St. Martin, formed the basis of his masterpiece, "Experiments and Observations on the Gastric Juice and the Physiology of Digestion." It is a classic report on the numerous experiments he performed.

I am sure that you all will recall the story which gave birth to this great work. It was in 1822 on Mackinac Island when St. Martin

Remarks delivered on the occasion of the presentation of the "Beaumont and St. Martin" painting to the Michigan State Medical Society, Tuesday, September 23, 1952.

suffered a gunshot wound. Although he recovered, the wound, which perforated to his stomach, failed to heal, making necessary the wearing of a compress over the permanent gastric fistula. He became known as the "man with a lid on his stomach."

Imbued with true scientific spirit, Beaumont, then the army surgeon assigned to Fort Mackinac, accurately recorded the movements of St. Martin's stomach during digestion, and studied the secretion of the gastric juices and the effects of hunger, anger and other emotions on digestion.

I would like to pay special tribute to those of you in this Society who have worked ceaselessly in behalf of your Beaumont Memorial Restoration Fund. When reconstruction of the old American Fur Company Store on Mackinac Island is completed, it will become a medical shrine. It will be a constant reminder to the thousands of annual visitors to the Island of the profession's continued efforts to advance the science of medicine. Wyeth is particularly proud that this painting of Beaumont and St. Martin will hang in the restored fur company store as a perpetual reminder of Michigan's part in significant and inspiring medical pioneering.

Ladies and gentlemen, it is with great personal pleasure and pride that I, in behalf of Wyeth, Incorporated, present to Dr. Otto O. Beck, as president of the Michigan State Medical Society, and as chairman of the Beaumont Memorial Restoration Fund, this canvas of Beaumont and St. Martin from among the Wyeth collection of "Pioneers of American Medicine."

MSMS

The solution to the problem of specific anticancer therapy awaits a better understanding not only of the metabolism of cancer cells but of the mechanism of normal growth as well.

* * *

The development of improved methods of cancer therapy seems certain. In the meantime, over-optimism concerning new remedies must be guarded against assiduously. Every effort must be made on the part of scientists, science writers, and pharmaceutical manufacturers to prevent the release to the lay press of over-enthusiastic news stories of new "wonder drugs" or therapeutic procedures. The false hopes raised by such stories have caused patients to postpone urgent surgery or to refuse irradiation until their lesions have advanced beyond all hope of control. Persons in high government office and other responsible positions also have an obligation to the public to refrain from promoting new and inadequately tested measures. Such misguided activity can result in incalculable harm to the health of the public.

The Value of the Beaumont Memorial to the Medical Profession of Michigan

Harvey M. Merker, Sc.D.
Detroit, Michigan

SINCE Dr. William Beaumont was the first medical man to suspect that there was some other active agent (now known as pepsin) in the stomach besides free hydrochloric acid, I feel it a great honor to be requested to make a few remarks in connection with the Beaumont Memorial. My first assignment at Parke, Davis & Company in 1909, was to develop a new process for the manufacture of pepsin, consequently it has been a real thrill to be connected with this Beaumont project.

When a doctor enters the room, a thousand men appear. He is a composite of—

Jenner—discovered smallpox vaccine
Harvey—discovered the circulation of the blood
Morton—gave the first public demonstration of ether anesthesia
Lister—used first antiseptic in the form of crude carbolic acid
Pasteur—established the fact that germs cause disease. —introduced pasteurization, sterilization, immunization and vaccination against rabies.
Robert Koch—isolated tuberculosis bacillus
Von Behring—produced the first antiserum in the form of diphtheria antitoxin
Roentgen—discovered x-rays
Curies—gave us radium
Walter Reed—proved that the Stegomyia mosquito was the carrier of yellow fever infection
General Gorgas—a great sanitarian, whose methods of sanitation made possible the building of the Panama Canal
Paul Ehrlich—the founder of chemo-therapeutics
Fred Banting—discovered insulin
Alexander Fleming—discovered penicillin, opening up the field of antibiotics

Is it any wonder that James Bryce, the famous English statesman and historian, made the following remark: "Medicine is the only science that labors to destroy itself?"

Address at the Beaumont Breakfast, Michigan State Medical Society Session, Detroit, September 25, 1952.
Dr. Merker is Director of Inventory Control and Chemical and Pharmaceutical Consultant, Parke, Davis & Company, Detroit.

You will note that in the previous list, the name of Dr. William Beaumont is absent. Because of the significance of his fundamental, physiological research, his name should be added. Beaumont's experiments are notable because:

1. They formed the basis of subsequent work on gastric digestion.
2. They shed new light on the nature of the gastric juice and the process of digestion in the stomach.
3. They represented the first study of digestion *in situ*.
4. They were one of the most romantic episodes in the history of medicine.
5. They were carried out in the backwoods of America by a much harassed Army Surgeon with no other laboratory than the gunshot-wounded body of a half-breed Indian, Alexis St. Martin, a human laboratory.
6. They were a milestone on the road to Pavlov's experiments.
7. They are a landmark of American Medical literature.
8. Beaumont was the true leader and pioneer of experimental physiology in the United States.
9. Every physician who prescribes for digestive disorders and every patient who is benefited owes gratitude to Beaumont.

Gentlemen, we have a marvelous opportunity to identify Michigan Medicine with Michigan. The Beaumont Memorial is a beacon to remind the public that medical progress is rooted in the history of this state. The Michigan doctor is privileged to honor this heritage.

Parke, Davis & Company is proud to have had a real part in the introduction of this memorial, having furnished funds for purchasing the original fur-trading post and land.

Medicine has the opportunity of identifying itself with the Beaumont Memorial and we should grasp it in convincing fashion.

Gentlemen, let us make the most of this opportunity, and in doing so, we will honor the medical profession, the people of Michigan, the state of Michigan, and give the Beaumont Memorial the place it deserves among the medical shrines of the world.

MSMS

YOUR SHARE

If everybody in the country were to contribute an equal amount to cover federal spending in 1952, the sum would be $548.38. In 1940, per capita federal expenditures totaled $68.16, while way back in 1900 they added up to only $6.85.

Case of Candida Asthma and Its Management

By O. Neufeld, M.D., and
W. L. Wallbank, M.D.
Toledo, Ohio

THE TERM Candida has been agreed upon by the Third International Microbiological Congress in 1939 to replace the familiar Moniliasis. Candida albicans is potentially pathogenic and may produce lesions in the mouth, vagina, skin, nail, bronchi, lungs and occasionally meningitis. This organism is pathogenic at all ages, in both sexes and in all races.

A case is being presented where candida albicans provoked and caused asthmatic manifestation of hypersensitivity, and the bronchial infection and asthmatic symptoms were probably cured by the persistent use of an aerosol of sodium caprylate.

It has been demonstrated previously that the sodium salt of caprylic acid inhibits, *in vitro,* the growth of Candida albicans (1), (2), and also that sodium caprylate, applied locally, has been effective in the treatment of cutaneous infection due to this organism (3). Due to the popularity of aerosols as a means of introducing chemical agents into the respiratory tract, sodium caprylate aerosol was prepared and proved to be effective in the treatment of an infection due to Candida albicans.

The patient, A.S.P., a white man, born in 1893 in Michigan, gives a history of bronchitis at the age of seven and persistent attacks of asthma since the age of eight. The patient does not remember any childhood diseases. There is no history of asthma in the family and no family history of allergy. The attacks of asthma, which began at the age of eight, were of different duration—from thirty minutes to two hours. At that time, the patient did not have any medication for relief and had to remain in a standing or sitting position until the attack of asthma disappeared. In 1926, he suffered with infection of the sinuses and a few polyps were removed. He did not, however, notice any improvement following this. Since 1931 he started using adrenaline quite frequently. In 1935, because of pyorrhea, upon advice of his dentist he had all his teeth extracted, which supposedly would influence his respiratory suffering. Skin tests were never done and an allergist was never consulted. In January, 1950, he was admitted to Crile Hospital in Cleveland for hemorrhoidectomy. At that time a routine chest x-ray was taken and sputum examined for acid-

fast bacilli which was positive on culture. Because of these findings he was admitted to the Wm. W. Roche Hospital February 1, 1951, where sputum has been found positive for tubercle bacilli.

X-ray Findings: Right—very soft irregular exudative infiltration scattered throughout the major portion of this lung with a thick-walled, well-outlined cavity at the level of the second rib anteriorly. Left—soft exudative infiltration from the apex to the fifth interspace anteriorly, most marked in the perihilar region, but no definite cavity could be found. Diagnosis: pulmonary tuberculosis, far advanced, bilateral, active, severe bronchial asthma.

Physical examination was essentially negative except for coarse râles and wheezing on inspiration and expiration over the entire chest and some moderate limitation of motion in the left ankle joint which resulted from an accident at the age of fourteen.

Blood—Hemoglobin 13.2, RBC 3.09, leukocytes 6.100, neutrocytes 79, lymphocytes 15, monocytes 6. Sed. rate 79 mm. (Westergreen). Urine—specific gravity 1012, no albumen, no sugar, a few leukocytes in the sediment.

FBS—110 mgm. EKG—normal. Blood cholesterol—240 mg. Cephalin cholesterol flocculation test—negative in twenty-four and forty-eight hours. PSP—over 60 per cent two hours.

Because of the positive sputum and x-ray findings, the patient was started on Streptomycin gram one daily combined with pneumoperitoneum. The soft scattered lesions throughout both lung fields did not respond very dramatically to Streptomycin and, as far as his asthma is concerned, he continued to suffer with very severe attacks almost every night. These were relieved with adrenaline.

Sputum collected very carefully to avoid contamination was cultured on Saboraud's dextrose agar. After five days, creamy moist colonies developed in all tubes which displayed the cultural characteristics of Candida albicans. The unstained sputum contained many hyphae and yeast cells which were Gram positive. Cultures were repeated with the same results. Staphylococcus aureus and alpha hemolytic streptococcus were cultured from the sputa on bacteriologic media.

In spite of the positive findings on culture examination, the possibility that Candida albicans may represent a common association in pulmonary tuberculosis was not excluded until the patient responded to specific therapy and repeated examination of sputum for Candida albicans following treatment was negative.

Treatment.—All drugs previously taken for relief of asthma as well as streptomycin were discontinued and a 10 per cent solution of sodium caprylate in propylene glycol was prepared and administered every three hours. Totally, he received one to two grams of sodium caprylate every twenty-four hours by inhalation. This therapy was continued for a period of four weeks. The patient became essentially free of asthma and at the time of this writing, four months after completion of the therapy, the patient has remained essentially free of asthmatic manifestation during the entire period.

Sputum cultures on Saboraud's medium showed no growth of Candida albicans on a number of occasions, and a drop in eosinophil count from 34 to 17 was noted. On physical examination, he has musical râles over the left chest posteriorly.

His pulmonary tuberculous lesions were not influenced at all by the sodium caprylate inhalation.

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CHARITY IS NOT MASS PRODUCED

Worthy desire sometimes cloaks unworthy principle. This may be happening in the present tendency to federate fund raising for charity. Nothing could be more worthy than charity. To give to others is the ultimate proof of civilization and maturity. But when charity takes on the aspects of mass production and dictatorial direction it becomes something other than charity. Hidden beneath the golden cloak of charity is the leaden foot of authoritarianism.

The very word *charity* implies something to which the principles of big business can never apply. It is derived from the Latin *caritas* meaning dearness or love. First definition in Webster is, "Christian love." This is followed closely by, "Divine love for man—act of loving all men as brothers because they are the sons of God." Thus true charity is an expression of warm human interest in the lives of others. It is an overflow from the deep well of kindliness within and carries with it the gift of money or goods. The word *charity* does not seem to fit very well when the giver, just to avoid embarrassment, parts with a sum of money, neither the amount of which nor destination of which is determined by himself.

The person who gives charitably should be free to choose the individuals or groups to whom he is to give. He should know who is to receive his money and how it is to be used. He should be convinced that the need is great and the expenditure is sound. Such individual freedom and individual responsibility is largely lost in federated giving. Amounts to be raised are determined not by the interest of the giver but by a board of experts. They, impersonally and with great impartiality, direct an affair which should be intensely personal and decidedly partial. No man should tell another whom he should love.

Charity is one of the divine attributes of mankind. Like Portia's quality of mercy it blesses both the giver and the receiver. There should be no restraint of charity. It should come freely from the heart for it is truly the result of individual generosity. It is not subject to mass production.—*Northwest Medicine,* September, 1952.

Recent Advances in the Diagnosis of Heart Disease

By Raymond D. Pruitt, M.D.
Rochester, Minnesota

I SHOULD LIKE to begin this discussion with an obvious comment upon the smugness evinced by its title. We say we are going to talk about recent advances in the diagnosis of heart disease when actually we have neither the wisdom nor the vantage point of time to judge whether the matters of which we speak are advances or regressions. When we shear away the scientific trappings, we recognize that these things which today we are doing differently from the manner in which they were done ten years ago have no unique qualities other than complexity and strangeness. Another ten years may find us reverting to the simpler methods presently discarded.

The Electrocardiogram

It would be a reasonable estimate, I believe, that fully one third of the articles in each issue of the two leading American journals of the heart and circulation are concerned with electrocardiography. I believe it would be equally reasonable to state that in so far as the care of the patient is concerned, there has been no publication of major significance since the article by Wilson and his associates on the precordial electrocardiogram in 1944.[5] Some interesting observations have been reported subsequently, a few of which we shall consider presently. But there is basis for wondering whether the continuing efforts at refinement in this particular field are justified.

There has been change, however, in the application of electrocardiography to the care of the patient. This change is the immediate consequence of dissemination of knowledge concerning those fundamental studies made and reported prior to 1944. It is becoming increasingly uncommon to see an electrocardiogram inadequate with respect to the number and type of leads. Interpretations generally speaking are becoming more exact and less speculative. "Coronary sclerosis" as a diagnosis apart from myocardial infarction or ischemia is being discarded as a proper electrocardiographic deduction. These changes truly are advances of a kind and at a level of greatest significance in the care of the patient with cardiac disease.

But as the physician has come to recognize the limitation of the routine electrocardiogram in the diagnosis of coronary sclerosis unattended by myocardial changes, he has sought other ways of identifying the presence of clinically significant sclerosis. The recording of electrocardiograms on patients subjected to some circumstance which places the heart under stress now has been carried on for a period sufficient to permit reasonably mature judgment on the usefulness of such procedures. The observations of my colleagues and myself would lead us to propose:

1. That the method of imposing the stress is not an issue of major importance in determining whether or not useful information is derived from the procedure. Either exercise or exposure to oxygen deprivation can be carried to a point of producing stress with comparable results.
2. That irrespective of the method used, the relationship between the degree of coronary sclerosis in the patient and the degree of abnormality appearing in the electrocardiogram during the test will remain frustratingly variable. We have observed two patients, one of whom exhibited marked electrocardiographic changes when subjected to oxygen deprivation and another who did not. Both died within a few months following the test and at necropsy were observed to have hearts of similar size and coronary sclerosis of equal degree.
3. That because approximately 25 per cent of patients whose coronary arteries are sclerosed to a clinically significant degree do not develop electrocardiographic changes of consequence when exercising or subjected to oxygen deprivation, neither of these procedures can be relied upon as a means for excluding the presence of coronary sclerosis. Since there is little joy to be had in proving that a patient has coronary sclerosis and since this is the only reliable contribution which can be derived from exercise and hypoxia tests, we as clinicians await the development of an effective means of ruling out rather than ruling in the disease.

From the Division of Medicine, Mayo Clinic, Rochester, Minn.

Presented at the Eighty-sixth Annual Session of the Michigan State Medical Society at Grand Rapids, Michigan, September 28, 1951.

The esophageal electrocardiogram has been studied carefully by a number of observers in recent years. In our own experience its usefulness has been primarily in making more evident in cer-

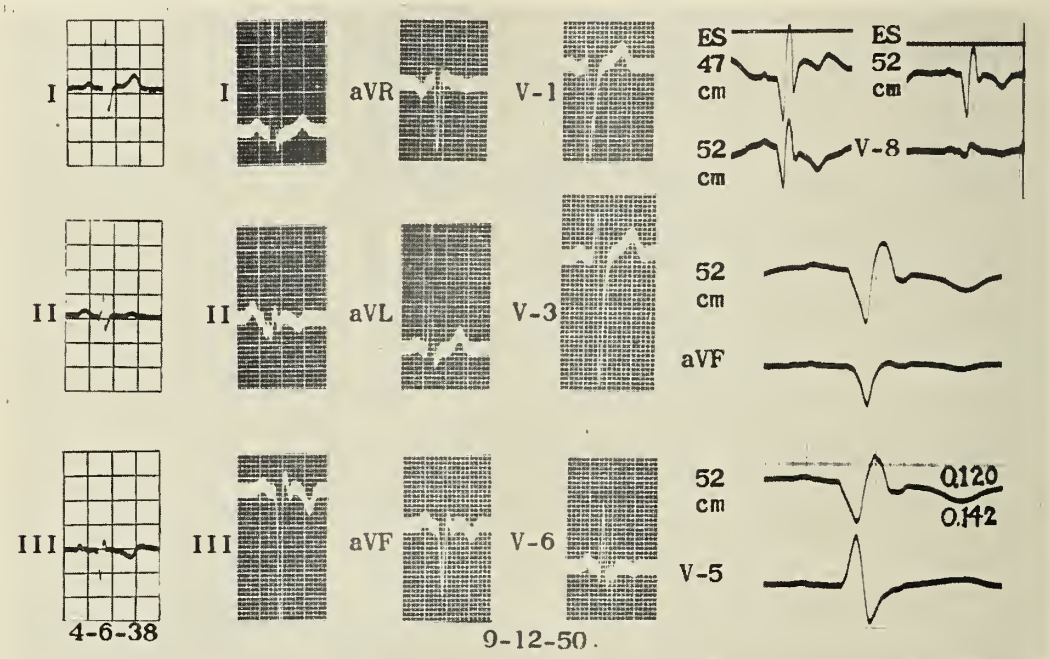


Fig. 1. Electrocardiograms in Case 1. The two sets of records in the lower right hand corner of the figure were made at triple the usual camera speed. "ES 47 cm" indicates an esophageal lead made with the electrode approximately 47 cm. from the dental margin. For additional details, see text.

tain instances the pathologic character of changes identified already in standard limb leads II and III and extremity lead aVF. We have found this technic helpful also in localizing more precisely the area of myocardium to which excitation is delayed in cases in which an increased width of QRS complex develops in the wake of an infarction.[1] In illustration of this function the following case is presented.

Case 1.—A man, fifty-four years old, registered at the Mayo Clinic in September, 1950. He stated that in 1948 he had suffered an attack of pain in his chest which persisted for three days. The attending physician concluded that the patient had experienced a myocardial infarction. The patient spent seventeen weeks in bed, returning to light work thereafter. He experienced pain in the precordial region with effort.

When he was examined at the clinic, his blood pressure was 170 mm. of mercury systolic and 108 mm. diastolic. His weight was 216 pounds. The roentgenogram of the chest showed moderate cardiac enlargement.

In the electrocardiograms (Fig. 1) are found changes indicative of previous posterior myocardial infarction. The duration of the QRS complex is between 0.12 and 0.14 second as determined in the conventional leads, yet the form of these complexes is not consistent either with right or with left bundle-branch block. In the esophageal electrocardiograms recorded with the electrode at a level 52 cm. from the dental margin (Fig. 1, ES 52 cm.), the "intrinsicoid" deflection occurred 0.12 second after the onset of the QRS complex, the total duration of which was 0.142 second. These findings indicate late excitation of that portion of the heart underlying the esophageal electrode, namely, the posterior aspect of the base of the left ventricle.

The increased duration of the QRS interval is related here not to bundle-branch block, but to a peculiarly slow spread of excitation, probably over aberrant pathways, into the posterobasal portion of the left ventricle. This phenomenon develops in the wake of myocardial infarction and is variously termed arborization, postinfarction[1] and periinfarction block.[2]

If consistency is to be maintained with those statements which introduced this discussion of electrocardiography, then it must be observed that the identification of postinfarction block is just that sort of refinement accounts of which fill the pages of journals on heart disease, intrigue the students of electrocardiography, produce despair in the minds of busy practitioners, and add little or nothing to the care of the individual patient.

Let us hope, however, that even these minutiae may contribute to that steady evolution of electrocardiography from an empiric study to a mathematically precise science, and may aid in solving the intriguing problem of how the excitation process spreads through the myocardium.

Ventricular Catheterization Studies

The popularity of electrocardiography as a diagnostic technic must be derived in part from the totally innocuous and altogether pleasant nature of the procedure from the standpoint of both physician and patient. That one can acquire valuable data pertaining to the state of the myocardium without so much as breaking the integrity of the patient's skin is indeed a remarkable business.

By contrast, ventricular catheterization is the devil's own game. But like many other diabolic devices, this one is exceedingly clever and its institution has opened for its students a whole new field replete with quantitative data so dear to the scientific mind. Because most of the reports concerning catheterization studies have been laden with detail or concerned with innovations for getting more detail, the basic simplicity of the technic sometimes has been obscured. The information derived from catheterization of the right ventricle and related vascular channels is of three kinds. These are: (1) pressure levels in these chambers, (2) oxyhemoglobin saturation at various points along the way and (3) the presence of abnormal communications as evidenced by varients in the course taken by the catheter during the probing process. It is from analysis of evidence derived from these three categories that the majority of diagnoses have been ascertained.

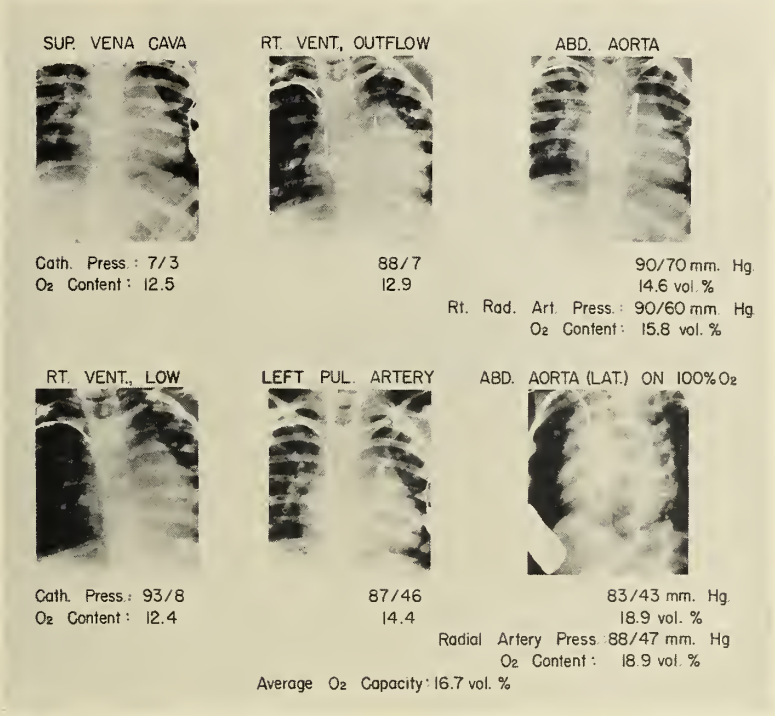


Fig. 2. Findings at the time of ventricular catheterization in Case 2. "Cath. Press." indicates the pressure in millimeters of mercury as obtained at the point where the tip of the catheter lay at the time the accompanying roentgenogram was made. "O_2 Content" refers to the number of cubic centimeters of oxygen contained in 100 cc. of blood.

In illustration of these points, consideration will be given to the following case.

Case 2.—The patient was a boy, four years of age. Examination revealed physical findings which were suggestive of pulmonary hypertension and indicative of a moderate degree of cardiac enlargement. A systolic murmur of moderate intensity was heard most distinctly in the second and third interspaces on the left side of the sternum with transmission toward the left clavicle and the back. In the roentgenogram of the chest the pulmonary vascular shadows were markedly increased. The electrocardiogram was interpreted as being compatible with hypertrophy of both ventricles. The clin-

ical picture was regarded as being most suggestive of a defect either in the atrial or in the ventricular septum, but the possibility of a patent ductus arteriosus was held to be sufficiently good and the patient's condition sufficiently critical that ventricular catheterization was undertaken even though the child's age necessitated that this procedure be done with the patient anesthetized.

The findings at the time of the catheterization are summarized in Figure 2. The pressure readings confirmed the clinical impression that pulmonary hypertension existed. The values for the oxygen content of the several samples of blood revealed definite "arterialization" of the specimen drawn from the pulmonary artery. And finally the course taken by the catheter indicated a communication between the pulmonary trunk and the descending limb of the aortic arch. Hence the diagnosis of patency of the ductus arteriosus associated with pulmonary hypertension was made. At the time of surgical exploration this diagnosis was confirmed and the ductus was ligated.

In what type of diagnostic problems has the procedure of ventricular catheterization established its greatest usefulness?

The answer is a simple one: In those problems in which study by catheterization has disclosed a surgically amenable lesion. Chief among such lesions are (1) atypical patent ductus (when typical, the diagnosis can be made on clinical grounds alone), (2) pulmonary valvular stenosis without ventricular septal defect, (3) mitral stenosis and (4) tetralogy of Fallot.

With the exception of mitral stenosis these conditions are relatively rare. The problem of mitral stenosis on the other hand sooner or later will present itself to every physician engaged in the practice of medicine. The results of ventricular catheterization are useful in three respects:

1. In excluding the presence of shunts. Only in exceptional instances does the diagnosis of mitral stenosis rest heavily on the results of catheterization studies. Instances are encountered in which the distinction between mitral stenosis and interatrial septal defect cannot be made with certainty unless catheterization studies are performed.

2. In establishing the presence of certain abnormal states characteristic of severe mitral stenosis, namely, pulmonary hypertension and a low, relatively fixed cardiac output.

3. In providing a means for studying objectively the results of attempts to relieve by surgical methods the obstruction imposed by the stenotic valve. In some instances in which a mitral commissurotomy has been done, we have observed a significant drop in the pressure within the pulmonary artery and a rise in the cardiac output particularly with mild exercise. On the other hand certain patients have had no appreciable improvement in these abnormal states. I should like to emphasize, however, that it is from a study of the facts in relation to patients that a sound position regarding mitral commissurotomy and related procedures will develop, and not from a study of the patients' subjective reactions alone.

One interesting corollary to the development of surgical treatment for mitral stenosis has been a sharpening of our discernment regarding certain features in the clinical diagnosis of the disease. We have come to recognize more clearly the rather remarkable variation in the nature of auscultatory findings which may occur from time to time in some patients. This recognition is the direct outgrowth of a plan whereby several consultants appraise a patient's problem within a brief time during the preoperative period. One may make an unequivocal diagnosis of mitral stenosis on the basis of a characteristic early and mid diastolic rumbling murmur. Within the hour, a second consultant, failing to hear the murmur, may question the diagnosis, recalls the first consultant, who, upon re-examining the patient, notes a definite change in the auscultatory findings with disappearance of the pathognomonic murmur.

We have thought again about the relationship between mitral stenosis and mitral regurgitation and are strongly inclined to the view that the existence of marked mitral regurgitation in the presence of an advanced stenosis is indeed uncommon. Hence when evidence can be assembled sufficient to make relatively certain a diagnosis of severe mitral stenosis, concern over coexisting regurgitation need not be serious even though a definite systolic murmur can be heard at the mitral area. The characteristics most helpful in recognizing the existence of severe stenosis are:

1. A typical rumbling diastolic murmur best heard at a point overlying the cardiac apex. This murmur occurs in coincidence with the phase of most rapid ventricular filling which takes place in mid and late diastole when the auricle is contracting rhythmically and in early and mid diastole when auricular fibrillation is present.

2. Pulmonary hypertension is evidenced in an accentuated second pulmonic heart sound, a



Fig. 3. Case 3. *(a)* Roentgenogram of the chest. *(b)* Angiocardiogram.

Graham Steell murmur and, in roentgenographic and fluoroscopic studies, dilatation of that portion of the cardiac shadow formed by the pulmonary artery. Precise measurement of the degree of hypertension is, as noted already, a valuable function of studies made at the time of catheterizing the right ventricle and pulmonary artery.

3. Right ventricular hypertrophy as evidenced by roentgenographic studies and by electrocardiographic findings.

On these clinical observations combined with careful appraisal of the historical data, the major steps can be taken in the selection of patients for mitral commissurotomy.

Angiocardiography

With respect to the technics of angiocardiography, I would make no pretext of competency. We are all familiar with the basic problems of the method which are (1) to get a sufficiently high concentration of dye in one or more chambers of the heart or in some portion of the great vessels to visualize adequately the structure under examination and (2) to secure roentgenograms precisely at those moments when visualization of chambers is most satisfactory.

The actual field of usefulness for the method has much in common with that of ventricular catheterization. Because catheterization can be done at a more leisurely pace, and because it provides information regarding pressure relationships and oxyhemoglobin saturations within the chambers of the right side of the heart and pulmonary arteries, this method has taken precedence in our hands over angiocardiographic study. However, in certain instances, the latter method is quite adequate and readily accomplished. This is particularly true when the problem concerns a structural peculiarity in the vascular tree or of the heart at a site beyond the pulmonary arterioles, the ordinary limit of penetration with a catheter. Such structural peculiarities are represented in coarctation or aneurysm of the aorta. A related field of usefulness is illustrated in the following cases:

Case 3.—The patient was a man, fifty-one years of age. He had no significant complaints related to his cardiovascular or pulmonary system. An examination ten years prior to his current visit had disclosed the presence of a fairly loud systolic murmur which was heard over the entire precordial area. During the intervening years, the character of this murmur had not changed. The roentgenograms of the chest revealed the presence of an anomalous shadow in the region of the hilus of the left lung (Fig. 3*a*). Study by fluoroscopic technic led to the conclusion that this shadow probably was cast by an enlarged pulmonary artery. However, a tumor of other origins could not be excluded and the decision was reached that an angiocardiogram should be made. Roentgenograms made 2.5 seconds after beginning the injection of iodopyracet (diodrast) showed marked filling of the main pulmonary artery and its trunks (Fig. 3*b*).

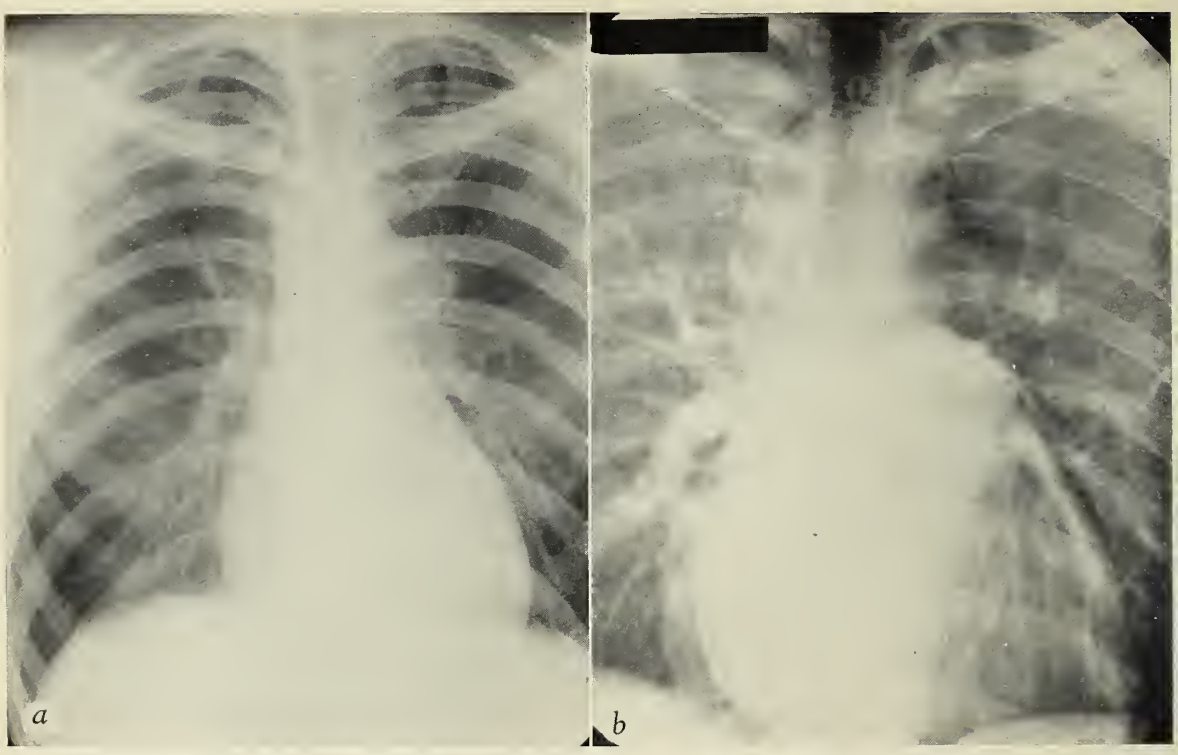


Fig. 4. Case 4. *(a)* Roentgenogram of the chest. *(b)* Angiocardiogram.

The left main pulmonary artery was quite large and formed the shadow in the region of the hilus of the left lung. Surgical exploration of the chest was held unjustified in view of these findings.

Case 4.—The patient was a man, thirty-three years of age. He complained of hoarseness which had developed six months prior to his registration at the clinic. Examination of the larynx disclosed fixation of the left vocal cord. The findings in routine roentgenograms and on fluoroscopic examination of the chest were interpreted as indicative of some enlargement of the left pulmonary artery (Fig. 4*a*). However, an angiocardiogram revealed that the pulmonary artery appeared to be of normal size and no opaque material entered the region of the shadow at the hilus of the left lung (Fig. 4*b*). Because of this finding, surgical exploration of the chest was undertaken. A fixed mass was found in the left hilar area. A biopsy was carried out, the specimen removed showing neoplastic cells of a highly malignant type.

In these two cases, the findings obtained by the usual roentgen-ray studies were essentially the same, yet the underlying structural abnormality was entirely different. By angiocardiography a sufficient degree of distinction was established to permit a logical decision regarding the necessity for undertaking further treatment.

Ballistocardiography

If I am to be honest, I must preface my brief remarks on the subject of ballistocardiography with the admission that my attempts to apply the ballistocardiogram to the analysis of clinical problems have been of limited scope. I have listened to a few individuals talk in a most interesting fashion about this device which records certain waves set up by "the impact of the moving blood in the heart and great vessels."[3] The form of these waves is influenced, among other things, by the amount of blood expelled by the heart and by the acceleration imparted to it as it is thrown out. If quantity expelled were the only variable influencing the curves, then the cardiac output could be calculated quite simply from them. Likewise, if acceleration imparted to the blood could be derived exactly, this would be information of a useful sort. But the two components cannot be separated and computations must be qualified as indicative of "maximum cardiac force."[4]

These efforts do not merit scoffing criticism. Almost certainly significant information of a sort ultimately will be made available by application of the method. For the present, however, the ballistocardiograph occupies a position not unlike that assigned by Dr. Logan Clendening to the

(Continued on Page 1432)

Missed Abdominal Emergencies

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EVERY DOCTOR of medicine, regardless of his specialty, will encounter and be challenged by acute abdominal conditions. All of us have missed diagnoses. To diagnose incorrectly after consultation, study of the indicated laboratory procedures and the help the x-rays readings can bring us, should cause few regrets, if the treatment remains surgical once the abdomen is opened. If, however, we add a surgical procedure to a failing coronary occlusion, or an acute pneumonitis, we shall always regret our part in shortening rather than prolonging a life.

The purpose of this paper is to review candidly a number of missed abdominal emergencies which have come under my observation.

Case 1.—The patient was a fifty-one-year-old white man who was admitted to the hospital October 31. He complained of right upper quadrant pain of a recurrent character and of four years' duration. Fats aggravated the symptoms. X-rays showed a non-functioning gall bladder. No stones were demonstrated. The laboratory findings were negative save for a leukocytosis of 17,600. An ECG had been normal two months prior to admission. He had had trauma to his left shoulder so that the pain he developed in his left arm was discounted as the result of this old injury. No repeat ECG was run. On November 5, the fifth day after admission, a cholecystectomy was performed. During the attempt to remove an incidental appendix, the patient suddenly ceased breathing and expired despite attempts to resuscitate him. Autopsy showed a recent coronary occlusion and rupture of the infarcted left ventricular wall.

Conclusions.—We now believe that the falling systolic and pulse pressures should have offered a warning and tipped us off to the expediency of running a second ECG. It is to be regretted that a chronically infected gall bladder, which incidentally did contain stones of a soft non-opaque nature, and the trauma of the left shoulder did camouflage this diagnosis. We would like to have had this patient receive oxygen inhalations in high concentration during one of his attacks of pain. Coronary insufficiency would have been relieved and thus perhaps diagnosed.

Case 2.—A sixty-one-year-old white woman was admitted August 4, complaining of swelling of the abdomen for two and one-half months. In January she had diarrhea for one week. The stool decreased in caliber and became dark. She had been treated for hemorrhoids and colitis for three years. An increase in the size of the abdomen was noted in May. On admission the abdomen was the size of a term pregnancy. Her only other complaint was weakness. Rectal examination showed impaction. She was cyanotic. Before much could be done she expired. This was the day following her admission on August 4. The autopsy showed a tremendous megacolon or Hirschsprung's disease.

Conclusions.—With a little x-ray help this case could have been diagnosed any time during the patient's last five years of life. Whether a low residue diet, saline laxatives, enemas, prostigmine, lumbar sympathectomy, section of the presacral nerve and partial or total exclusion by ileosigmoidostomy or ileorectostomy would have materially altered the final results we do not know. We believe her life could have been prolonged if she had been accurately diagnosed before the onset of an acute toxic state.

Case 3.—A twelve-year-old white girl was admitted to the hospital March 25, complaining of diarrhea of three days' duration. She had six to ten watery stools a day. She had frequency but no burning on urination. On the day of admission she had nausea and vomiting. There was a dull pain in the right kidney area and epigastrium on walking and coughing. Examination and laboratory findings were negative. The following day there was definite right lower quadrant spasm and rebound tenderness. It was decided to do an appendectomy. During the operation, the patient suddenly ceased breathing and there was cardiac arrest. Two intra-cardiac injections of adrenalin were made. Pressure oxygen was used. Approximately twelve minutes after cardiac arrest, the pericardium was entered through the abdomen and the heart massaged. Approximately one and one-half hours after artificial respiration was started, she breathed by her own volition. Fifteen minutes later pulmonary edema developed. She was given atropine and serum albumin. Her lungs were clear three hours later. She was given 500 cc. of blood shortly after cardiac arrest and 500 cc. after her lungs cleared of edema. Despite this and digitalis, she expired nine hours after cardiac arrest had occurred. At autopsy, an atypical bilateral pneumonia was demonstrated. There was pulmonary edema and the usual anoxic petechial hemorrhages of pericardium, lungs and brain were noted.

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Conclusions.—Our sincere sympathies are extended to anyone who encounters a problem of this nature. It is most unusual for even an atypical pneumonia to be accompanied by the physical and laboratory findings recorded in this case. Most devastating of all was the unexplainable development of deep shock during the operation. This emphasizes the necessity of a well-organized preconceived set of procedures to be utilized in such an emergency. We would summarize shock treatment in the operating room as follows:

1. Stop all operative procedures at once and concentrate on supportive treatment.
2. Lower the head of the table.
3. Give artificial respiration and pressure oxygen in high concentration.
4. Maintain body heat.
5. Intravenous infusion of blood, plasma, saline or glucose depending in that order whichever is more quickly available.
6. Avoidance of vasoconstrictors in profound shock because they reduce venous inflow and cardiac output. Do not "blitz" the patient.
7. Cardiac massage as soon as arrested heart action is diagnosed.

Case 4.—A sixty-year-old white man was admitted to the hospital on January 8, 1952, with a history of having been struck by an automobile. When examined in the emergency room, he complained of pain in the xiphoid region, left lower thoracic region and the area adjacent to the left iliac crest.

Chest x-rays indicated that the diaphragm was abnormally high. It was smooth in outline and showed the usual gas bubble and fluid level just beneath that.

Intercostal block was ordered at that time and relieved all but the xiphoid pain.

On January 9 in an attempt to relieve the cyanosis, he was taken to the operating room and a thoracotomy tube was inserted and air was obtained followed by about 1000 cc. of thick, blood-stained material. Check-up x-rays showed the fluid level below the second interspace. A second tube was inserted at the fifth interspace.

On January 10 blood pressure was 60/40. The patient was still very cyanotic. Gastric contents were observed coming from the thoracotomy tube. Review of the x-rays showed what was probably a rupture of the diaphragm with the stomach in the left chest.

The patient was then taken to the operating room and the left 9th rib removed. Part of the transverse colon, stomach and spleen was observed in the chest cavity. A rent in the stomach, 3 inches long, was repaired. The abdominal contents were replaced in the abdomen. At 11 P.M. that night blood pressure was 178/124.

Conclusions.—There is a standing rule in this hospital that if a patient is injured severely enough to suspect a severe chest or abdominal injury that a Levine tube be inserted. Certainly, if the patient goes to the operating room he will be a better operative risk.

In this case, the Levine tube was not inserted and the accurate diagnosis was not made until the third day following the accident. Fortunately, this oversight did not result in a fatality.

Case 5.—This fifty-four-year-old woman was admitted on November 26, 1951, with a history of having had stomach pain for over four months. At present she had severe abdominal pain with nausea and vomiting. This continued until the day of admission to the hospital when she took nine tablets of phenobarbital and was rushed in as a mental patient who had attempted self destruction.

The impression at the time of admission was:

1. Gastritis.
2. Possible peptic ulcer.
3. Possible intestinal obstruction.
4. Possible pancreatitis.
5. Dehydration.
6. Hypochondriac.

X-ray reports on the date of admission stated there was no evidence of free air under either diaphragm.

In the erect view the stomach appeared to be filled with fluid to about 80 per cent of its capacity. There was also a fluid level of the duodenal bulb. No other fluid levels were seen.

This patient expired at 4 A.M. on November 27, 1951. Her stay in the hospital was short.

She went to autopsy and was found to have had a small perforated ulcer which had sealed and undoubtedly accounted for the lack of air under the diaphragm.

Conclusions.—This patient undoubtedly took the phenobarbital in an attempt to relieve her severe upper abdominal pain. Had she been fortunate enough to receive early medical care and if those administering the medical care had not been too greatly influenced by her depressed state, it is entirely possible that an accurate diagnosis might have been made and the patient's life saved. Certainly her physical condition at the time of admission to the hospital would preclude any other results than the fatal one which followed.

The only warning that can be obtained from this peculiar case is that one should not be crowded into the position of diagnosing a mental state when perhaps a patient is taking strong sedation in order to relieve severe physical distress.

Case 6.—This thirty-nine-year-old colored man was admitted on June 25, 1951, in apparent shock. Four days previous to admittance he gave a history of being beaten while he was intoxicated. He complained of pain in his left chest and that on exertion he became short of breath and blue.

His blood pressure was 90/70. There was crepitation over the left ribs. X-rays showed a fracture in the post-axillary line. He was given a transfusion but did not respond satisfactorily.

He was taken to the operating room on June 27, and a ruptured spleen was removed. Arterial bleeding in the tail of the pancreas was also controlled and a superficial laceration in the superior pole of the left kidney closed. The patient appeared to be doing very well but on the second postoperative day vomited a large quantity of blood. Transfusions could not keep ahead of the bleeding.

On exploration on June 28, gangrene of a section of the small bowel was noted and this portion was resected.

He expired the following day, June 29, 1951. The final diagnosis of the tissue removed was acute infarction of the jejunum.

Conclusions.—This patient received the usual treatment which included long tube suction, 3000 cc. of intravenous fluids daily, Vitamin K, Vitamin C. Flocillin and Streptomycin. The extent to which supportive measures were used is indicated by the fact that thirteen blood transfusions were given during his short period of hospitalization.

In spite of the fact that this patient came to the hospital on the fourth day following the original injury, his progress probably would have obtained a satisfactory end if the acute infarction of the jejunum could have been discovered at the time of the first operation. Apparently, the possibility of infarction was uppermost in the mind of the surgeon because it is recorded that he looked for such a complication..

Some cardiologists have reported ECG evidence simulating that of coronary insufficiency following mesenteric embolism. If this help proves reliable and can be offered early it will be most welcome and will save lives.

Case 7.—This patient was a white man, aged sixty-two, with a history of heart trouble of ten years' duration. He was employed as a truck driver.

Two days previous to admission he was apparently well but suddenly developed severe abdominal pain. A coldness and numbness developed in the left leg followed an hour later by similar changes in his right leg. He was unable to move his legs. It was this condition which caused him to seek help. The blood pressure was 70 with a questionable diastolic.

Impression at time of admission:

1. Thrombus of the common iliac arteries.
2. Syphilitic aortitis.
3. Dissecting aneurysm.

On the day of admission the patient was taken to the operating room. A transverse incision was made. The surprising pathologic condition was a large perforation of the anterior wall of the stomach just above the pylorus. A second incision was made over this area and it was noted that the perforation measured approximately 3 cm. Palpation of the right common iliac artery revealed normal pulsation. Pulsation of the left iliac artery was absent. The patient was in extremely poor condition and for that reason the abdominal wounds were closed and no attempt was made to remove the thrombi from the common iliac arteries.

Conclusions.—If this patient had been observed and accurately diagnosed at the time his ulcer first ruptured there might have been a chance of recovery. Inasmuch as the ulcer was one that was extremely large and inasmuch as it had perforated two days before his entry to the hospital, his condition was of necessity very precarious. The fact that the ruptured gastric ulcer was not diagnosed previous to operation could not in this case materially alter the course. This patient unfortunately waited too long before seeking help. I am sure this case could have been accurately diagnosed before the complication of iliac thrombosis and a life might have been saved.

Case 8.—This thirty-nine-year-old white man was admitted on October 28, 1951, in a state of acute alcoholic intoxication. He complained of severe fullness in his upper abdomen.

The abdomen appeared to be soft but there was some tenderness. The primary diagnosis was chronic alcoholism and acute alcoholic gastritis. It was further noted that the patient had been in the hospital about six months previously because of his drinking with the same diagnosis.

On October 31, 1951, the patient was transferred from psychiatric service to a surgical ward. The second examination gave the impressions of:

1. Convalescent stage, acute alcoholism.
2. Chronic alcoholism.
3. Acute alcoholic gastritis, convalescent.
4. Possible ruptured gastric ulcer.

An x-ray was requested and a flat plate of the abdomen was taken. Some dilatation of the small bowel was noted. There was some free air under the diaphragm in the upright position.

In view of some work that has been done recently, this patient was treated expectantly because of the time that had elapsed from the onset until the discovery of the ruptured ulcer. It was thought that expectant treatment was the ideal one for this type of case. At any rate, his progress was good and he was discharged from the hospital on November 12, 1951, as recovered.

Conclusions.—Perhaps this patient consumed large quantities of alcohol to obtain relief from pain caused by his ulcer. We should take this into consideration and be more aware of the possibilities of ruptured gastric ulcer when these patients complain of upper abdominal pain.

Although the results were satisfactory in this particular case, we believe that an operative procedure, if the perforation had been discovered earlier, would have been indicated. I am also of the opinion that an operative procedure in this case was indicated under existing conditions. Without exploratory examination, it is difficult to tell how large the ulcer is, how well it is sealed off, and how long the closure obtained by nature is going to maintain. Certainly, if a small omental tag is sealed in this opening, any undue pressure is apt to break it loose with a recurrence of all the previous symptoms. We believe early operation with repair and removal of the contaminating fluid will aid in preventing adhesions with obstruction. We are aware that this case should arouse an active and interesting discussion. We hope it does at the surgical discussion period this afternoon.

We believe further that this patient should be carefully followed and when sufficient time has been allowed for complete recovery from his infective peritonitis, he should have a gastric resection if there is any evidence of recurrence or pyloric obstruction.

Case 9.—This forty-three-year-old woman was admitted July 22, 1951, with a small bowel obstruction as seen by x-ray. Symptoms had been present for a period of thirty-six hours previous to admission. The patient gave a history of hysterectomy performed one and one-half years ago. She complained of anorexia and severe cramp-like abdominal pain. The pain was intermittent in type. She had vomited several times.

The abdomen was distended but non-tender and was not rigid. X-rays showed a few dilated loops of small bowel with fluid levels present. The impression at the time of admission was intestinal obstruction from adhesions. A number of these patients have received excellent results when given supportive treatment with long tube suction.

On August 9, 1951, the patient became restless, vomited and apparently had generalized convulsions. She had renal insufficiency for three days prior to death. It was thought that her death was due to the renal insufficiency, bowel obstruction and electrolytic imbalance and a possible pancreatitis.

The final diagnosis in this case from the autopsy findings were:

1. Internal hernia about 10 inches proximal to the ileocecal valve.
2. Intestinal obstruction due to adhesive bands.
3. Cardiovascular disease, hypertensive and aortic sclerosis, nephrosclerosis.

Conclusions.—The question is raised in this case as to whether or not an exploratory operation would have obtained different results if instituted early and the obstruction released. We believe it would.

Case 10.—This fifty-three-year-old white man entered the hospital on September 26, having sustained multiple stab wounds of the abdomen and left arm. The small bowel was herniating through the abdominal wound. Two holes in the jejunum were found. Five deep lacerations of the forearm were sutured. There was also a small stab wound of the left lateral chest wall about the midaxillary line at the level of the ninth interspace.

Before instituting general surgery, a thoracotomy tube was inserted in the left anterior chest at the second interspace. The small bowel was cleaned with saline and the perforations were repaired. Further exploration of the abdominal cavity was essentially negative. The abdominal incision was then closed. All the superficial lacerations, five in number, in the left upper extremity were repaired. The postoperative condition of the patient was good.

October 28 was the thirty-second postoperative day. It was thought that the left lower quadrant should be drained and a colostomy done. On October 30, the patient had a right transverse colostomy performed under general anesthesia. On November 15, fluoroscopy again demonstrated a fistulous tract extending from the distal colon or sigmoid anteriorly into the left lower quadrant.

Conclusions.—From the time this patient entered the hospital until he had his emergency treatment completed which consisted of suturing the superficial lacerations and closure of the perforations of the intestines, we would say that his care had been excellent. In view of what developed later, however, we wonder whether the surgeon would have been better satisfied with a wider incision and a more extensive exploratory procedure. Certainly the perforation of the large bowel which resulted in the fistulous tract complication prolonged the patient's hospital stay and increased the cost of his medical care. Without the facilities at hand in this large hospital and without the excellent care and treatment available, this patient might not have survived this ordeal.

This is one of the complications that can be avoided only if you and I and every other doctor doing surgery make ourselves follow a meticulous

routine of examination and take the extra time that is necessary to make careful examinations. With the general supportive measures available and the type of anesthesia that is offered us today, we certainly have no pressure being brought to bear as in the days of old. The extra precautions required may take an added fifteen to thirty minutes but carries no unusual hazards.

Case 11.—This thirty-year-old white Porto Rican was first admitted April 22, 1950. He said that he had been admitted one year previously for a bleeding peptic ulcer. He did well until the day of admission on April 22, 1950, when he passed dark, tarry stools. His history states that he had epilepsy for fifteen years and he had a two and one-half year history of indigestion and a burning discomfort in the abdomen, which had been quite well relieved by alkalies. He had had no night pains. His first bleeding episode had been in September, 1949; a second slight one in January, 1950, and finally this present sickness.

Laboratory work done revealed a hyperchromatic anemia. He was given two blood transfusions with good results and was discharged. He was re-admitted on April 5, 1950, with the history of a sudden onset of tarry stools, abdominal cramps and some bleeding from the mouth. His blood pressure was 110/80. The rest of the physical examination was essentially negative except for epigastric tenderness. On May 9 and May 11, 1950, x-rays were taken of the gastrointestinal tract and they revealed a filling defect of the ileum, which on further studies disappeared. The stomach was normal at this time. A sigmoidoscopic examination was negative.

He was re-admitted on September 19, 1950, at 5 P.M. He was vomiting coffee-ground material. His blood pressure on admission was 100/50. The patient's condition became rapidly worse and he expired at 6:05 P.M., September 19, 1950.

Gross Pathological Diagnosis.—1. Severe anemia. 2. Carcinoma of the stomach, fundus portion, with metastases to the liver.

Conclusions.—The confusing issues in this case were:

1. The history and findings resembling gastric ulcer.
2. The negative x-ray reports which on later review by the staff proved to be positive.
3. The involvement of the much written about "silent area" of the stomach.
4. The possibility of a Meckel's diverticulum.

It is possible that this man's nationality prevented his seeking aid with the very early symptoms. There must have been some deviation from normal at least two years prior to his death. At that time a gastroscopic examination might have given us a diagnosis in time to do a gastric resection.

Case 12.—This fifty-six-year-old negro complained of a sudden sharp abdominal pain three weeks ago. The pain awakened the patient out of a sound sleep. He had had no stools without the help of enemas. He claims to have eaten something every day.

The x-rays taken at the time of admission showed air under the diaphragm. There were distended loops of small bowel present. The chest was clear. The impression was that of:

1. Perforated peptic ulcer—three weeks' duration.
2. Ileus and small bowel obstruction.

On October 3, 1951, the patient was taken to the fluoroscopy room to check the suction tube. It was found that he had pulled it back to the stomach. His condition was poor so that progress in advancing the tube could not be obtained.

Further history at the time of admission elicited that there had been a gradual onset of lower abdominal pain with cramps in the lower back and the testes. The pain had been fairly constant until the present time, keeping him awake at night. He vomited several times with the onset of this pain three weeks previous. There have been no normal bowel movements in the past three weeks.

Sigmoidoscopic examination on October 2, 1951, was negative. X-ray examination on the same date showed free air under the right diaphragm indicating a ruptured viscus. There was diffuse clouding in the pelvic region.

Conclusions.—This is another unfortunate case in which medical aid was not sought until too late. This patient came to the hospital one day and died the following day. The final diagnosis was not made previous to death, but even had it been made the treatment would probably have remained the same.

In this case, the course would have been entirely different if the patient had been seen directly following the onset of his trouble.

Final diagnosis in this case was:

1. Obstruction of the ileum with a closed loop due to a postoperative adhesive band.
2. Gangrene of a segment of the ileum.
3. Perforation with fecal peritonitis.

Case 13.—The last case to be presented is one of my own. It stimulated the writing of a paper entitled "Missed Meckel's Diverticula." This patient, as is frequently the case, gave an excellent history of an acute exacerbation of a recurrent appendicitis. The examination and laboratory work supported this diagnosis. The conclusions of the x-ray report were: "There is no evidence of a lesion in the upper gastrointestinal tract. There is very definite localized tenderness over a barium-filled appendix and our findings would support a diagnosis of appendical disease." Final diagnosis then was subacute appendicitis.

From the operative report we read, "The appendix was of average size, bound down by adhesions, with a kink in its central portion but apparently not the seat of the

patient's trouble. Fourteen inches from the cecum a small soft mass, about the size of one's thumb, was palpated in the ileum. Opposite the proximal and apparently the point of attachment of the intra-ileial mass was a small opening at the mesenteric border of the gut. This opening was spread with Kelly forceps and an intussuscepted Meckel's diverticulum expressed.

The tissue report is as follows:

Specimen, appendix and diverticulum.

Gross—The specimen consists of an appendix 7.5 cm in length; uniform diameter of 7 mm. It shows no active hyperemia or exudate. The slightly nodular diverticulum measures 2 cm. in diameter, shows some hemorrhagic discoloration and no exudate. When sectioned the diverticulum has a firm polypus mass projecting into the lumen.

Microscopic.—The appendix shows slight pressure changes from retained feces, but no active inflammatory reaction. The diverticulum in typical mucosal pattern of the ileum exhibits mild congestion and a moderate eosinophilic infiltration of the mucosa. In one section there is an area of ulceration, granulation tissue and purulent exudate.

Diagnosis.—Acute Meckel's diverticulitis.

Conclusions:

1. Only 17 per cent of existing Meckel's diverticula are discovered during intra-abdominal operations.

2. Recovery occurs frequently enough following diverticulectomy, even if not acutely inflamed, to warrant its removal.

3. Only ten per cent of those removed are diagnosed preoperatively.

4. The small intussusceptions cannot be seen but are readily found by passing the gut through the fingers.

5. The laboratory and x-ray offer little aid in the diagnosis.

6. In a series studied, 33⅓ per cent had had previous intra-abdominal operations and the Meckel's diverticula were missed. In all three the abdominal symptoms disappeared following diverticulectomy.

7. Diverticulum should be suspected if there is tarry or bright red bleeding per rectum and when the upper gastrointestinal tract is roentgenologically negative.

8. Intermittent colicky pain localized just above and to the right of the umbilicus is a frequent symptom.

9. Simple resection, with the clamps parallel to the long axis of the bowel and inversion of the base transversely, is the usual procedure. Occasionally, a resection of the involved ileum is necessary with closure of the ends and side-to-side anastomosis.

RECENT ADVANCES IN THE DIAGNOSIS OF HEART DISEASE

(Continued from Page 1426)

cremasteric reflex: an interesting thing to do but no one knows quite what it means.

Summary

Perhaps some of you may recall the remark made by a seasoned and discerning professor in one of our local colleges. The old academic said that football bears the same relation to a college education as bull-fighting does to farming. I am certain that as many of you go back to the practice of medicine, you will wonder if that same remote relationship does not pertain in respect to recent advances in the diagnosis of cardiac disease and the care of the patient. However, viewed from a broader perspective than the word "recent" permits, progress has been the order of events in cardiology as in all other branches of medicine. If Einthoven were to look in on current practice of electrocardiography and fail to be amazed at its valuable clinical applications, he would lack that quality of astuteness we commonly ascribe to him. Even those in the junior ranks of medicine can recall the first clinical studies accomplished by ventricular catheterization. These and other methods constantly are serving as the type of hard, factual check on clinical impressions which once could be afforded only by death of the patient and performance of a necropsy. If we fail, therefore, to practice better medicine than our forebears, our deficiencies spring not from want of a diagnosis but from lack of grace, humility, and affection in its application to the patient.

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Office Treatment of the Urological Patient

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SUCCESSFUL treatment of the urological patient in the office presupposes some diagnostic acumen, and, therefore, some aspects of diagnosis may be added to the discussion of this elemental subject.

Office practice, including visits to the home, represents the initial point in our efforts in treating patients, even though they may finally arrive at the hospital, and therefore is important in the early relief of the sick. We might begin by discussing essential points in the history that aid in the diagnosis, and thus make treatment more promptly effective.

Early in the history, it is well to determine the sex, age, and marital status of the individual. It happens in our office practice, we see more women than men. This, I believe, is accounted for by the fact that the short female urethra is more vulnerable to chronic infection arising from the external and internal genitalia, than the male. Early age leads one to suspect the recurring infections incident to poor hygiene or urinary stasis in the very young patient. The young adult, male or female, is more liable to be the victim of an acute venereal disease. Men above fifty are entering the prostatic age, and women of this age suffer from menopausal hormonal and emotional imbalance that at least may aggravate a real or fancied bladder complaint.

Marital status may give a lead in several circumstances: the young unmarried vigorous man who has perineal and leg pains, and burning on urination due to excessive, ungratified sexual excitement; the newly married woman with urinary discomfort, due to the trauma and perhaps infection, from excessive and possibly awkward coitus; the divorced or widowed man in whom the cessation of regular coitus has resulted in a congested and possibly painful prostate and seminal vesicles.

Urinary complaints to be noted are diurnal and nocturnal frequency, discomfort or difficulty in voiding and possibly the presence of blood, with or without pain. The presence of blood in the urine is usually reliably told by a man, although I recall one patient who was referred because of blood in the urine, the source of which proved to be a bleeding wart, on the ventral surface of the shaft of the penis. Blood in the toilet noticed by a woman may lead to uncertainty as to its source but is quickly verified by catheterization. Painless hematuria almost certainly suggests a bladder tumor. Blood mixed with pus in the urine and associated with an acute onset may be presumed to be inflammatory but, if recurrent or chronic in its appearance, certainly demands complete investigation of the urinary tract, preferably by cystoscopy and retrograde pyelograms. Allow me to warn that there are still too many doctors and patients who are inclined to postpone the investigation of hematuria, resulting in the late diagnosis of tumors of the urinary tract. Hess[2] has stated that 90 per cent of the patients he has seen during or shortly after the first evidence of hemorrhage have a five-year, or more, period of survival. If there have been two episodes of hemorrhage, the five-year survival rate drops sharply to around 40 per cent. Even the first attack of hematuria, at times, represents a late stage of a tumor of the bladder or kidney and, in fairness to the patient, we cannot try to outguess the presence or absence of a new growth. My greatest surprise was a man in the 20's, who presented himself with a rather inconsequential terminal hematuria. Although inclined to dismiss it as the result of an over-active sexual life, I cystoscoped him and found a grade I papillary tumor that was easily treated transurethrally and is today apparently cured.

Increased frequency of urination may be the result of inflammation, infection or both. Almost the rule in acute infections, it may be absent in chronic infections. Inflammation may be present without infection, as in chronic granulations or polyps of the female urethra, interstitial cystitis or Hunner's ulcer in either sex, prostatic hypertrophy in the male, or because of ingestion of excessive amounts of fluid, particularly of the alcoholic or carbonated variety.

Difficulty in voiding is usually a symptom of mechanical obstruction which may be secondary to acute infection with resultant swelling and edema of the urethra, or peri-urethral structures, or due to stricture of small or large calibre, prostatic hypertrophy, stone or tumor.

Previous history of gonorrhea may or may not be important. If it occurred before the sulfa-antibiotic era, the possibility of persistent non-specific infec-

tion of the peri-urethral structures or urethral glands or stricture is more likely.

Trauma is a factor to be noted as possibly affecting the urinary tract and responsible for the delayed appearance of obstruction.

The patient's *habits* in regard to eating (excessive spicy foods) or drinking (excessive coffee, tea, carbonated or alcoholic drinks) may be helpful in suggesting a cause for his complaint.

Sexual habits are to be noted, especially in the patient who appears nervous or apprehensive. Unnatural sexual practices may be the sole cause of the difficulty in patients who present themselves with pelvic or perineal discomfort. The practice of withdrawal by the male before ejaculation is particularly harmful to the male and slightly less so to the female. A particularly striking case of this type presented himself to me recently:

H. C. L., male, aged fifty-six, married, a mail carrier, complained of frequency of urination, urgency and inability to control his urine. These complaints had been present for about one year and were getting progressively worse, so that he had to void every half to three-quarter hour, thus interfering with his work and popularity because he wet his clothing but not his bed. Sex habits disclosed very infrequent coitus but he had practiced withdrawal on intercourse for several years. Physical findings were largely negative, except for blood pressure of 170/100. Urine analysis was negative. Residual urine: 2 oz. Cure followed in three weeks by stopping the practice of withdrawal, diathermy to prostate, and passage of sounds on two occasions.

No particular harm is done by the use of contraceptives except possibly to the false pride of some individuals. A rare case of sensitivity to rubber may be encountered—indeed, the sense of safety engendered by their use may help immeasurably in the satisfaction of more normal coitus. Too frequent intercourse may be a factor in some cases of sterility, as an interval of about five days is necessary for the semen to recover its most potent quality and quantity.

Eating and drinking habits, especially spicy foods and excessive drinking of coffee, tea, cocoa, carbonated drinks such as coca-cola, pop, ginger ale, alcoholic drinks, and, in some cases, excessive consumption of citrus fruits, may account for frequency and burning of urination. An adequate fluid intake, however, is important for a healthy urinary tract and in the prevention of calculi.

Constipation is very often a factor in aggravating, at least, a genitro-urinary complaint. This seems to be particularly true in children where the bowel habits are not always known too well by the mother. It seems especially likely that the normal inhabitant of the bowel, B-coli, may invade the contiguous urinary tract in large bowel stasis. An enlarged prostate in the male is, of course, actually the cause of mechanical constipation in some instances.

Family history is not often relevant in diseases of the urinary tract.[1] Polycystic kidneys are liable to follow a pattern of heredity. Cystine and zanthine calculi seem at times to occur in brothers and sisters particularly. It is well to know of the presence of tuberculosis in the immediate family as a possible source of urinary tract infection, but the antecedent history of tumor is not particularly significant.

The physical examination should consist of a complete appraisal of the patient and not be confined to the urinary tract alone. Does the patient look well generally? If so, the urinary complaint may be a disorder localized to one system. However, if he is sick in appearance, the urinary complaint is more likely a part of some more generalized disorder. If the patient is obese, is diabetes present to account possibly for a polyuria and frequency?

The eyes reflect the general vigor of the patient, the corneae being cloudy in the aging individual. Arcus senilis denotes an aging process that may reflect a hypertension or inadequate kidney secreting substance, possibly associated with albuminuria. Infected tonsils or teeth may represent foci of infection that affect the urinary tract by metastatic invasion.

Auscultation and percussion of the chest leads one to suspect a chronic lung disorder, or tuberculosis or cardiac embarrassment which may be an adverse factor if surgery to the urinary tract is contemplated. Blood pressure determination is routinely recorded as an element in the general appraisal of the patient, and if elevated, and without obvious cause, an intravenous pyelogram at least is indicated.

The abdomen should be palpated with the patient in the supine position and a careful appraisal of the lumbar and costo-vertebral areas made. Using bimanual palpation and palpating in the exhaled and inhaled position, the kidneys may or may not be palpable. Costo-vertebral angle tenderness is very significant if definitely localized. With the patient sitting up, inspection of the back may show fullness in either costo-vertebral area,

as in a peri-nephritic abscess, or gentle fist percussion in these areas may be helpful in localizing a pathologic condition of the kidney.

Ureteral tenderness may be elicited on deep palpation along its course. The presence of hernia is noted with the patient in the upright position, as it may be the source of lower abdominal or pelvic pain associated with genito-urinary pathology.

The suprapubic area should be percussed to determine the possible presence of an appreciable amount of residual urine.

Examination of the external genitalia includes deviations from the normal gross anatomy in the male and female, and should be very thorough, beginning with the external urethral meatus. In the male, the epididymus should be carefully differentiated from the testes and the size of the testes noted for any atrophy that might be present, or tumor. A urethral discharge should be noted and if one is complained of, but not present at the examination, the patient may be given two glass slides with instructions to collect a drop of discharge on one slide, spread it out by sliding the end of the other slide over it, allowing to dry ten minutes, then placing the slides face together and returning for stain. A methylene blue stain is the simplest and quickest to use, but the gram stain is necessary to further differentiate invading organisms. After a urethral discharge is obtained or excluded, the urine is obtained either by voiding or catheterization.

The two-glass test is used quite routinely in the male. The first glass contains the washings of the anterior urethra, the second glass giving a more true picture of the bladder urine, without contamination by foreign sediment in the anterior urethra. Shreds in the first glass alone denote a chronic low grade exfoliative urethritis limited principally to the anterior urethra. Cloudy urine in both glasses may be due to a simple phosphaturia, easily differentiated by clearing with acetic acid, or to the presence of white blood cells, red blood cells, bacteria, alone or in combination. The two-glass test may also be used in the female, but it is more difficult mechanically and a catheterized specimen is the procedure of choice.

If cultures are to be obtained, a sterile container must be used, of course; otherwise, a clean receptacle is satisfactory. Specific gravity, pH, albumin, sugar, and centrifuged sediment are recorded. A drop of the centrifuged sediment is placed on a slide, covered with a cover glass and the slide examined with the high power field. Bacteria can usually be noted if present in any appreciable amount and, in general, may be differentiated into cocci and bacilli in the wet smear. This may be sufficient to designate the type of drug to be used. I believe the simpler inexpensive drugs should be tried initially, reserving the high-priced antibiotic drugs to be used if necessary. In general, Sulfadiazine or one of the combined sulfa drugs may be used in ½ or 1 gram doses every six hours for three to seven days in the coccal infections. Gantrisin, Sulfacetimide, or Mandelamine may be used in the bacillary types of infection. In the acute infections not of long standing and uncomplicated, this treatment will be usually successful. If the result is not satisfactory, after being certain there is no obstruction in the urinary tract, an antibiotic may be used. It may be best, however, to isolate the organisms by culture and determine the drug to which the particular organism is most sensitive.

Jawetz, et al,[3] have cautioned against the indiscriminate use of combinations of antibiotics, although a beneficial synergism has been noted in some cases, and in others a definite antagonism has been found.

If no result is obtained after two to three weeks of this treatment or if the infection is recurrent, a complete investigation of the urinary tract by cystoscopy and retrograde pyelograms is warranted. Intravenous urograms are valuable as a screening process and show opaque stones in the urinary tract and gross abnormalities, but cystoscopy adds to the record of vision in the lower tract with differentiation of kidney urines, more accurate determination of separate kidney function, and more accurate pyelography.

Rectal examination. The normal prostate is described as about the size of a horse chestnut and has a medium firm texture and smooth surface. A soft, boggy gland may represent a retention of normal prostatic fluid constituents or a markedly infected gland. An acutely infected gland is extremely tender and should not be massaged except possibly two or three strokes of the examining finger may be used to express a drop of the secretion for examination. It is examined under a cover slip with high power and normally there should be no more than 2 to 4 wbc./hpf. If secretion is not obtained, you may have the patient pass an additional few drops of urine or, if necessary, the

patient may be catheterized if it is important to obtain the information on the secretion at that particular visit. Acute prostatic infections are well treated with penicillin and dihydrostreptomycin, but without massage, and diathermy with a prostate electrode may be very comforting. Bed rest, light diet and relaxation are helpful adjuncts.

Rectal examination is a must in the male patient over fifty years of age, if we are to detect early carcinoma of the prostate. It is only by doing many rectal examinations that one can familiarize himself with the normal prostate and thus be able to detect changes in the gland that suggest early malignancy. The number found will not be large, but as in tumors of the breast, periodic palpation and removal of the small lesion is our only hope of cure of cancer of the prostate. The palliative therapy of advanced carcinoma of the prostate is, of course, highly satisfactory, but the stony hard prostate is a late, not an early, malignancy. The administration of diethylstilbestrol or similar substance in dosage of 3 to 5 mg. daily may change a definitely carcinomatous gland to a fairly normal feeling prostate. The change is at times unbelievable and the patient may again be able to void under this treatment alone.

Nesbit[4] has shown that orchiectomy to remove the principal androgenic producing substance in combination with stilbestrol is the procedure of choice in the control of prostatic carcinoma of the late variety. Transurethral resection is reserved for those cases in whom the obstruction is marked or unrelieved by hormonal therapy.

Chronic prostatitis is an entity similar to chronic tonsillitis in its many manifestations. It may cause general ill feeling with malaise, vague pelvic, leg or perineal pain. Occasionally, it may be a source of pyuria or even episodes of acute genital infections, as epididymitis. The mere presence of an increased number of white blood cells in the prostatic fluid is not an indication for prolonged prostatic massage. If a chronically infected prostate is a significant factor in the patient's complaints, prostatic massage should give quite prompt relief, although the actual eradication of the infection may be time-consuming. Medication with sulfa drugs or antibiotics has, in our experience, not been particularly helpful in the chronically infected prostate but in the acute infections they are very valuable. Diathermy in the chronic infections, in our experience, is of doubtful value. Intraprostatic injections of penicillin alone, or combined with dihydrostreptomycin, are sometimes of value in at least reducing the infection and occasionally effecting a cure.

The acute venereal infections are not so often seen in the urologist's office as formerly because the treatment has become much more simple. Gonorrhea is diagnosed by the stained smear of the discharge with the Gram or methylene blue stain—intracellular diplococci being for all practical purposes diagnostic. If there is a question of the presence of gonorrhea, the culture is a valuable tool to be used in the male and female. Treatment by penicillin is very effective. It is our practice to give a daily injection of 400,000 units of penicillin for two days, the cure rate being close to 100 per cent. One injection will probably suffice, but if I had the infection I would want two, and that is what I advise. One must be sure to warn the patient to have a monthly Kahn or similar test for three months because the low dosage of penicillin may mask a contracted early syphilis. Other antibiotics, such as Aureomycin and Terramycin, may also be used, apparently with very good results, but to date I favor penicillin.

Chronic non-specific urethritis in the male is not as common as in the female, but may be manifest by a low grade early morning urethral discharge of the muco-purulent variety, and discomfort in the urethra is also occasionally complained of.

A chronic anterior urethritis may be suspected by a cloudy first glass of urine with a clear second glass. Administration of a sulfa drug or Gantrisin or one of the sulfa combinations may be successful in clearing the infection. If not, a very cautious use of sounds may be employed to improve drainage in the urethral glands, starting with a No. 20 French metal sound and increasing two sizes French once a week, perhaps followed by instillation of 5 per cent Argyrol.

Urethral strictures of small or large calibre may be found in either the male or female. Since the advent of improved urinary antiseptics and less local treatment of gonorrhea, there are fewer strictures from this source but strictures from prolonged catheter drainage or following transurethral resection are seen. It may be necessary to use a filiform with following bougies or sounds in the manner described above (urethral instruments—

(Continued on Page 1494)

Differential Diagnosis of Jaundice

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THE DIFFERENTIAL diagnosis of jaundice may be extremely simple when the history and physical findings are typical and when the liver function tests, too, are clear cut and easily interpreted. Frequently, however, the complex physiology of the liver may cause considerable confusion.

The clinician is primarily interested in whether the jaundiced patient needs medical or surgical treatment. The correct solution of this dilemma is of practical importance since patients with "medical jaundice" do poorly if subjected to surgery and the "surgical types" deteriorate if neglected.

It is unfortunate that despite intensive study there is, as yet, no infallible methods for the differential diagnosis of jaundice. It is still necessary to evaluate the results of hepatic tests in the light of probabilities rather than certainties.

A great deal of this discussion will deal with tests of hepatic function but I would not have you believe that they are all important as I believe strongly that history and physical findings should take precedence over laboratory studies in a given case. The majority of cases of jaundice can, I am sure, be diagnosed correctly without elaborate laboratory studies.

In the presence of jaundice a careful history is the first and perhaps most important step in deploying our resources to reach an eventual diagnosis.

Age should be given some consideration, but undue emphasis should be avoided, since stones and malignancy may occur in the young and hepatitis in the elderly.

Jaundice due to malignancy and alcoholic cirrhosis occurs more frequently in males than females but the sex incidence of liver disease is more apparent than real, and depends on social customs, occupation, exposure, et cetera.

History should concentrate on determining previous digestive disturbances, type and character of pain, rapidity and amount of weight loss, intake of hepatotoxins, such as cincophen, alcohol and industrial toxin, previous blood or plasma transfusions, hypodermic medication and contact with jaundiced patients. Great care must be exercised to obtain accuracy. The patient should be questioned repeatedly and at different times, relatives should be interviewed since not infrequently they have an entirely different concept of the onset and symptoms than the patient.

It is surprising, but well known, that many patients seem to have remarkably little insight into their illness and the true facts can only be obtained by careful and skillful questioning.

The physical examination of the patient should be carried out with great care and attention to detail. The degree of jaundice, changes in the skin, the presence of spider angiomata, the size, consistency and tenderness of the liver and spleen should be sought for and carefully noted. Evidence of neoplasms anywhere in the body should be searched for, the prostate, colon and lung being particularly prone to metastasize to the liver. A palpable distended gall bladder indicates relatively rapid extrahepatic obstruction and a gall bladder that is elastic. *Carcinoma* of the *ampulla* or of the head of the pancreas may produce such a finding but only rarely will a primary carcinoma of the gall bladder be responsible for a palpable mass in the right upper quadrant. The history and physical findings should aid us in our approach to the problem but in order to have a logical approach we must follow some classification or other of jaundice.

It is immaterial which classification is followed so long as the particular classification is well understood.

I find Ducci's simple classification of Jaundice to be understandable and useful.

TABLE I.

1. *Prehepatic Jaundice*
 a. Hemolytic
 b. Non-hemolytic
2. *Hepatic Jaundice*
 a. Hepato-cellular
 b. Hepato-canalicular
3. *Post Hepatic Jaundice*
 a. Incomplete obstruction
 b. Complete obstruction

In order to fit the jaundiced patient into the classification a certain amount of basic laboratory work as well as certain special tests of liver function may be needed. It is wise, I believe, to

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TABLE II. FUNCTIONS OF THE LIVER

1. Storage
 - A. Glucose as glycogen
 - B. Protein
 - C. Neutral Fats and Phospholipids
 - D. Antipernicious anemia factor vitamins: A and D probably factors of the B complex minerals: Copper and Iron
2. Synthesis
 - A. Food Material
 1. Glycogenesis
 2. Amino Acids to Glucose
 3. Fats from glucose, protein and glycerol
 4. Amino acids (some)
 5. Dehydrogenation of fats
 6. Production and oxidation of some organic acids
 7. Carotene to vitamin A.
 - B. Other substances—(all or in part)
 1. Fibrinogen, heparin
 2. Ketone Bodies
 3. Bile salts
 4. Cholesterol
 5. Urea and uric acid
 6. Some bilirubin from hemoglobin
 7. Urobilinogen to bilirubin
 8. Glucuronic acid conjugates
 9. Albumin and globulin
 10. Histamine
 11. Possibly some antibodies
3. Detoxification
 - A. Chemical means
 1. Conjugation
 2. Methylation
 3. Oxidation
 - B. Excretion in bowel
 - C. Storage in liver cells
 - D. Phagocytosis by reticulo-endothelial activity
4. Regulates
 - A. Body heat
 - B. Blood volume
 1. Reservoir for red cells and fluid
 2. Aids in ionic equilibrium
5. Excretory
 - Bile, dyes, calcium, cholesterol enzymes, fatty acids, et cetera.
6. Endocrine relations
 - Pancreas—thyroid, pituitary, adrenals and gonads.

always secure a urine analysis, red and white cell count, a sedimentation rate and a blood sugar.

Certain x-ray studies may be necessary such as a gastro-intestinal series to rule out carcinoma of the stomach and colon. Deformity of the duodenum may suggest a pancreatic malignancy and should be looked for.

An x-ray examination of the lungs may be indicated to rule out either primary or secondary malignancy.

An x-ray of the bones, the so-called "metastatic series" may also be indicated in obscure cases of jaundice.

These procedures carried on either before or during the liver function tests often help to clarify what might otherwise be obscure.

TABLE III. NORMAL VALUES FOR LIVER FUNCTION TESTS

Biliribuin (serum)	
1 minute	0.4 mgm. per 100 ml.
Total	0.7 mgm. per 100 ml.
Urobilinogen (Urine)	0 to 5 mgm./24 hrs.
Urobilinogen (feces)	50 to 300 mgm./24 hrs.
Cholesterol (Total) serum	160 to 210 mgm./100 ml.
Cholesterol (Esters) serum	90 to 120 mgm./100 ml.
Bromsulfalein (5 mgm. dose)	45 min. less than 5%
Cephalin Cholesterol Flocculation	Negative to 2 plus
Takata Area Reaction	Negative
Thymol Turbidity	0 to 10 units
Thymol Flocculation	0 to 1 plus
Hippuric Acid	
Oral	2.5 to 3.5 gm.
I. V.	1.0 to 0.7 gm.
Phosphatase (Alkaline)	
King Armstrong	1 to 12 units
Protein (serum)	5.5-7.8 gm./100 ml.
Albumin	3.3-4.3 gm./100 ml.
Globulin	2.2 to 2.8 gm./100 ml.
Albumin—globulin ratio	1.6-2
Prothrombin (Blood)	11-13 seconds

Liver function tests have received a great deal of attention in the past decade and their number alone is enough to cause confusion. The functions of the liver are many and diverse and include storage, synthesis, detoxification and such nondescript functions as helping to maintain water balance and acting as a reservoir for red cells.

There is no single test of liver function which is completely satisfactory and if tests are to be done, a battery of tests should be employed and they should be done simultaneously so that the patient will suffer the least inconvenience.

It is wise to follow the progress of the patient by repeating the tests, perhaps omitting some and adding others as indicated.

Liver function tests must be done carefully by competent personnel or they may give more misinformation than information. This does not mean that the tests are extremely difficult. They are not; they only require meticulous attention to detail.

Table III gives a list of the more commonly used liver function tests with their normal values. Their significance will become apparent as we progress.

Prehepatic jaundice need not detain us too long, since, if thought of, it can easily be confirmed. *In the hemolytic type* (Table IV) the indirect reacting bilirubin will be high and will make up most of the total bilirubin, there will be increased urobilinogen in the stool and perhaps in the urine. There will be no bilirubinuria. Classi-

TABLE IV. PREHEPATIC JAUNDICE

	Hemolytic	Non-Hemolytic
Bilirubin		
1 minute	Normal	Normal
Total	Increased	Increased
Bile Pigment/Urine	None	None
Urobilinogen		
Urine	Increased	Normal
Stool	Increased	Normal
Liver Functions	0 to 1 plus	Normal
Reticulocytosis	Yes	No
Spherocytosis	Yes	No
Red Cell Fragility	Increased	Normal

cally there is no disturbance in liver function and reticulocytosis, spherocytosis and anemia will be present.

The *non hemolytic prehepatic jaundice* is a poorly understood, unexplained type of jaundice with a familial or hereditary overlay. Here, too, the liver is spared and function tests are characteristically normal; there is no reticulocytosis or anemia. The indirect reacting bilirubin may be increased and urine and stool urobilinogen will be normal.

Hepatic jaundice (Table V) can be divided into hepato-cellular and hepato-canalicular, but mixed is the type most commonly encountered and gives the greatest difficulty in diagnosis. This difficulty is markedly increased if the patient is first seen three to six weeks after the jaundice began.

In hepato-cellular jaundice we may expect the fecal urobilinogen to be normal or slightly decreased and the urine urobilinogen to be increased due to the inability of the liver to utilize the urobilinogen brought to it from the gut, and hence, the excess is excreted by the kidney. Thus an increase in urine urobilinogen in the face of normal or decreased focal urobilinogen is a sensitive test of liver function.

Bilirubinuria may occur in the pre-icteric stage but will be absent when icterus develops and the indirect reacting bilirubin in the serum will be increased.

Total cholesterol will be normal or slightly decreased and the cholesterol esters will be decreased indicating a disturbance in the ability of the liver to esterify cholesterol.

The cephalin-cholesterol flocculation and thymol turbidity tests will be positive. The thymol turbidity being more constant than the cephalin flocculation test which is frequently positive in other diseases such as malaria and infectious mononucleosis. The thymol turbidity may remain positive after the cephalin cholesterol flocculation has returned to normal.

TABLE V. HEPATIC JAUNDICE

	Hepato-cellular	Hepato-canalicular
Bilirubin		
1 min.	Normal	Increased
Total	Increased	Normal/Increased
Bilirubinuria	Positive/Negative	Positive
Urobilinogen		
Stool	Normal or low	Low
Urine	Increased	Decreased
Cholesterol		
Total	Normal-Decreased	Increased Normal
Esters	Decreased	0-2 plus
Cephalin Flocculation	Positive	Negative/Positive
Thymol Turbidity	Positive	Negative/Positive
Thymol Flocculation	Positive	Negative/Positive
Alkaline Phosphatase	Normal	Increased
Serum Protein	Decreased	Normal
Albumin	Decreased	Normal
Globulin	Normal/Increased	Normal

The alkaline phosphatase is usually normal or only very slightly elevated.

The total plasma protein may be normal or slightly decreased, the albumin may decrease, the globulin may be normal or increased.

In a case of pure hepato-canilicular jaundice one may expect an increase in the direct reacting bilirubin, bilirubinuria, elevated cholesterol and an increase in the serum alkaline phosphatase. Watson[5] is of the opinion that this type of jaundice may follow acute hepatitis and be designated cholangiolar hepatitis and that under these circumstances the tests of parenchymal damage will show only minimal changes. Such a picture is rare. Steigman and Popper,[4] on the other hand, feel that intrahepatic obstruction which occurs during hepatitis indicates a severe liver disease and find the liver function tests more markedly deranged than in a simple hepatitis unassociated with intrahepatic obstruction. Their concept is that a mixed form is most common.

On the basis of my own experiences I, too, favor this concept, but be that as it may, it is important to realize that intrahepatic obstruction does occur with considerable frequency with hepatitis and may last from one to ten days and on occasion may persist for as long as three weeks. Therefore, it is extremely important to follow the fecal and urine urobilinogen with regularity.

In the mixed type in which both hepato-cellu-

TABLE VI. POSTHEPATIC JAUNDICE

	Incomplete Obstruction	Complete Obstruction
Bilirubin		
Direct	Increased	Increased
Indirect	Normal-Increase	Increased/Normal
Bilirubinuria	Yes	Yes
Urobilinogen	Variable	
Stool	Decrease/Normal	
Urine	0 to 1 plus	None
Cholesterol	Increased	None
Total	Normal/Increase	Increased
Esters		Normal/Increase
Cephalin-Cholesterol Flocculation	Negative	Negative early
Thymol Turbidity	Negative	Negative early
Thymol Flocculation	Negative	Negative early
Alkaline Phosphatase	Elevated	Very high
Serum Diastase	Normal to Elevated	Normal/Elevated

lar and hepato-canalicular elements are present, the hepato-cellular aspects may overshadow the obstructive aspects and the disease is frequently classified as hepato-cellular jaundice.

Extra hepatic or posthepatic jaundice may be subdivided into complete and incomplete obstruction and these two constitute, as a rule, surgical jaundice.

In *incomplete posthepatic jaundice* the direct reaction or one minute bilirubin is increased, bilirubinuria is present, fecal urobilinogen is decreased or may be completely absent for a time. The urine urobilinogen will be absent or markedly decreased. The total cholesterol is increased and cholesterol esters will be normal or increased. The alkaline phosphatase will be moderately increased above 10 units and *the flocculation tests* will be normal unless the disease has existed for months or years. The serum diastase is usually normal unless the jaundice is the result of chronic recurrent pancreatitis in which event the diastase may be elevated.

In complete obstruction which is permanent there will, of course, be no urobilinogen in the stool or urine at anytime. An exception to this might be an infection which occured above the obstruction, in which case, the bile in the biliary tract might be altered by bacteria and urobilinogen would then appear in small amount in the urine and not in the feces. The direct reacting bilirubin of the serum is increased, bilirubinuria is present, alkaline phosphatase is very high, 20-40 units, and the flocculation test are normal unless obstruction has persisted long enough to produce changes in the liver parenchyma. This usually requires a complete obstruction lasting from six weeks to as many months.

It is impossible at times to make a differential diagnosis of jaundice from the history, physical findings and laboratory studies and in such cases a needle biopsy of the liver is indicated.

In a considerable experience our mortality from this procedure has been less than 0.5 per cent. There are few hard and fast contraindications to the needle biopsy of the liver. Cardiac decompensation with congestion of the liver or a complete biliary obstruction are two things which may give trouble, the former through bleeding and the latter through leakage of bile into the peritoneal cavity. Obviously patchy diseases of the liver may be missed occassionally but if an attempt is made to pick the site of biopsy this does not occur too frequently. Obviously too, the abdominal approach is somewhat less hazardous than the transpleural approach.

Conclusion

1. The differential diagnosis of jaundice may be difficult at times but is best accomplished by careful history, physical examination and a battery of liver function tests which are carefully performed and well understood by the physician who employs them.

2. A liver biopsy is indicated when laboratory findings are conflicting or confusing or before exploratory laparotomy.

3. When doubts cannot be resolved a period of observation and study of three to six weeks is indicated and if, at the end of that time, the diagnosis is not established and the possibility of a surgical jaundice still exists exploratory laporotomy is not only indicated but mandatory.

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Refinements in the Diagnosis of Early Tuberculosis

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TUBERCULOSIS and syphilis are diseases whose specific organisms may live long periods of time in the human body without causing serious illness. At any moment, however, they are capable of resulting in clinical disease. Each disease starts with primary lesions which *per se* are usually relatively insignificant, since the body's defense mechanism promptly brings them under at least temporary control. Often, however, this mechanism is unable to destroy either the Spirochaeta pallida or the tubercle bacilli. Primary lesions of syphilis are much more likely to be diagnosed promptly than those of tuberculosis because they are frequently located on the surface of the body or within orifices easily inspected. The majority of primary tuberculous lesions occur in internal organs, a preponderance of which cannot be located by any phase of examination during the lifetime of the individual.

Specific diagnostic tests have been devised for both tuberculosis and syphilis. Good chemotherapeutic agents, capable of destroying Spirochaeta pallida, are now available for syphilis. Chemotherapeutic agents are now in use for tuberculosis which have good bacteriostatic actions, but as far as is yet known, they are not bacteriocidal.

No dependable immunizing agent is available for either of these diseases; therefore, their prevention is dependent upon avoidance of initial invasions of the organisms.

Thus, our profession still labors under considerable difficulty with tuberculosis. Despite the handicaps, we have brought this disease under better control in this country than has been done in any other major nation. Moreover, there are large areas in this country which have suppressed tuberculosis far more successfully than has any minor nation of comparable size. Although our accomplishment is the most outstanding in the world, we have not yet reached the half way mark to the eradication goal.

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The most important factor in our present and future work leading to eradication of tuberculosis is diagnosis at the earliest possible time after first invasions with tubercle bacilli occur. This necessitates a clear comprehension of the early pathogenesis of the disease. Tuberculosis is rarely congenital. Therefore, practically all primary invasions occur after birth. In some parts of the world nearly all children still become infected with tubercle bacilli. In other parts, including the United States, tuberculosis has been so nearly eradicated from animals, particularly cattle, and so much has been done to isolate and treat tuberculous people that relatively few infants and children become infected. In fact, primary invasions with tubercle bacilli now occur more often among adults than among children, and large numbers of adults avoid infection throughout life.

When tubercle bacilli first invade the human body, regardless of the portal of entry or the age of the individual, they are promptly phagocytosed by neutrophils, many of which promptly enter the lymph and blood streams. Thus, there is an early bacillemia. Tubercle bacilli are so toxic to neutrophils that they soon lose their ability to change shape, and as they approach small capillaries they cannot elongate and enter. Wherever a neutrophil lodges in this manner its tubercle bacilli are focalized. Obviously, these points of focalization are multiple and occur in various organs of the same individual, such as the brain and kidneys. They are most frequently found in those organs richly supplied with fine capillaries, particularly the lungs.

At these various points of focalization, tubercle formation is likely to occur. From these areas, some of the tubercle bacilli escape to regional lymph nodes in which they are trapped and produce lesions. In the vast majority of cases the body's defense mechanism builds walls around the original and lymph node lesions. Within these lesions tubercle bacilli may remain alive and virulent for brief or long periods of time.

While primary lesions and their lymph node components are developing, the tissues of the body, including the skin, become sensitized to tuberculoprotein. This sensitivity usually can be elicited by the tuberculin reaction within two months or less after the initial invasion occurs. We know of nothing in nature which results in such a degree of sensitivity but the tubercle bacillus. Therefore the tuberculin reaction informs the physician of

the presence of tubercle bacilli and the lesions they have produced.

Immediately after allergy has been established, lesions can rarely be located by x-ray inspection or other phases of the examination. If they are in the 75 per cent of the lungs visualized by x-ray inspection, most of them are too small or not dense enough to cast visible shadows. They may be in the 25 per cent of the lungs obscured from view by shadows of other organs, such as the heart. Again, they may be extrathoracically located. When tissues first become allergic, evidence of disease is revealed by x-ray film inspection of the chest in less than 10 per cent of cases.

In a small percentage of persons recently infected there may be fleeting symptoms such as those of a cold or a mild attack of influenza, and the erythrocyte sedimentation rate may be moderately accelerated. Tubercle bacilli may be recovered from gastric washings in a few cases.

The tuberculin test is the sole agent by which one is able to diagnose the presence of primary lesions containing tubercle bacilli with great accuracy in practically all persons who have them.

From time to time, propaganda has been launched against the tuberculin test. Papers have been published in condemnation of it because the occasional person with a demonstrable pulmonary lesion with acid-fast bacilli reported in the sputum or gastric washings does not react. Account is not always taken of the fact that laboratory errors are frequent and that not all acid-fast organisms are tubercle bacilli. In some of these reports there is a rare, unmistakable case of tuberculosis who does not react to the usual test doses. In the over-all picture these isolated cases are of little significance. Such large and excellent studies as those conducted at Maybury Sanatorium, Northville, Michigan, and the Chicago Municipal Sanitarium have shown that practically all proved cases of tuberculosis react to the usual test doses of tuberculin. The main exceptions are those with advanced, acute or chronic disease, and elderly persons. These are not significant because their disease is readily diagnosed without tuberculin. Even in these persons the reaction can be elicited by larger doses of tuberculin.

Attention has often been called to nonspecific tuberculin reactions, especially when the usual second dose is administered. These are not characteristic reactions. Therefore the physician need not worry about them if he adheres to the distinguishing qualities of the true reaction. Nearly forty years ago the veterinary profession encountered noncharacteristic reactions among cattle in certain areas of the United States. They found that these were caused by nonpathogenic acid-fast bacilli which inhabit soil. It is probable that this or even other nonpathogenic acid-fast bacilli are responsible for so-called nonspecific reactions in people.

It is often said that physicians vary so much in reading and interpreting tuberculin reactions as to partially nullify the value of the test. This is not a condemnation of the test, but a failure of physicians to become informed of the characteristics of the reaction—namely, induration or edema, or both. Moreover, physicians do not vary as much in reading tuberculin reactions as they do in reading and interpreting x-ray shadows. Therefore there is no reason for the medical profession to become confused. The tuberculin reaction has stood the test of time and remains our number one ally in combating tuberculosis.

Physicians who have used the tuberculin test most and have kept up long periods of observation on reactors and nonreactors regard it as the most specific and accurate test now available for any disease. In diagnosis, it finds tuberculosis earlier than any other phase of the examination. With well known but uninportant exceptions, one is almost certain that the nonreactor does not have tuberculosis. It is our best epidemiological and case-finding method. Every child and every adult who has recently become a reactor to tuberculin has lately been in effective contact with a tuberculous person or animal. This information can be obtained in no other way. It immediately places the physician on the trail which, if he follows diligently, often leads him to a person or an animal with contagious disease.

The tuberculin test is the only agent we possess for determining promptly and accurately the effectiveness of a tuberculosis control program. Willful administration of anything, including living or dead tubercle bacilli of any degree of virulence such as BCG or vole bacillus vaccine which artificially sensitizes tissues to tuberculoprotein thereafter, deprives the physician of the use of his best diagnostic and epidemiological agent and denies the individual of his inalienable right to know if and when he becomes infected with virulent tubercle bacilli.

Far too long our profession has labored under

the concept that illness must occur or gross lesions be demonstrable before an individual can be said to have tuberculosis. In reality, tuberculosis exists as soon as tubercle formation begins. The lesions which later become demonstrable and cause illness are often the result of evolution of these microscopic beginnings.

The only method we have of diagnosing tuberculosis early is to test uninfected persons, both children and adults, periodically with tuberculin. Those who have become reactors since the last test have developed primary lesions containing living tubercle bacilli. In addition to making an accurate diagnosis, the test informs the physician that the newly reacting individual has been in contact with someone who has contagious tuberculosis and who should be found.

As soon as we have a drug that will destroy tubercle bacilli in human tissues, the best time to administer it will be promptly after the individual becomes a tuberculin reactor, regardless of clarity of x-ray films of the chest and freedom from symptoms. At this time the lesions are nearly always small and vascular. A germicidal drug in the blood stream would then be expected to reach all tubercle bacilli and result in complete sterilization. Only in this way may one ever expect to cure tuberculosis in the sense of destroying all foci of tubercle bacilli. If we wait until lesions become avascular with necrotic and caseous areas, there is little hope of a drug reaching their bacilli regardless of its concentration in the blood stream.

Until a bacteriocidal drug is available, our best procedure consists of periodically examining all persons who are or who become characteristic reactors to tuberculin. Only in this way is it possible to regularly locate chronic reinfection type of pulmonary lesions as early as they evolve to macroscopic size and are of such density as to cast visible x-ray shadows. By this method most chronic lesions can be visualized long before symptoms appear or tubercle bacilli are being eliminated in sputum.

Many persons who develop primary tuberculous lesions and become tuberculin reactors never have the disease progress to clinical proportions. However, everyone who does develop clinical disease passes through the stage when no phase of the most complete examination reveals its presence except the tuberculin reaction.

As yet, we have no way to determine which persons who react to tuberculin will at some subsequent time develop clinical disease. Therefore, everyone who is found to be a reactor should have those parts of the body which clinical tuberculosis frequents examined periodically. If the individual is in infancy, the parents should be instructed to inform the physician at once if symptoms appear suggestive of miliary or meningeal tuberculosis. When generalized miliary tuberculosis is suspected, bone marrow studies are essential for accurate diagnosis, just as it is necessary to find tubercle bacilli in spinal fluid to be sure meningitis is tuberculous. In fact, these acute clinical forms must be kept in mind among reactors in all ages of life. If these conditions develop, there is no time to temporize before instituting chemotherapy.

If the individual is in early childhood, one must watch for extrathoracic lesions, particularly those of bones and joints, and especially the spine, hip and knee joints. Only rarely does chronic pulmonary tuberculosis develop in children. Among individuals approaching adolescence or who are in later periods of life, including old age, the lungs must be examined periodically. Throughout adulthood, 10 to 15 per cent of clinical tuberculosis develops extrathoracically.

Inasmuch as 85 to 90 per cent of clinical tuberculosis develops in the lungs of adults, it is important that every adult tuberculin reactor be alerted to the necessity of periodic examinations. However, these should always include but never be limited to x-ray inspection of the chest.

By x-ray film inspection we are able to detect chronic gross clinical lesions earlier in their evolution than by any other phase of examination. These chronic lesions usually evolve slowly so that six to twelve months intervals between examinations are nearly always adequate. Among those persons in whom such lesions are destined to evolve, they can often be found by the shadows they cast long before symptoms appear and before they are contagious. As yet, we have no method of preventing such lesions from evolving in a considerable percentage of infected persons and, obviously, our only recourse is to find them as early as possible. When found in the early stage of their evolution the majority of them can be treated successfully with far less inconvenience and expense to the patient and society than those which are permitted to become extensive. Moreover, most early lesions can be prevented from becoming contagious.

There is one group of pulmonary tuberculous

lesions which should always be mentioned to tuberculin reactors who are being examined periodically. It consists of acute, exudative disease which, in reality, is tuberculous pneumonia. Such lesions may be plainly in evidence on x-ray film days or weeks after the chest appeared entirely clear. They are usually due to bronchogenic spread of tubercle bacilli. Apparently they occur much less frequently than chronic lesions and often result in symptoms soon after they appear. Therefore, every adult tuberculin reactor who is being examined periodically should be told that if any symptom develops, he should report at once rather than wait for the next scheduled examination. Persons with such disease may have tubercle bacilli in the sputum much earlier than those with chronic lesions.

Many physicians and hospitals are now making routine x-ray film inspections of the chests of all persons, regardless of the cause for which examination is requested or for which they are admitted. This, together with the mass photofluorographic surveys that are being conducted in so many places, is bringing to light a good many shadow-casting lesions previously unsuspected. These are due to a wide variety of causes. Inasmuch as x-ray shadows are never pathognomonic, the only function of the initial x-ray film inspection is to determine that gross lesions are present. It then becomes the duty of the clinician, the laboratorian, the roentgenologist, and often the bronchoscopist, working as a team, to determine etiology. This may be a simple task, or it may be time-consuming and laborious. Occasionally it is impossible.

There are two procedures which should supersede all others:

1. Administration of specific tests such as tuberculin and fungus antigens. If the individual is not seriously ill, the absence of a tuberculin reaction practically rules out tuberculosis. If a reaction is present, it does not determine with certainty that the lesion in question is tuberculous, although it may be. It indicates that tuberculous lesions are present, but the one under investigation may still be nontuberculous.

2. If sputum is present, it should be examined for pathogens, including malignant cells. If none is found which may be responsible or there is no sputum, gastric washings should be subjected to the same laboratory examination as sputum. If superficial lesions or enlarged lymph nodes are present, biopsy should be done for histological changes and bacteriological determinations.

When sputum and gastric washings are unrevealing and a lesion appears sufficiently significant, bronchoscopy is next indicated. The bronchoscopist looks for lesions involving the mucosa of the trachea and bronchi. He determines whether exudate is exuding from one or more ramifications. He looks for obstructions which may be caused by foreign bodies, mucus plugs, adenomata, malignant growths, as well as evidence of extrinsic pressure. If mucosal lesions are present or intrinsic obstructions are seen, material is removed for biopsy and bacteriological and pathological study. If no exudate or other abnormality is seen, the bronchoscopist introduces small amounts of normal saline solution and aspirates it for bacteriological and cytological determinations. He may then introduce iodized oil, after which the roentgenologist makes bronchograms.

Obviously, with most modern equipment the bronchoscopist is unable to inspect beyond the larger bronchial ramifications. Therefore, when lesions lie peripheral to his domain and no material is available for laboratory study, bronchograms may reveal partial or complete obstruction in smaller bronchial ramifications. Whether or not such evidence of obstruction is found in some cases, particularly those in the cancer age, thoracotomy is necessary to arrive at a diagnosis. If material removed in this manner is not found to be malignant or tuberculous, various other organisms, including fungi, should be sought. Chemical analyses may also be necessary for such substances as beryllium.

With all these diagnostic refinements, we are still unable to make a specific diagnosis in occasional lesions. Even at necropsy, microscopic, bacteriological and chemical tests sometimes fail. Many shadow-casting lesions found by routine x-ray chest film inspection are of no present clinical significance. They have long since been brought under control by the body's defense mechanism. Nevertheless, the physician should investigate every lesion to be sure that those which are significant are detected and do not go unattended.

The Use of Oral and Topical Calcium Preparations in Pruritus

A Preliminary Report

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THE TREATMENT of dermatologic conditions often poses interesting therapeutic problems to the physician. Treatment cannot always be directed at the etiology since this is often undetermined. For this reason, empirical therapeutic approaches have been developed in an effort to treat some of these dermatologic conditions successfully. One of the problems involved in these conditions is that there are many aspects which must be considered in therapy. The etiology must be controlled; the emotional factor must be properly handled; the symptoms, *per se,* must be treated in order to alleviate the discomfort if the condition itself cannot be readily controlled.

Pruritus is one of the most unpleasant symptoms that may develop during or in association with many dermatologic conditions. The treatment of pruritus in these disorders often taxes the physician's therapeutic ingenuity. It is in some cases the easiest symptom to alleviate, and in the next, the most perplexing and difficult. What is good for one patient may increase the severity of the pruritus in another.

Among the preparations found beneficial for the control of pruritus can be listed those which contain calcium. It has been found that the calcium ion administered parenterally, will bring about relief in a majority of patients. Reports on the use of topical calcium have been sparse. This report presents the use of a combination of oral and topical* forms, the oral material being Neo-Calglucon Syrup—a highly concentrated preparation.

The use of calcium in dermatology is primarily empirical. However, a review of the basic physiology involved may explain some of the rationale for the use of this material to control various symptoms found in dermatologic disorders. Best and Taylor,[1] in a review of calcium metabolism, point out that this mineral is a constituent of all animal fluids and tissues, constituting about 2 per cent of the weight of the adult body, most of which is contained in the skeleton. It plays a role in blood coagulation, bone formation, maintenance of normal neuromuscular excitability, cardiac rhythmicity, milk production and membrane permeability. The chlorides of calcium and magnesium decrease membrane permeability, so that a change in blood calcium will affect fluid balance. The amount of edema in skin conditions may therefore, in part, be related to the amount of calcium present. It has been shown many times that depression of calcium will produce convulsions. Since, in tetany, calcium concentration in the tissues is unaffected, it appears that the neuromuscular excitability results from calcium imbalance between ionic calcium in the fluids within the tissue cells. From a review of calcium metabolism it can be concluded that therapeutic administration of this ion would be indicated to control neuromuscular excitation and fluid imbalance stemming from improper blood calcium levels.

The use of calcium in allergic diseases is widely controversial. There is no doubt of its effectiveness in controlling angioneurotic-edema and other similar conditions. Cantarow[2] showed the rapid effects of calcium upon glottic edema and vasomotor rhinitis. Tobias[4] reported that calcium ointment is of value in selected cases of subacute and chronic types of contact dermatitis, atopic eczema and localized neurodermatitis. Pruritus, associated with such conditions, was definitely controlled with a return of the affected parts to normal. The Schoch[3] letter of November, 1950, points out that L. Goldman observed that the same calcium ointment employed by Tobias was effective in treating the flexual type of atopic dermatitis. The product used by these men and also in this study is a water soluble base containing 10 per cent calcium gluconate with a pH of 5.5.

We employed both oral and topical calcium preparations in this series of cases. Oral calcium was administered in order to sustain calcium levels. The topical application was made in an effort to alter the calcium balance directly in the affected area.

Material

In this preliminary study, twenty patients with various pruritus dermatoses were treated with both topical calcium and oral calcium syrup. Seven patients had atopic eczema, two had nummular

*Calcium ointment is a research preparation of the Sandoz Pharmaceutical Company.

eczema, four had chronic infectious eczematoid dermatitis, two had chronic urticaria, two had chronic disseminated neurodermatitis, and three had contact dermatitis. In all, pruritus was the prominent and disturbing symptom. Some of the chronic cases which were relieved had continued for periods as short as six months and as long as ten years.

TABLE I. RESULTS IN TWENTY PATIENTS WITH VARIOUS PRURITIC DERMATOSIS

Disease	No. Patients	Good Relief from Pruritus	Disappearance of Lesions
Atopic Eczema	7	7	3
Chronic Infectious Eczematoid Dermatitis	4	2	0
Nummular Eczema	2	2	0
Chronic Urticaria	2	0	0
Chronic Disseminated Neurodermatitis	2	2	1
Contact Dermatitis	3	3	3
Totals	20	16(80%)	7(35%)

Method

Patients were instructed to apply the calcium ointment four or five times daily as required to control the itching. The experimental preparation contained 10 per cent calcium in a water dispersible organic base. To ascertain that the patients were not reporting imaginary beneficial effects, six patients were treated with the base alone. Two of these patients reported moderate relief. In cases where the ointment failed to alleviate the itching, the oral preparation—Neo-Calglucon Syrup—was used as a supplement, one tablespoonful, three to four times daily for adults.

Discussion

The best way to show those conditions which respond to this type of therapy is to discuss each individually. The action of calcium in relieving edema and nerve irritability is well demonstrated in our results. Although the skin lesions disappeared in only seven of the twenty cases, the important fact was that relief from the very annoying symptom of pruritus was obtained in 80 per cent of the cases.

Atopic Eczema—Seven cases in which pruritus was a very annoying symptom and which had lasted for a long time, responded well to this therapy. Only two of the patients did not show good response, but nevertheless, pruritus was diminished. In this particular condition, the original skin lesions also responded to the treatment in three of the seven cases. One of these was a case of hives. The hives also disappeared. Where fluid balance of the cells cannot be disturbed propitiously, then it can be postulated that topical calcium will be of benefit.

Nummular Eczema—The pruritus in these cases responded only moderately well while the lesions persisted.

Chronic Infectious Eczematoid Dermatitis—These cases of short duration responded to therapy. Two of the patients had excellent relief from the itching, but in none of the four cases treated did the lesions disappear.

Chronic Urticaria—Cases of three months' to one year's duration did not respond. Neither the itching nor the lesions improved under the therapy.

Disseminated Chronic Neurodermatitis—The itching in these cases responded extremely well and in one of the cases, the lesions disappeared. Here again, where nerve cell irritability and permeability is a factor, calcium seems particularly suitable as therapy.

Contact Dermatitis—The itching related to these cases responded to the therapy. Complete relief was obtained and, in addition, the lesions disappeared within 10 days to two weeks after start of therapy. Here the dermatitis was present for only one to two weeks in both patients, and both patients were taken away from the original offending contact agent.

The ointment used was found to be nonsensitizing in the twenty-six patients treated and was cosmetically acceptable to the patients.

In approximately one-half of the cases treated, the local calcium was augmented by oral calcium. It would appear that with the more recalcitrant cases, this augmentation is both necessary and helpful. The results obtained justify, in our opinion, the further use of calcium ointment with or without oral or intravenous calcium.

Summary

1. Twenty patients with various pruritic dermatoses were treated with calcium ointment with or without oral calcium.

2. Of the patients treated 80 per cent reported good relief of pruritus; 35 per cent showed dis-

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The Use of an Antiseptic Synthetic Detergent for Local Hygiene in Pruritus Ani

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THERE ARE a number of perianal dermatoses, usually characterized by itching, which have been grouped under the non-specific heading of pruritus ani. As with the other diseases of obscure origin, a variety of therapeutic modalities has been employed. These measures include the use of numerous ointments and applications having protective, anesthetic, antibacterial, fungicidal or antihistaminic properties; the injection under the perianal skin of anesthetic solutions with prolonged action, dilute hydrochloric acid or alcohol; superficial radiation; dietetic régimes; psychotherapy; tattooing; and in chronic intractable cases which present profound and irreversible skin changes, some type of definitive surgery.[1] Most writers also emphasize the importance of local hygiene, but no effective or practical hygienic agents have up to now been available. During the past seven months the authors have employed an antiseptic synthetic detergent, pHisoHex,® with gratifying response.

Whatever the initiating factor in the production of perianal irritation, the skin becomes increasingly inflamed by the presence of fecal material, mucus and other secretions. The serous ooze from the cracks and erosions which are so often present, tends to create a sticky matrix to which bits of feces and dried mucus adhere. This tenacious film gives rise to an uncomfortable and itching sensation. The groundwork is laid for secondary infections with bacteria, monilia and other fungi. The various ointments and creams which are prescribed or self-administered produce further irritation and a feeling of stickiness which leads to additional scratching and traumatism of the affected parts. Cleansing with soap, even of the superfatted variety, and the mechanical rubbing involved, seems to exaggerate rather than to alleviate the symptoms. Water alone does not adequately remove the detritus.

pHisoHex®, which is pHisoderm containing 3 per cent hexachlorophene,* is used as a surgical scrubbing agent in both the hospitals with which the writers are connected. It is a bland, nonirritating bactericidal and bacteriostatic detergent which has a pH value of 5.5 which corresponds to that of normal skin.[2,3] It suds readily with a minimum of water, and its surface activity is estimated to be about 40% greater than that of soap.[4] Theoretically, is seemed well adapted for perianal hygiene, as a soap replacing agent which might rid the parts of adhering foreign material, lessen secondary bacterial or fungus development, at the same time preserving the normal pH of the skin. Accordingly, a small group of patients having perianal itching was selected and instructed to employ this preparation as a local cleansing agent. The use of soap and all medication was interdicted. The relief obtained was so satisfactory that the study was continued.

The following technique has been found effective. Bathing is recommended once daily. Because of the tendency to nocturnal itching, if practical, the bath is taken at bedtime. Water is drawn into the tub and the buttocks immersed until wet. The patient then stands and squeezes on to the palm of one hand several cubic centimeters of the soap replacement which is worked up with water until suds begin to form. These suds are then transferred to the perianal region and the area gently but thoroughly washed. Sitting back in the tub serves to rinse off any remaining detergent. Emphasis is given that only one lathering should be done at each bath to avoid over-treatment. While drying, the towel should be used by patting as if it were a blotter, and care taken not to rub the irritated parts. This method of perineal hygiene should be continued indefinitely.

In those persons who are accustomed to a shower, similar instructions are given with the added caution that the rinsing should be done with especial care. It is important to give detailed directions. In spite of careful exposition of the technique, some patients have applied the detergent cream on dry skin or have used it as an ointment.

Thus far, forty-five patients have used this routine. Care was taken to select only those cases in which it was felt that improper hygiene was a primary or secondary factor in their pruritus. Although many had had symptoms for long periods of time (one instance twenty-five years), no more

*Sodium octylphenoxyethoxyethyl ether sulfonate with 3 per cent (2 hydroxy-3,5,6-trichlorophenyl) methane.

than moderate skin changes had taken place. Patients presenting pathological conditions such as vaginal discharges, rectal fistulae, mucosal prolapse, protruding hemorrhoids, anal stenosis, chronic anal fissures and the like, were purposely omitted from the study. Also, intractable cases of pruritus ani in which there were huge skin tags, chronic anal ulcers and marked lichenification of the skin, were not included.

The response of this group was surprisingly gratifying. Most of the patients reported a welcome feeling of cleanliness and an early diminution in the amount of itching. Physical examination demonstrated lessening of the inflammation and in many instances a complete resolution of the skin to normal. The following observations are typical.

M.A.L., a white restaurant owner, aged sixty-two, complained of intractable perianal itching for five years. He had been treated with many therapeutic agents including anesthetic ointments, subcutaneous injections of anesthetic drugs and superficial x-ray therapy. None of these procedures had given more than temporary relief. Bathing in the prescribed manner was begun November 1, 1951. Itching diminished within twenty-four hours and gradually ceased in the next few days. Relief has continued to date. While the time involved is brief, the early and complete improvement has been typical of the group.

Perhaps the most spectacular response was that of B. M. R., a fifty-year-old physician who had been observed with pruritus ani over a period of twenty-five years. Treatment by various local applications had been in the most part disappointing. On many examinations, the perianal skin was found moist, fissured and macerated. Tag formation and lichenification, which would indicate surgery, had never been present. Perianal hygiene by soap replacement was started June 12, 1951, and brought about a cessation of itching within a few days. The régime has been continued daily since that time, and in the seven months which have elapsed there has been no return of symptoms. At a recent examination the perianal skin appeared normal.

Mrs. L. McC., aged forty-five, was referred by her gynecologist with a history of vulvar itching dating back to 1947. There was concomitant itching about the anus. Smears had shown the presence of trichomonads, and she had been given several courses of anti-trichomonad therapy. The perianal itching persisted, however, and the process extended to the vulva on both sides. Examination demonstrated a reddened and thickened perianal skin with redness extending to both labia majora. Detergent baths were prescribed October 16, 1951. Both the perianal and vulvar itching disappeared within a few days and there has been no recurrence.

Dr. M. H., an optometrist, aged thirty-five, was referred November 7, 1951, because of intractable itching and irritation about the anus of eight months standing. He had used many local preparations, including several antibiotic ointments. Examination demonstrated a raw, irritated, moist perianal skin with many superficial erosions. Within forty-eight hours after institution of the soap replacement method, itching and burning had ceased. The moisture about the perianal region was much reduced. On November 14, 1951, examination showed the perianal skin to be normal in appearance.

The following case illustrates the untoward effect by over-treatment with the detergent. L. McC., an electrical operator, aged forty-seven, first reported for examination September 19, 1951, with a history of perianal itching of eight months' duration. Examination showed the skin about the anus moist and reddened, with numerous small erosions. He was advised to use the detergent bathing technique as outlined above. Detailed instructions were given as to the method of application. A few days later he reported that he had obtained considerable relief. On October 8, 1951, there was a return of irritation. Questioning brought out that he was applying the soap replacement after each bowel movement with a wet cloth several times a day. Again he was asked to follow the directions explicitly. This he did for several weeks and was symptom-free. Again he reported with a flare-up of the irritation. This time he admitted applying the detergent with wet toilet tissue on dry skin after bowel movements.

It must be emphasized that the detergent baths are recommended only as an effective and practical means of obtaining local hygiene. When improper cleansing of this area is a primary or secondary factor in pruritus ani, the routine described above may be found helpful. Because of the short period of time (seven months) since the authors have begun this study, no conclusions as to the permanence of the benefit can be made. Nonetheless, the pa-

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Fractures of the Upper Extremity

By Robert J. Bannow, M.D.
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THE PURPOSE of this paper is to present for your consideration, several fractures commonly seen in the upper extremity, pointing out common errors in management, and suggesting methods of treatment which we have found satisfactory.

The first type of fracture I should like to mention is that of the so-called baseball or mallet finger. This is a fracture commonly encountered among athletes, particularly baseball players, and occasionally in industry, where a blow may be struck upon the extended distal phalanx. The mechanism of such a fracture is that of a blow inducing passive forced flexion of the distal phalanx, while the extensor tendon is firmly contracting to prevent this motion. The distal insertion of the long extensor tendon may be avulsed without carrying with it a piece of bone. On the other hand, a fragment of bone may be avulsed at the time of injury. A characteristic dropping of the distal phalanx into an attitude of partial flexion is seen. Passive extension is normal, but the joint cannot be actively extended. The unopposed pull of the long flexor tendon produces a 60 to 80 degree flexion deformity and the typical baseball finger configuration. A secondary disability often develops at the proximal interphalangeal joint, which may prove even more incapacitating than the deformity at the terminal joint. This consists of a hyperextension deformity at the proximal interphalangeal joint level, due to laxity of the extensor tendon sheath.

Better results are obtained in treatment, when a small portion of bone has been avulsed and is brought into apposition and securely held long enough for firm healing to occur. Generally speaking, less satisfactory results may be anticipated when the tendon has been torn without carrying with it a small fragment of bone.

The common practice of applying a tongue blade splint with the proximal interphalangeal and distal joints in extension is not satisfactory. Watson-Jones, Bunnell, and others have repeatedly stressed the necessity for splinting fingers in flexion at all times, and state definitely that there are *no* indications for splinting the finger in extension at any time.

We have employed plaster fixation of the finger in the following manner: With a plaster-of-Paris application, the distal interphalangeal joint is held in hyperextension while the intermediate interphalangeal joint is maintained in 90 degrees of flexion. Two tabs used for tying about the wrist serve to steady the cast and keep it from gliding upon the finger. The technique for application of the cast is similar to that for applying a clubfoot type of cast in that the skin is cleansed carefully and tincture of benzoin is painted over the finger. Thereafter, a layer of outing flannel is applied. Over this, the plaster-of-Paris is molded. The finger should be maintained in this type of fixation for a period of six weeks to permit consolidation of the bone fragment to the distal phalanx.

A second type of fracture to which I should like to call attention, is that of an oblique fracture of a phalanx. This fracture occurs very frequently and there is often difficulty in securing anatomical reduction and reposition of the fragments. In such a fracture there is a tendency towards overriding of the fragments and if the point of one fragment is very near to the joint it may interfere with joint function in the future. All too frequently, we have had the experience of seeing these fractures slip out of position with a resulting crippling deformity when healed in malposition. Therefore, our current practice is to treat these fractures with traction applied as a *preventative* measure to keep the fracture from slipping into an unfavorable position.

The application of traction to the finger is accomplished by an adhesive type of covering. The finger is painted with collodion, followed by the application of a one-half inch strip of webbing material which is then again painted with collodion. Traction may then be applied, consisting of a rather substantial pull through rubber bands attached to a wire incorporated in a plaster-of-Paris cast. The remaining fingers of the hand are left free to be mobilized and exercised, and, after a period of three weeks, it is possible to remove the traction and allow restricted use of the hand, including the affected finger. It is far better to anticipate the prospect of this fracture slipping out of position than to deal with it once

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it has gone into a position of deformity. It is not necessary to apply skeletal traction for this particular kind of fracture.

A third type of fracture is that of the metacarpals in the palm. A transverse fracture of a metacarpal in which some lateral displacement has occurred can be controlled by the use of a banjo-type of splint with adhesive traction to the finger.

This particular fracture demonstrated what, to our mind, is a very important point in the management of all fractures of the hand, particularly with reference to the metacarpals and phalanges. Local infiltration and manipulative reduction is seldom very satisfactory, and traction applied with the aim of obtaining a satisfactory reduction *in time* has not been satisfactory. It is our strong feeling that manipulative reduction should be carried out under general anesthesia or brachial block anesthesia, so that accurate reposition of the fragments is obtained very early. After this, it is far less important as to what method of fixation is employed, as the results, generally speaking, will be satisfactory if an early anatomical reduction is obtained.

In one of our cases in which there had been persistent lateral displacement and the patient was not seen by the orthopedic surgeon until some ten or fifteen days following the fracture, it was impossible to do very much except reduce the fracture by open methods. This was declined by the patient and, as a result, he has a weakened grip in the hand with a nodule which he feels and which is palpable in the middle portion of the palm of the hand. It exerts a constant factor of disability from which he will probably not fully recover. This deformity is particularly disabling to workmen who must grasp tools firmly in the hand.

Two fractures of the base of the thumb metacarpal are of interest. The first type is that of the so-called Bennett's fracture. This should more properly be called a "Bennett's fracture dislocation." There is a triangular fragment of bone which remains in its normal position while the metacarpal slides downward along the surface of the trapezium. The *only* method by which this fracture may be maintained in reduction is by traction. In this instance, skeletal traction is applied. Our method of doing this is that of insertion of a small Kirschner wire through the distal phalanx of the thumb. The proper site of insertion can be easily determined by placing the wire in line with the base of the thumb nail and two-thirds the distance between the flexor and extensor surfaces of the finger. It may be drilled through the bone satisfactorily under local anesthesia if desired. Brachial block anesthesia may be preferable in view of the foregoing remarks pertaining to other fractures about the hand. The Kirschner wire may be inserted under the same anesthetic. It is done under sterile precautions and may be an out-patient procedure if desired. Following the application of a plaster-of-Paris cast to the forearm, incorporating a piece of coat-hanger wire for traction, the Kirschner wire is bent into a traction bow apparatus and attached to the coat-hanger wire by means of a rubber band.

A device, used by us, to hold the wire in place is made by wrapping a piece of sterile cotton fiber around the Kirschner wire at the point of skin insertion and touching it with a drop of collodion. When this solidifies, it constitutes a "bead" which will immobilize the wire in the finger at this point, and prevent lateral slippage. No dressing is required in addition to this treatment of the Kirschner wire. Traction is maintained for a period of at least three weeks. The position of the thumb is the same as when it is used to grasp the arrow in shooting with a bow and arrow.

The second type of fracture involving the base of the first metacarpal occurs through the base of the shaft and not through the articular surface. In this instance, there is likely to be lateral angulation. The general contour of the fracture is quite unsatisfactory, although the functional impairment is not as great, should the fracture heal in a moderate position of angulation. The fracture habitually lies within one-half inch of the joint. There is no joint injury. After reduction, the position of the fragments is stable and there is little or no difficulty in preventing displacement. Continuous traction is seldom necessary. The treatment of this fracture is, therefore, in marked contrast to that of the Bennett's fracture dislocation, where reduction is unstable, continuous traction is essential, and the penalty of imperfect reduction is a painful stiff joint and a serious disability.

Another upper extremity fracture of interest occurred in a man approximately forty years of age. An injury of the carpal scaphoid bone was seven months old when an x-ray examination was made. There was a fracture through the carpal scaphoid bone with rotation and displacement of the proxi-

mal fragment. In this position, no one could anticipate healing of any kind and disability should be expected. It is probable that this fracture was not completely recognized for its true extent at the time of injury. It is our habit to take three views of the wrist at the time of suspected injury to the carpal scaphoid bone. These consist of an antero-posterior, a lateral and a three-quarters view of the bone. A fracture line can usually be observed in one or another of these views, particularly when compared with similar views made of the opposite wrist. In the event of suspected fracture, although the x-rays do not reveal it upon initial examination, the wrist may be splinted in plaster or a conventional splint for a period of about ten days. At the end of ten days re-examination by x-ray is done. If a fracture is present, demineralization along the line of fracture will have occurred in this time and one can then be more certain of the existence of the fracture.

In the patient mentioned there was also a displacement of the carpo-lunate bone. This dislocation may exist without associated fracture but is more common in the presence of a fracture of the carpal scaphoid. Of the two injuries to this man's wrist, the dislocation of the carpal lunate may prove to be the more serious one over a period of time in view of the impingement of the median nerve at the wrist. This ultimately results in pain, weakness, and a median nerve palsy in the hand.

When seen initially, a preliminary period of immobilization of the carpal scaphoid fracture should be carried out, anticipating some degree of bony healing. After a period of about three months, one can decide by the progress of healing whether or not other measures may be necessary to secure solid healing. These methods include bone graft operation, excision of one or both fragments of the bone, and arthrodesis of the wrist.

A very difficult type of fracture encountered in the upper extremity is that of the forearm with consequences at the elbow joint. Monteggia described a fracture of the upper shaft of the ulna with dislocation of the radial head in 1814. It has taken more than a century to find a treatment for this injury. No fracture presents so many problems and no treatment is characterized by more general failure. The special complications are mal-union of the fracture of the ulna, non-union of the fracture of the ulna, unreduced dislocation of the head of the radius, stiffness and arthritis of the elbow joint, myositis ossificans around the radial head, and ankylosis of the radio-ulnar joint. Occasionally, cross-union at the level of the fracture between the ulnar and radial shafts occurs. Watson-Jones, in his book entitled Fractures and Joint Injuries, states that 90 per cent of his cases has shown some evidence of permanent disability.

Special care must be taken in the interpretation of the x-rays to recognize that a fracture of the upper shaft of the ulna is *seldom* an *isolated* injury. It is nearly always associated with a dislocation of the head of the radius and avulsion or rupture of the orbicular ligament. A typical patient seen in our practice was a fifty-five-year-old woman. Reduction of the fractured ulna was accomplished and maintained with a stainless steel plate of the usual variety. The end result, several months after the application of the plate and screws, was recurrence of disability at the elbow joint with forward displacement of the head of the radius. The disability was rather slight. The patient had a full range of pronation and supination and lacked only the last 15 degrees of complete flexion of the elbow, while extension was complete. In this case, one would not consider further intervention. However, more often than not, a great deal of disability may result and it is recommended that special attention be paid to this type of fracture in the very beginning.

Sometimes it is possible to reconstruct the annular ligament at the elbow at the time of open reduction of the ulna. We have a case in which this was satisfactorily performed on a teen-aged boy who is an athlete in school. He has resumed normal active motion of this elbow and has participated and excelled in basketball, football, and track following repair of the annular ligament. A normal range of motion was possible and there was excellent power and stability.

One of our patients had an epiphyseal injury to the elbow. The initial x-ray was made in 1942 and demonstrated a severe supracondylar type of fracture with comminution and displacement. During the interval between 1942 and 1946 difficulty had developed with an angulation type of deformity, limited flexion and extension, and irritation of the ulnar nerve at the elbow. Transposition of the ulnar nerve anteriorly was done in order to overcome an ulnar neuritis of mechanical origin.

On another of our patients a corrective wedge osteotomy was done above the elbow joint, in order to bring the axis of flexion into a more nearly normal plane. When the patient was last seen the elbow had about 90 per cent of the normal range of flexion and extension, and normal pronation and supination. There was some shortening of the arm, but function was good and the deformity not very noticeable.

A typical supracondylar fracture of the humerus occurred in a boy aged six. There was a severe displacement with marked swelling of the forearm and elbow and we properly anticipated a Volkmann's ischemic contracture. This particular fracture was seen within an hour of the time of injury and an early manipulative reduction was done. In this instance, a small rotational deformity could not be completely corrected, but in view of the comparatively good control over a very difficult fracture, it was decided to leave the arm in this position. The functional result has been excellent and the youngster, at the time of this writing, has regained approximately 85 per cent of the normal range of flexion and extension of the elbow joint and has normal pronation and supination of the forearm. With further passing of time and advancing growth of the distal humeral epiphysis, a better result should follow.

I should like to mention at this time, the use of traction in control of such a deformity as this. Where the swelling is severe it is often unwise to attempt a manipulative reduction and add insult to injury. Very often, if manipulative attempts are carried and acute flexion of the elbow is performed with a plaster-of-Paris cast application, the embarrassment to the circulation is such that a Volkmann's contracture will ensue. At least the risks are very high. The price of this error is extremely high in functional impairment in the future. An alternative method has been presented in which traction is exerted upon the extended arm, with weights and pulleys so disposed as to cause a downward pull upon the arm along the axis of the humerus, while a counter-traction weight is applied just above the elbow to pull the proximal fragment posteriorly in relation to the distal fragment. This type of traction accomplishes two things. Namely, the arm is left in extended position and circulation is less embarrassed than by acute flexion of the elbow. Secondly, satisfactory reduction can often be accomplished in this manner and after early callus formation about the fracture, the elbow may be flexed to any desired position and maintained in plaster until the healing is complete.

Fractures of the head of the radius occur relatively frequently. In dealing with these fractures, one should remember that the optimum time for operation is within the first ten days of injury. The surgeon must decide early whether or not an operation is necessary. He is not at liberty to defer the question for several months in order to see what would happen. Delayed excision of the radial head seldom improves the range of extension movement. Some writers have stated that it is inadvisable to perform the operation before the third or fourth week because early operations may be followed by ossification of the hematoma. This complication does not occur if the operation is performed properly. Excision of the whole head appears to be preferable from the standpoint of satisfactory end result rather than removal of a marginal section of the fracture.

An example of a fracture of the shaft of the humerus is given here in order to outline the current popular method of internal fixation using a Rush intramedullary nail. A transverse type of fracture with angulation and displacement was treated by making a short incision over the head of the humerus at the level of the greater tuberosity and inserting a Rush intramedullary nail in the axis of the humerus. Manipulation of the fracture was carried out under fluoroscopic control and the Rush nail was driven to its complete depth into the distal fragment.

It is not always possible to secure satisfactory manipulative reduction at the time of insertion of the Rush nail, and accordingly, a separate incision is often required over the point of fracture to visualize the fracture and the protruding portion of the nail as it is being driven into the proximal fragment. The fragments may then be reduced by manipulative methods under direct vision and the Rush nail can be driven to its complete distance. No form of external immobilization is employed, although a sling is commonly given. Early active motions of the arm, wrist, forearm and hand are encouraged and the disability from limitation of flexibility is minimal. All of these fractures treated as above have healed satisfactorily in the usual time. Sometimes, it is necessary to remove the Rush nail at a later date, although if the proximal portion of the

nail is buried in the notch between the head of the humerus and the greater tuberosity, it does not interfere with joint function and may not require removal.

A severe fracture involving the head and neck of the humerus can often be treated satisfactorily in a hanging type of cast. Satisfactory functional results may be obtained even though an anatomical reduction is not secured.

Occasionally, one will encounter a type of fracture in which there has been such marked comminution of the head or such severe displacement of the capital fragments into the commonly described position of dislocation of the shoulder, that surgical removal of the head becomes necessary. We have excised the head of the humerus in several cases and the end results have been quite satisfactory. From the standpoint of elimination of pain, most of them have been good, although stability is often sacrificed. If care is taken to preserve the attachments of the rotator muscles into the proximal portion of the shaft of the humerus, excellent control of internal and external rotation is frequently possible, although the power of abduction of the shoulder is usually weak.

Another type of injury about the shoulder area which has been quite common consists of an acromio-clavicular joint separation. This may involve the acromio-clavicular joint itself, and may, in its more severe form, involve the conoid and trapezoid ligaments. In the early stages of the suspected diagnosis, a comparative anteroposterior x-ray should be made with a weight of ten pounds in each hand. This will readily reveal any loss of stability of the acromio-clavicular joint. If the separation is mild and the injury is acute, a satisfactory taping of the joint may be carried out.

If the separation at the time is severe or if later the result of an old, acromio-clavicular separation is seen, selection of the type of repair is often difficult. Repair of the conoid and trapezoid ligaments is difficult. Wiring of the acromio-clavicular joint is mentioned only to condemn the procedure, since it will eliminate the rotational motion of the clavicle in its long axis at the acromio-clavicular joint and prevent certain overhead motions of the shoulder. One method of treating this condition is that of excision of the acromio-clavicular joint. In this instance, approximately 1 to 1.5 inches of the distal end of the clavicle is resected. The procedure has much to recommend it from the standpoint of short disability and hospital stay and early use of the arm.

One of our patients had an excision of the acromio-clavicular joint and, within ten days of the operation, was beginning to use his arm for feeding and dressing himself. Within six weeks he was using it to pursue his usual occupation in one of the automobile plants in the city. In ten weeks, he had resumed activities including bowling and states that his score is better now than it was prior to the time of injury to his shoulder.

The final type of fracture I should like to mention is that of the clavicle with particular reference to complications. We have had two experiences with this type of injury which apparently are somewhat unique. The first of our patients, a woman aged thirty-eight years, was the victim of a freak accident in which an automobile tore through the side of her home while she was sleeping, knocking her out of bed and across the room. She sustained multiple injuries including a fracture of the clavicle. Delayed union followed the conventional method of manipulation and immobilization. In addition to this, it was discovered on re-examination that the proximal portion of the clavicle had become dislocated at the sterno-clavicular joint. It was decided to attempt an open reduction of the clavicle and to provide some type of internal fascial sling repair of the sterno-clavicular joint. At the time of surgery, it became apparent that in order to secure apposition of the bone ends a further resection of bone would be necessary, causing foreshortening of the shoulder girdle. It was decided, in view of the presence of both of the above lesions, that excision of the entire clavicle should be carried out. This was subsequently done. The arm was immobilized in a light Velpeau type of bandage immediately following surgery. The sutures were removed on the tenth postoperative day, and the wound was healed satisfactorily. Early flexibility exercises of the shoulder were instituted on the fifteenth day, and the patient continued to develop increasing flexibility and power in the shoulder. She is now capable of full range of flexibility in the arm in respect to all essential functions, including reaching in the overhead position. There is a little weakness of the shoulder in the extreme overhead position, but otherwise there is no limitation of flexibility and there is no spontaneous pain or other disability.

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Rural Practice Can Be Fun

By John R. Rodger, M.D.

Bellaire, Michigan

"CAN I practice good medicine there? Can I make a decent living there? Will I enjoy making my home there?" These are the three questions which every medical student and intern eventually asks himself. Let us relate these three questions to rural practice, but first clear the decks of some hazy ideas about general practice as a whole and rural practice in particular.

The medical student or intern contemplating general practice may make an error in either of two directions. First, he may think of general practice as too comprehensive and therefore fear it if he doesn't excel in all the branches of medicine. Only a general practitioner in an extremely isolated area would find himself in such a situation. Second, he may view the field of general practitioner as too limited, thinking he will turn out to be just a glorified first-aid man or treater-of-minor-illnesses, with anything interesting or complicated going to the specialist.

Neither of the above views is correct. Medicine is a teamwork proposition that requires both the general practitioners and the specialists working with, not against, each other. An adequately trained general practitioner can do approximately 95% of the work which comes his way in obstetrics, and 85% of that in general medicine, pediatrics, and surgical diagnosis. With an average of twenty to forty patients a day I refer from one to five of these to a specialist.

The man deciding against general practice may do so partly on the grounds that he thinks such a practice will cause him to miss a lot of interesting professional experiences, such as the roentgenologist discovering a parathyroid tumor from a study of areas of decreased density in a tibia, or the surgeon finding an acute Meckel's diverticulum, or the pediatrician picking up a pulmonary stenosis. But consider what these different specialist miss! No x-ray man ever has the chance to diagnose an acute Meckel's diverticulum; no surgeon has the fun of catching on to the presence of a parathyroid tumor from an x-ray study of a tibia; no chest surgeon operating upon a congenital heart was ever the first to pick up the case on a routine examination; no pediatrician delivers the babies he takes care of; and no obstetrician sees his babies after he has tied the cord! There are no fields more limited by hard and fast boundaries than the specialties. Depth of knowledge in specialization at times seems to be in direct ratio to loss of surface area. Conversely, breadth of surface area does not have to mean shallowness of knowledge unless a man is inept or lazy.

Medical practice in rural areas today is as far distant from the old practice of yesteryear as is the modern car from the horse and buggy. People in rural areas have always deserved as good medical care as those in the cities, and they are now demanding it. The farmer won't operate his land with old-fashioned machinery, and he doesn't want the doctor to operate on his child on the kitchen table! When it comes to modern medical science, we don't have to sell the rural population a "bill of goods"; we only have to supply the medical care they want.

Professional Activities

Now to the first question, "Can you practice good medicine in the country?" My answer is a definite "Yes." No man in the country need go to seed professionally unless he so wills it through his own laziness. All areas have monthly county or district medical meetings, most of which are built up around scientific programs. Hospitals in the area have scientific programs at staff meetings. Many states now bring post-graduate education right out to a spot within 50 or 75 miles of the doctor. State and national medical meetings are always available. Your patients expect you to go to some of these, but if your area has only a few doctors, you and your colleagues should stagger your absences. Medical centers have their post-graduate courses and many M.D.s in rural areas are members of the Academy of General Practice, with it stimulating requirement for membership of at least 150 hours of post-graduate study every three years. Last but not least, there are your journals and books. You should find time to read them in your regular week's routine, but at least you can read them while waiting for that delivery or while on vacation. My summer's journals are usually read before an open fire during a September week in a cottage by the shore of Lake Michigan. Sometimes they are digested better that way!

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Specialists Available

Good practice also means the availability of consultants. Most smaller towns are grouped around a larger trading center town or small city. It is usually here that the largest hospital will be found. Around this hospital will invariably gravitate a growing number of specialists. In my section of Michigan, there are two such trading center cities. Sixteen years ago, both together could provide only four Board-certified specialists—now there are 24, with all major specialty groups represented except neurosurgery. The man contemplating specialization should remember that very frequently he will make a better living and enjoy life more in a small city than he would if he settled in a large urban area. In a few years, with the present stimulus of Federal matching funds for hospital construction, it will be an unusual trading center area which does not have adequate hospital facilities.

Medicine today depends greatly upon the help of the laboratory, and going to the country does not mean leaving the laboratory behind. Some of the more routine jobs you will do yourself! These include blood counts, urinalyses and sedimentation rates. Recently, an easy and short method of doing a blood sugar in the office has been evolved. Many state health department laboratories provide an excellent service for Kahns, Rh determinations, sputums, throat, stool and blood cultures, smears, widals, and guinea pig inoculations. The private lab in connection with your area hospital can do your blood chemistries, BMR and EKG studies, or cultures on which you want quick returns. Biopsies taken in the office can be sent to the best pathology lab available.

Necessary Equipment

You will need a certain amount of equipment beyond that of the man in urban practice. In addition to the bare essentials everyone needs, you should have a microscope, hemocytometer, splints, and sedimentation apparatus (a very usable and portable "micro" method for the latter is available). Sedimentation apparatus is of inestimable value in diagnosing and appraising both coronary and rheumatic fever cases. You should also have oxygen therapy equipment, with an E tank for the car, a BLB mask and a reduction valve for using with the larger garage tanks. If you have it, you will use oxygen even more than adrenalin. Optional office equipment to be added later if you so desire would be x-ray, diathermy, EKG and BMR apparatus.

In your car you should carry a fair-sized bag containing all the drugs usually needed in an emergency. You can't go ten miles out in the country and just leave a prescription. You should also carry home obstetrical equipment, oxygen equipment, a microscope if the call sounds like an acute abdominal emergency, a sedimentation outfit if it sounds like a coronary or if you are evaluating the convalescence of a youngster with rheumatic fever.

Transportation

If you live in the north country, you should have a reliable car with good heater, a warm light weight driving coat, warm mittens, a cap, and possibly snow-shoes for the semi-occasional time you have to get off on an unplowed road. In some areas of the country a jeep will save you time. When the neighbors see you bouncing across-country in a jeep with an oxygen tank, they won't know if it is the garage man coming to weld Pa's tractor, or the doctor coming to care for Grandma's cardiac asthma!

Finally, in the country there is a certain type of mental equipment which you will need. You should have an interest in people so that you will get to know as much as possible of the total background of your patients. This is very important today with the emphasis upon psychosomatic medicine, and something which is much easier to do in the country than in the city. In the country, you don't need a social service worker to dig out the picture of your patient's environment. You should also have a certain degree of self-assurance without being "cocky." There will be times when you must make some important decisions by yourself without the help of colleagues. Perhaps General Stonewall Jackson's advice to his younger officers is also good for us, "Never underestimate yourself in action, and never overestimate yourself in the official report."

Lower Expenses Help

Next, can you make a decent living in the country? Remember that your expenses to begin with are lower, and that there is a shorter waiting period before the money starts to come in. Many communities needing doctors are adopting the "Kansas plan" of financing office space and equipment for the young M.D. who cannot easily estab-

lish bank credit. The community becomes his bank and takes him on as a credit risk with no mortgage. Collection percentages invariably are better than they are in the city, "dead-beats" are fewer and don't float from doctor to doctor. In 16 years of practice in what the Michigan State Tax Commission rates as the sixth poorest county in this state, I have always collected from 90 to 98%, send out statements not over four times a year, and have never turned over an account to a collection agency! My experience is typical of that of hundreds of other men in rural areas.

A less ambitious retirement and insurance program is needed than would be true in the city. In terms of home maintenance, a $60-70,000 insurance program in a small town would have to be matched by one of at least $100-125,000 in the city. Don't forget that over a certain limit the inheritance tax takes a huge bite.

Build Your Own Office

If you decide to build an office rather than to rent, it is much easier to build exactly what you want if you are in a small town. Remember that rural people appreciate a neat, well-planned office just as much as city people do. I know a fine old doctor who, after practicing for fifty years in Chicago, partially retired but still maintained a limited practice in the country where he has vacationed for years. He built a beautifully panelled office as an addition to his cottage. When I remarked about it he said, "For fifty years I practiced in Chicago. I had to rent space and I never had the kind of an office I really wanted. Now, even though I practice comparatively little, I have the kind of office I've always wanted." He practiced in Chicago for fifty years before he had the kind of an office he wanted. I practiced in the country and waited five!

I know of no young doctor in rural practice who is not making a very decent living. Beyond a certain point, there is no incentive to roll up a large income, because the extra hours only help pay off a tiny crumb of the national debt! The extra work gives one a fine chance to have a coronary at forty-five to fifty; your widow will then put a nice stone over your grave, and your children will say, "How nice of the Pater to carry all that insurance so that we can go to college in style—but it's too bad we never got to see much of him!"

Life in a Small Town

Now we come to the third question, will you and your family enjoy living in a small town? Modern methods of communication have made the small town and the city much closer to each other than we sometimes realize. Good roads and modern cars bring you near the big city hospital, shopping center and concert hall. Young college graduates in other fields are going to the country in increasing numbers. In almost any small town, you will find a number of "kindred spirits."

In the country, there is less artificial living than is often found in the city. If you and your wife just have to have a certain amount of night life in urban "hot spots" every week, then the country may not be for you! However, there are other compensations not found in night clubs. For instance, you should be prepared in time to accept a certain degree of community leadership in whatever fields of activity you enjoy the most—health council, boy scouts, luncheon clubs, church, or school board. The community hopes you will be a leader, but a democratic one. The same goes for your wife. The community wants both of you to be neither garrulous nor aloof. People want you to become a part of the community and not be just outsiders.

Planned Vacations

In rural as in urban practice, don't forget your vacations. A perennially tired doctor is a poor one. The community will expect you to take a vacation just as it expects the teacher, the minister and the business man to do the same. The only thing it asks of you is that you will see to it that a colleague in your town or an adjoining one will be available for emergencies. We endeavor to take a two-week vacation for all the family when school is out in June. My wife and I take another week in the early fall. In addition, I take off from one to two weeks a year for state and national professional meetings, and another twelve to fifteen days scattered over the year for committee and other meetings in connection with organized medicine's activities.

To really enjoy rural life you must love the out-of-doors. Your enthusiasms may range over the fields of hunting, fishing, sailing, skiing, canoeing, sketching, picture-taking, hiking, or just driving over the countryside. In the city, we go to an art gallery to see a Rembrandt painting or a Grant Wood landscape. In the country, we learn to search in a patient's face for a little of what Rem-

brandt would have found if he could have seen it, and we can get our Grant Wood landscapes first hand instead of via a canvas!

The Intangible Things

I would not want to leave the impression that all is always sweetness and light in rural practice. Sometimes you have crotchety and heedless patients, just as in the city; many times you will be late to meals, just as in the city; family plans get upset at the last minute, just as in the city; you may battle blizzards, but in the city you will battle iced streets with considerably more personal hazard; you will get discouraged sometimes and wonder why you ever took up medicine at all—just as happens at times in the city. But by and large, the country presents no major disadvantages not also found in the city, omits no major advantages found only in the city, and provides many rich resources for living which are peculiarly its own.

The chief satisfactions of medicine, as in all of living, are the intangible ones. "The things which count the most are the things we can't count." There is no greater vocational satisfaction than the feeling that you "fit in," that you are needed and wanted.

Medicine encompasses both the fields of research, plus the bringing of the results of this research to sick patients. If you feel that the latter job is to be your chief role in medicine, then don't forget that relatively speaking, the rural areas of America need M.D.s more than the cities do. If you finally become convinced that in the country you can practice good medicine, make a decent living, find certain individual satisfactions in your work there, and if you and your wife want to give rural living at least a try, then come on!

FRACTURES OF THE UPPER EXTREMITY

(Continued from Page 1453)

Our second patient to undergo excision of the clavicle was a man aged twenty-eight years, who sustained a fracture of the clavicle as a youngster. This healed with a firm mass, oval in contour, in the region of the fracture. He had difficulty in the army carrying a pack upon his shoulder. Following discharge from the service, he had increasing disability with pain. He was unable to lie upon the affected side at night during sleep and, for several months prior to our initial examination, had a sensation of numbness in the arm. Examination revealed a large mass of calcareous material in the mid-portion of the clavicle. X-ray revealed a non-union of the fracture in the mid-portion. The cartilagenous mass of callus about the fracture was not visible in the initial x-rays. It was decided that open operation should be carried out. Again, it was discovered that when the mass of cartilaginous material at the bone ends was removed, not enough of the shaft of the clavicle remained to provide contact of the major surfaces. Rather than attempt a free bone graft to the fracture site, we decided to perform an excision of the clavicle. The incision was extended and the entire shaft of the clavicle was removed from the sterno-clavicular to the acromio-clavicular joint. The wound was repaired and healed uneventfully. The patient was discharged from the hospital in ten days. Early active and passive movements of the shoulder were carried out.

At this writing, the patient has developed a full range of flexibility in the shoulder with no symptoms referable to the shoulder itself. There is a slight depression cosmetically in the area of the clavicle and there appears to be some exaggerated motion of the shoulder girdle such as one might see in a congenital absence of the clavicle (cleido-cranial-dysostosis). At the last visit, he was performing vigorous manual duties, using his arm in his work as a rug cleaner where scrubbing motions of the arm were required. He no longer has any parasthesias in the forearm or hand and can use his arm normally for all purposes.

These two cases, in particular, are of great interest to us since they have demonstrated that one may resect a portion of the clavicle and even the entire bone without disability from a mechanical-functional viewpoint.

Michigan Clinical Institute

Sheraton-Cadillac Hotel, Detroit

Popular "Block System"

TIME	WEDNESDAY March 11, 1953	TIME	THURSDAY March 12, 1953	TIME	FRIDAY March 13, 1953
A.M. 8:30	Registration. Exhibits Open	A.M. 8:30	Registration. Exhibits Open	A.M. 8:30	Registration. Exhibits Open
	Four SURGICAL Subjects		*Four CANCER Subjects*		*Six HEART AND RHEUMATIC FEVER Subjects*
9:00	Everett N. Collins, M.D. Cleveland	9:00	Raymond W. Houde, M.D. New York City	9:00	Harold B. Houser, M.D. Warren A.F.B., Wyo.
9:30	Lester R. Dragstedt, M.D Chicago	9:30	Matthew H. Griswold, M.D. Hartford, Conn.	9:20	Harper K. Hellems, M.D. Detroit
10:00	Intermission to View Exhibits	10:00	Intermission to View Exhibits	9:40	Forest D. Dodrill, M.D. Detroit
11:00	Gaylord S. Bates, M.D. Detroit	11:00	*R. S. Sykes Lecture* Harold W. Dargeon, M.D. New York City	10:00	Intermission to View Exhibits
11:20	Robert S. Dinsmore, M.D Cleveland	11:30	James R. Driver, M.D. Cleveland	11:00	Edward M. Kline, M.D. Cleveland
P.M. 12:00	Discussion Conference *Leader* W. H. Huron, M.D.	P.M. 12:00	Discussion Conference *Leader* F. A. Coller, M.D. Ann Arbor	11:20	Robert A. Gerisch, M.D. Detroit
				11:40	William B. Kountz, M.D. St. Louis, Mo.
1:00	Luncheon	1:00	Luncheon	P.M. 12:00	Discussion Conference *Leader* E. D. Spalding, M.D. Detroit
	Six OB.-GYN.-PED. Subjects		*Seven SURGERY OF TRAUMA Subjects*		
2:00	Lester E. Bauer, M.D. Detroit	2:00	A. Jackson Day, M.D. Detroit	1:00	Luncheon
2:20	John M. Nokes, M.D. Charlottesville, Va.	2:20	Albert D. Ruedemann, M.D. Detroit		*Six INTERNAL MEDICINE Subjects*
2:50	Donald J. Barnes, M.D. Detroit	2:30	Joseph L. Posch, M.D. Detroit	2:00	William S. Reveno, M.D. Detroit
3:10	Intermission to View Exhibits	2:40	Elmer R. Jennings, M.D. Detroit	2:20	Winthrop N. Davey, M.D. Ann Arbor
4:10	Joseph C. Gemeroy, M.D Detroit		Discussion Period	2:40	Final Intermission to View Exhibits
4:30	Cleary N. Swanson, M.D Detroit	3:00	Intermission to View Exhibits	3:15	Abraham I. Braude, M.D. Ann Arbor
4:50	John S. Lundy, M.D. Rochester, Minn.	4:00	Prescott Jordan, Jr., M.D. Detroit	3:35	Carl B. Beeman, M.D. Grand Rapids
		4:15	Homer M. Smathers, M.D. Detroit	3:55	Henry A. Luce, M.D. Detroit
		4:30	George T. Aitken, M.D. Grand Rapids	4:15	Michael M. Dasco, M.D. New York City
		4:45	Discussion Period	4:45	End of Institute
6:30	Dinner Hour	6:30	Dinner Hour		
8:30	Public Meeting Atomic Energy		No Scientific Meeting Thursday Evening		

No Registration Fee for MSMS Members at Michigan Clinical Institute

Cancer Must be Detected Early— In Your Office

The fourth Annual Michigan Cancer Conference was held at East Lansing on October 9, 1952, and, as usual, was well attended by an attentive group of people interested in cancer control education. These conferences, originated by the Cancer Control Committee of our State Society and co-sponsored by the Michigan Department of Health and the Michigan Division of the American Cancer Society, are of distinct value in refreshing and stimulating the leaders of cancer control education throughout the state.

Two facts should stand out in our thinking about cancer control. First, the ability of the individual to recognize certain abnormal signs, that may lead one to suspect cancer, has been and increasingly should be the prime objective in our lay education program. There are, of course, other aspects of cancer control education that should be included in a well-rounded program, and it is my hope that an even more co-ordinated effort can be accomplished to this end by the combined efforts, perhaps working through a liaison committee of the Michigan State Medical Society, the Michigan Department of Health, and the two divisions in Michigan of the American Cancer Society.

Secondly, it follows that if we urge people to recognize signs of cancer and they are inclined to act on their observation, we should not fail in our responsibility to listen to them and see that they are satisfied that everything is being done to prove the presence or absence of cancer to the best of our ability. Certainly, much has been accomplished by a simple but effective plan as in Michigan's own Hillsdale and Van Buren Counties to implement cancer detection, but it can be even more simple if *every* physician would conscientiously make his office a cancer detection center. It may or may not be that this is the answer to the problem, but it behooves every one of us to be willing to respect our patients' observations and even their anxieties over their own condition. No M.D. may discuss lightly what to the patient is important and indeed may be diagnostic perhaps more times than we are willing to believe.

R. J. Hubbell

President, Michigan
State Medical Society

President's



Message

A Physician's Thanksgiving

ALMIGHTY GOD, I am thankful for the task Thou hast given me. I am thankful for the science of my profession that overcomes superstition and clarifies the true nature of disease. I am thankful for the means of practice so generously placed at my disposal and for the art of my calling. I am thankful for the strength of my physical being that permits me to minister to the weak and needy and for the courage of my soul that enables me to endure the spectacle of human suffering. I am thankful for the faith and friendship of my colleagues who so willingly come to my assistance and generously overlook my shortcomings. I am thankful for my failures and the priceless lessons they have taught, for they drive from me conceit and thoughts of easy victory and urge me to greater and more perfect attainments. I am thankful for the pitfalls and disappointments that surround and beset me, that teach me caution and protect me from hasty judgment and actions. I am thankful for ingratitude that teaches human understanding and for the gratitude that is my most lasting reward. God of human destiny, I am thankful for Thy manifold blessings and for the privilege that is mine.

E. C. Baumgarten, M.D.
November 26, 1929

Editorial

AMA STILL FIGHTS SOCIALISM

DURING THE session of the House of Delegates of the Michigan State Medical Society, in Detroit, September 22, 1952, the delegates and members were greeted on Tuesday morning with the following announcement in the *Detroit Free Press:*

SATISFIED AMERICAN MEDICAL ASSOCIATION ENDS FIGHT ON HEALTH PLAN

Chicago—The American Medical Association Monday ended its stormy, four-year fight against national compulsory health insurance, contending that it has been "eminently successful."

Leaders of the American Medical Association campaign resigned from their posts to form a committee in support of Dwight D. Eisenhower, the Republican candidate for president.

Dr. Louis H. Bauer, American Medical Association president, said the battle against what the medical group called "socialized medicine" was terminated because it had served its purpose.

A *plan* for compulsory national health insurance was advanced by President Truman, but never made any headway in Congress.

Bauer also announced the resignation of Dr. Elmer L. Henderson, chairman of the American Medical Association Co-ordinating Committee, and Clem Whitaker and Leone Baxter, directors of the American Medical Association national education campaign.

They resigned, Henderson said, to form a "National Professional Committee for Eisenhower and Nixon," which will seek to enlist the support of doctors, dentists, pharmacists, lawyers and other professional groups behind the Republican ticket.

He said the American Medical Association "is a nonpartisan, professional organization, and cannot participate in the presidential election campaign."

"Whitaker and Miss Baxter, a public relations team, along with Henderson, directed the American Medical Association's vigorous and often bitter battle against health insurance from the inception of the drive in January, 1949.

To finance the fight the American Medical Association assessed each member $25 to raise a war chest of $3,000,000.

The medical men in attendance in Detroit on September 22-23 could scarcely believe their senses, and the House adopted a resolution pledging the Michigan State Medical Society to a continued opposition to the advancement of Socialized Medicine, and asking the parent organization for an explanation.

The next day Louis H. Bauer, M.D., American Medical Association president, attended our Annual Session and gave an assurance. The fight against the socializing program, the fight to maintain the independence of the medical profession has been carried on actively for four years, but now has evolved into a political partisan fight, one party against the other. The American Medical Association is a scientific organization, not allowed morally or ethically to support a political party or candidate. It was therefore determined to withdraw from this active campaign, and allow the workers to make a new association and devote their efforts to a whole-hearted and unhindered program. We quote Dr. Bauer's release:

"Dr. Elmer L. Henderson of Louisville, Kentucky, Chairman of the Association's Co-ordinating Committee, which has supervised the campaign against socialized medicine, has resigned his committee chairmanship so that he may be free to participate in the presidential election campaign.

"Clem Whitaker and Leone Baxter, Directors of the American Medical Association National Education Campaign, have asked to be released from their public relations assignment for the same reason.

"These resignations mark the official termination of the American Medical Association National Education Campaign, which for the past four years has been eminently successful in arousing the American people to the dangers of socialized medicine, and which has played a vital part in accelerating the growth and development of Voluntary Health Insurance. The American Medical Association, on this occasion, wishes to thank the American people for their heartening demonstration of confidence and support.

"The American Medical Association, as a nonpartisan, professional organization, is barred, both ethically and legally, from participating in election campaigns, which explains the action of Dr. Henderson and Mr. Whitaker and Miss Baxter in asking for their release from American Medical Association duties. The association will take no part in the presidential election, except to join with other nonpartisan groups in urging all eligible voters to cast their ballots on election day, regardless of their affiliations or preferences. Individual doctors, of course, are entirely free to engage in election activities and, in fact, have a very real responsibility to make their influence felt for good government."

Dr. Bauer assured The Council of the Michigan State Medical Society that the American Medical Association is just as opposed as ever to the socializing of medicine, and if the need arises will be unreservedly back in the fight.

TRUMAN'S BIT—AMA REPLY

AT HIS press conference President Truman said that from press reports he had seen "he had the impression that the American Medical Association was giving up, and acceding to his demands for a national compulsory health insurance program." There was confusion in the way some of the stories were written; headlines, especially, gave some readers that impression. But, this was not true.

The President added to the misunderstanding when he said he thought his Philadelphia speech on medical care for the American people—the speech he delivered before the American Hospital Association—caused the American Medical Association to disband its organization setup to fight his national health program.

He asserted the American Medical Association officials admit now by their action that they have been wrong.

The President of the American Medical Association, Louis H. Bauer, M.D., in Chicago, quickly issued a statement to the press, saying that Mr. Truman had some mistaken ideas about the American Medical Association's giving up.

"The American Medical Association will never cease its fight against national compulsory health insurance," Dr. Bauer's statement said, adding: "Mr. Truman's Philadelphia speech had no bearing whatsoever on the decision to disband a special committee set up to conduct an intensive short term, educational program against socialized medicine. This decision was reached by the American Medical Association House of Delegates last June, and was widely publicized at the time.

"The National Education Campaign was merely one intensive phase in the medical profession's long-range effort to keep medical care on a voluntary basis. This effort will continue as long as attempts are made to shackle the people's health in bureaucratic red tape.

"Mr. Truman is naive indeed if he believes that any speech he delivers could change the medical profession's basic beliefs concerning high quality medical care."

THE DOCTOR AND HIS CORONARIES

THERE IS a general belief that the doctor is somewhat more susceptible to coronary disease than the rest of the population. This was recently given additional support by a study in England which found a higher incidence of this disease among general practitioners than in either specialists and consultants or civilians. All of which quite naturally sets the doctor to wondering why he has achieved this unwelcome distinction and what he can do about it.

The answer is not readily available. At least not until more is known about heredity, body build and the habits we acquire defensively such as smoking, overeating and underexercising. The nature of the occupation itself, with the wide swings in its demands and the variation in imposed stress, offers a tempting explanation but does not disclose why the arteries to the brain and kidney should not break down as readily as those to the heart muscle.

Studies on the stress reaction, on the steroid chemistry in the body and on lipid metabolism hold some promise, but the prevailing attempts at influencing these in the human are still unimpressive. Until some more startling revelation comes along we should follow the same advice we give our patients: to eat, drink, smoke and play moderately; to rest adequately; and to have ourselves examined more frequently. This may at least put us on a par with the average citizen.

WILLIAM S. REVENO, M.D.

Elections

PRESIDENT FOR A DAY

THE MICHIGAN State Medical Society is well known throughout the land as an organization which does new things, makes new plans, takes a lead in medical progress, both scientifically and economically. There are so many "Michigan Firsts" that we hesitate to even enumerate them. However, there is one project which shows a very unusual and striking aptitude for recognizing and doing honor to its deserving members. Three years ago the House of Delegates designated the Editor as President for a Day. We value this honor as the highest in the gift of the society. Again the House of Delegates of the Michigan State Medical Society has conferred upon one of its honored members the most exclusive, and highest honor it can confer. It is given to one of our members most deserving by any standard. It is a recognition of eleven years of the most devoted and arduous work on behalf of the medical profession, the people of our State, and the advancement of our unrelenting fight against the socialization of our profession, all with absolutely no recompense except the knowledge and satisfaction of a tremendous task well done.

Robert L. Novy, M.D., of Detroit, was chosen by unanimous vote as President for a Day. He wore the badge of office from the meeting of the House on the evening of September 22, 1952, to



President-for-a-Day
R. L. Novy, M.D.

the meeting of the Biddle Lecture, September 23.

Dr. Novy was born April 1, 1892, in Ann Arbor. He married Elsie Lois Backus in 1916, has six children and eight grandchildren.

Dr. Novy's education was: He was graduated from the Ann Arbor High School in 1909, received an A.B. degree from the University of Michigan in 1913, and an M.S. in Organic Chemistry, 1914. He was instructor in charge of premedic chemistry and assisting in physiological chemistry, at the University of Iowa, 1914-15. He received his M.D. from the University of Michigan in 1919, and interned at Peter Bent Brigham Hospital and Boston City Contagious Hospital. He was a Fellow and Instructor in cardiology at Washington University, St. Louis, Mo., and in charge of cardiology at Barnes Hospital from 1921-1922. Dr. Novy has been in practice in Detroit from 1922 to this date, specializing in internal medicine and cardiology. He is a diplomate in cardiology.

Dr. Novy's professional and extracurricular activities show an unusual interest in the welfare of the profession, and good service to the people as exemplified by his decided influence on the Blue Shield movement of the nation.

We list Dr. Novy's activities:

Elected to Michigan Medical Service Board of Directors in 1941; President of Michigan Medical Service, 1942 to date.

Member and President of Detroit Board of Health, 1940 to date.

Instructor and Professor of Clinical Medicine, Wayne University Medical School, 1922 to date.

One time extramural lecturer, University of Michigan Medical School.

Wayne County Delegate to Michigan State Medical Society.

Michigan Delegate to the American Medical Association.

Former Trustee, Wayne County Medical Society.

Commissioner-at-large and Vice President, National Blue Shield Care Plans.

Member of Board of Trustees of Michigan Hospital Service.

Chairman of Michigan State Medical Society Committee on Fee Schedules.

Senior Physician, Harper Hospital.

Consultant and member of staff of number of hospitals.

Recreation: hunting, camping, fishing and photography.

PRESIDENT



READER J. HUBBELL, M.D., of Kalamazoo, was advanced from president-elect to president of the Michigan State Medical Society. Dr. Hubbell is a graduate of Northwestern University Medical School, 1923. He is a Fellow of the American College of Surgeons, and a diplomate of the American Board of Urology. He has held many staff and professional positions in his home hospitals and medical societies. He served on the Council of the Michigan State Medical Society for many years, and was chairman from 1950 to 1951.

PRESIDENT-ELECT



LEROY W. HULL, M.D., of Detroit, was elected president-elect. Dr. Hull was born June 3, 1888, in Lawrenceville, New Jersey. He was educated at the University of Michigan with the degree of A.B. in 1909, and M.D. in 1911. He interned at the Calumet and Heckla Mining Company Hospital, 1911-1912 and was physician at the Winona, Michigan, Mining Company, 1912-1915. He engaged in private practice of medicine and urology, in Detroit, in 1915. He was attending urologist at Receiving Hospital, Detroit, 1925-1942, and at Grace Hospital. He was made

chief of the Urology Department at Grace Hospital in 1948. Dr. Hull was Clinical Instructor, Wayne University Medical School, 1935-1942. He was instructor in the Department of Postgraduate Medicine at the University of Michigan in 1936. He is a member of the Wayne County Medical Society; president, 1944-1945 and trustee, 1945-1950. Dr. Hull was a member of the Council, Michigan State Medical Society, 1949-1952, and vice chairman, 1952. He is a member of the American Medical Association, the American Urological Association, the Detroit Urological Society (president 1929 and 1940), member of the North Central Branch, the Detroit Academy of Medicine, Delta Upsilon and Nu Sigma Nu.

Dr. Hull's election as president-elect made his place on the Council vacant.

THE COUNCIL

THE COUNCILORS of the seventh, eighth, ninth and tenth districts whose terms expired this year were all re-elected: H. B. Zimmer, M.D., Lapeer; L. C. Harvey, M.D., Saginaw; G. B. Saltenstall, M.D., Charlevoix, and Fred H. Drummond, M.D., Kawkawlin.



ARCH WALLS, M.D.

One new Councilor elected by the House of Delegates at the annual session in September, 1952, was Dr. Arch Walls of Detroit. Dr. Walls will fill the unexpired term of Dr. Hull, Councilor from the first district, who was elected president-elect.

Dr. Walls was born in 1895 in Pontiac and received his medical degree from the University of Michigan in 1923. He interned at Harper Hospital, and is on the staff of Florence Crittendon Hospital. He has been an active member of the Wayne County Medical Society since 1923; president in 1951-1952; secretary, 1944-1945, and trustee, 1949-1951. He was delegate to the Michigan State Medical Society; chairman of the Post-War Planning Committee; chairman of the Entertainment Committee; member of the Medical Advisory Committee of Michigan Medical Service; chairman of the Movie Subcommittee of the Public Relations Committee of the Michigan State Medical Society, and chairman of the Public Relations Committee of the MSMS.

Dr. Walls has been very active in promoting the interests of the general practitioners. He was a leader in organizing the first general practice section in various hospitals; one of the members of the American Academy of General Practice, past president of the Wayne County division of the American Academy of General Practice and past chairman of the Board of the Academy.

He and his wife, Lucille, have two children, Robert and Jean. He is a member of the Plum Hollow Country Club and the Detroit Athletic Club.

The House of Delegates re-elected Robert H. Baker, M.D., Pontiac, as speaker, and J. E. Livesay, M.D., Flint, vice speaker. L. Fernald Foster, M.D., Bay City, holds over as secretary and Wm. A. Hyland, M.D., Grand Rapids, as treasurer.

During the session of the Michigan State Medical Society, elections to the Board of Directors were held. The following were elected to succeed themselves: Earl I. Carr, M.D., Lansing; J. S. DeTar, M.D., Milan; Carelton Fox, D.D.S., Detroit; Wilfrid Haughey, M.D., Battle Creek; E. F. Sladek, M.D., Traverse City; W. I. Stoddard, Grand Rapids; Ronald Yaw, Grand Rapids, and William Bromme, M.D., Detroit. Mr. Glen W. Fausey, superintendent of the Edward Sparrow Hospital, Lansing, was elected as a new member of the board, representing the Michigan Hospital Association.

The Board of Directors at its organization meeting, October 8, 1952, in Detroit re-elected its officers: Robert L. Novy, M.D., Detroit, president; Wilfrid Haughey, M.D., Battle Creek, vice president; Robert H. Baker, M.D., Pontiac, secretary, and Waldo I. Stoddard, vice president, Michigan National Bank, Grand Rapids, treasurer.

MSMS

WHY IS A YAWN "CATCHING?"

Yawning may be considered to be a form of inspiration tic, associated with dyspnea. P. Janet describes yawning as related to sighing, sobbing, and hiccoughing, and refers to it as an example of "imitative contagion" (The Major Symptom of Hysteria, New York, The Macmillan Company, 1907, p. 259). It is a complex nervous respiratory reflex associated with mild boredom, irritating mental effort, or mild emotional anxiety. It is classified by R. Burton-Opitz (A Textbook of Physiology: For Students and Practitioners of Medicine, Philadelphia, W. B. Saunders Company, 1920, pp. 592-593) among the association or perception reflexes. These "skirt the realm of volition without being actually influenced by it and may be invoked in us in consequence of a visual impression of some one else already engaged in the act." Yawning is catching as a conditioned visual reflex when persons in a group are subjected to the same general boring or frustrating environment.—From "Queries & Minor Notes," *J.A.M.A.*, 148:16 (August 16) 1952.

FROM THE MINDS OF MEN - - -

- - - - THE BIRTH OF AN IDEA

1943 -- Michigan Health Council -- 1952

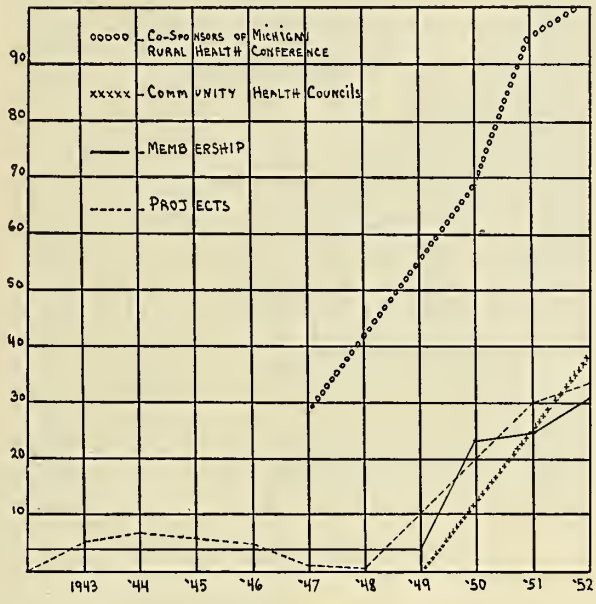
Reproduced on the cover of this issue of THE JOURNAL is a graphic record of the origin of the Michigan Health Council.

Taken in Detroit on November 3, 1943, this picture* shows eight of the ten men who accepted the challenge to transform an idea into a going concern—The Michigan Health Council.

With the conviction that a state-wide health council organization could be an effective co-ordinating vehicle in health, this group came together in regular monthly meetings to explore the possibilities and crystallize the idea.

Early in their deliberations the committee framed the purposes of the Michigan Health Council program and unanimously adopted the following basic objectives:

Growth Chart



TO PROMOTE THE HEALTH OF THE PEOPLE BY:

1. Co-ordinating the efforts of the Michigan State Medical Society, the Michigan Hospital Association, Michigan Medical Service, Michigan Hospital Service and other groups interested in the health of the people.
2. Conducting a general educational program regarding the advantages to the health of the people to be gained through the private practice of medicine and dentistry, and the operation of voluntary non-profit hospitals.
3. Taking all necessary and practical steps to arrange for the availability of medical, dental, hospital and related services.

Proof of the soundness of their thinking lies in the fact that while the program has been expanded in many directions since 1943, the original basic objectives still prevail.

During recent years more emphasis has been focused on Items 2 and 3 mentioned above while Item 1—co-ordination of the efforts of Michigan State Medical Society, Michigan Hospital Association, Michigan Medical Service and Michigan Hospital Service—has been accomplished effectively by a joint effort of all, with Michigan Health Council co-operating in every manner possible.

Progress in the development of the idea, defined in those early meetings, is shown on the accompanying growth chart. Four basic factors of growth are recorded on this chart: (1) growth of voting membership; (2) expansion of associate membership; (3) increase in the number of projects, and (4) growth in the number of organizations co-sponsoring the annual Michigan Rural Health Conference.

*Cover Photo—left to right—Graham L. Davis; A. S. Brunk, M.D. (deceased); R. L. Novy, M.D.; C. E. Umphrey, M.D.; Jay C. Ketchum; L. S. Woodworth, M.D.; John R. Mannix; L. V. Ragsdale, M.D.; also on the original committee, but not shown in this photograph were: W. E. Barstow, M.D., and William J. Griffin.

Continuing Projects Expanded

One factor responsible for the steady growth of the total program is the continuing nature of the projects making up the total MHC program. With but one exception, every project adopted since the Expanded Activities Program was launched in 1949, is still in being, and in the process of expansion.

That one project was the work done in collaboration with Brookings Institution in their study of Health Resources in the United States, for which MHC was given credit in the preface of the volume just released. There is a possibility that even this project may be reopened and continued if present negotiations for publication of the Michigan findings materialize.

New Projects Launched

The growth chart accompanying this article shows the gradual increase in the total number of projects adopted and emphasizes the marked expansion during the past three years.

Newest projects added to the MHC "Parade of Projects" (JMSMS—November, 1951) are: (1) periodic health appraisal; (2) Medical Associates procurement; (3) weekly television series, The Court of Health —all of which are being guided by special subcommittees on which doctors of medicine serve.



Registration Desk
Michigan Rural Health Council

M.D. Participation Increased

One of the important factors in the growth of the MHC program lies in the ever-increasing participation of Michigan doctors of Medicine (JMSMS—November, 1950). This participation has been present ever since the inception of the Council, as evidenced in the cover photograph, with the circle ever widening into all areas of Michigan and all branches of medicine.

To cite specific instances of this increasing M.D. participation, the following areas of co-operation might be considered:

1. *MHC Weekly Television Program, "The Court of Health."*—While this series has been produced by MHC only since June, 1952, more than twenty Michigan doctors of medicine have appeared on the program. Others are already scheduled for appearance in the near future. Appearing in another part of this article is a list of names of the doctors of medicine who have given of their time and knowledge to make this television series a success.

2. *Fifth Annual Rural Health Conference.*—Sponsored by the Michigan Foundation for Medical and Health Education and co-sponsored by ninety-four Michigan health groups, doctors of medicine from various areas of the state attended and participated. Eight doctors of medicine made scheduled appearances on the two-day program contributing effectively to the success of the conference.

3. *Counsel in Membership Expansion.*—Michigan doctors of medicine have been helpful in counseling member organizations on the advantages of affiliating with Michigan Health Council. Serving on boards of ancillary medical groups they have been in a position to counsel their groups on the effective utilization of the various MHC services available to them as member organizations. On numerous occasions they have given freely of knowledge and time in guiding various MHC projects.

4. *Community Health Council Activities.*—During the past year there has been a noticeable increase in M.D. participation in Community Health Council activities. In some instances doctors have played an important part in organizing of Community Health Councils and on many other occasions have given valuable advice to these community groups in planning and implementing community health programs.

Continued Growth Anticipated

Thus, starting with something as intangible as an idea—a very tangible organization has evolved.

Under the capable leadership of the late A. S. Brunk, M.D., first president, and the continued stimulation and guidance of President J. S. DeTar, M.D., the Michigan Health Council looks forward to an ever-broadening horizon of service.

With the continued co-operation and participation of Michigan doctors of medicine, further growth is assured.

The Court of Health

MHC Weekly Television Series

Working in the friendly atmosphere afforded all medical and health groups, Michigan doctors of medicine have played an important part in the new MHC weekly television series, "The Court of Health."

Carried over WJBK-TV, Detroit (Channel 2) Sundays, 10:30 to 11:00 A.M., the series features programs from three basic sources of material: (1) MHC member organizations, (2) Community Health Councils, (3) Seasonal health subjects.

With this wide variety of material, resources and personnel on which to draw, MHC has been able to cut across a broad field of medical and health subjects. In so doing, MHC has called freely on the knowledge and experience of Michigan doctors of medicine who have responded in a genial manner.

While the show is now beamed to the greater Detroit area, consideration is now being given to the possibility of utilizing the facilities of kinescope to broaden the range to the entire state of Michigan.

Michigan Heart Association
"New Hope for Hearts"



(Left to right)—Frederic Johnson, M.D., Detroit, Wayne University College of Medicine; "Judge" Morris; Mrs. Hugh Wilson, Ann Arbor, President, Michigan Heart Association.

"Farm Safety Week"



(Left to right)—William Buchinger, Farm Safety Engineer, Detroit Edison Company; "Judge" Morris, professional moderator; Robert Richards, Lansing, Past President, Michigan Safety Council.

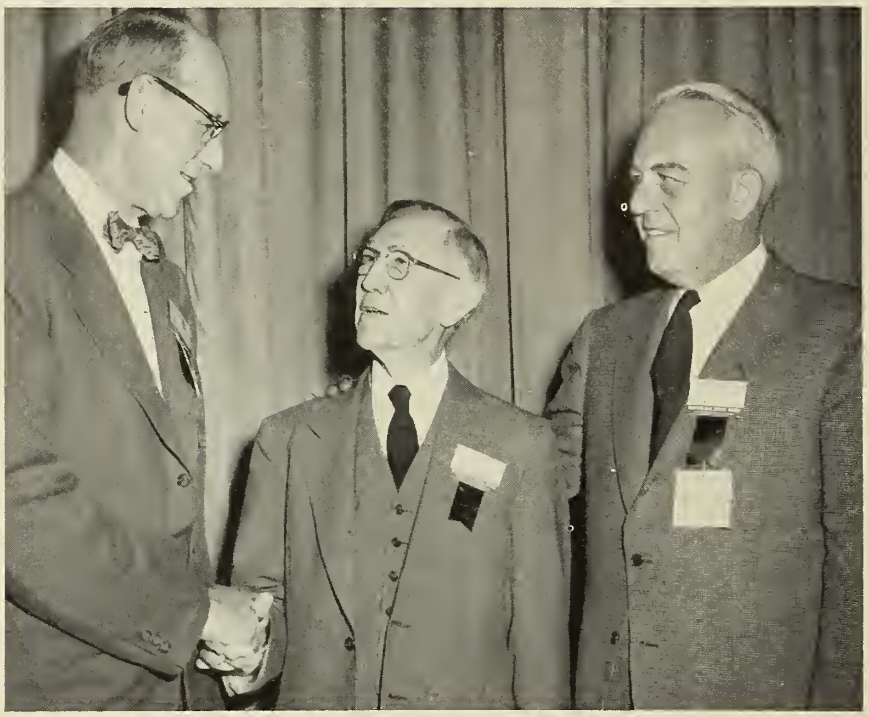
Michigan M.D.'s who have appeared as guests and resource persons on MHC television series, "The Court of Health"—10:30 A.M., Sundays, WJBK-TV Detroit—Channel 2.

1. Otto O. Beck, Birmingham
2. J. K. Altland, Lansing
3. Arthur E. Schiller, Detroit
4. Frederic Johnson, Detroit
5. J. N. Mandiberg, Detroit
6. Thomas Francis, Jr., Ann Arbor
7. E. A. Irvin, Detroit
8. Clifford H. Keene, Ypsilanti
9. W. A. Dawson, Inkster
10. W. H. Kern, Garden City
11. Arch Walls, Detroit
12. L. Fernald Foster, Bay City
13. G. W. Slagle, Battle Creek
14. W. S. Jones, Menominee
15. R. W. Shook, Kalamazoo
16. Oscar Stryker, Mt. Clemens
17. Geo. C. Thosteson, Detroit
18. W. L. Anderson, Detroit
19. Wm. L. Simpson, Detroit
20. A. D. Reudemann, Detroit
21. Carleton Dean, Lansing

87th Annual Session Highlights

DETROIT SCENE OF LARGEST SCIENTIFIC-SOCIAL MSMS MEETING

A record registration marked the 87th Annual Session in Detroit—despite conflicts with two national medical meetings!



MICHIGAN'S FOREMOST FAMILY PHYSICIAN

President R. J. Hubbell, M.D., of Kalamazoo, congratulating Michigan's Foremost Family Physician, S. L. Loupee, M.D., of Dowagiac, while Otto O. Beck, M.D., Birmingham, looks on. Dr. Loupee was selected as the 1952 foremost practitioner by the MSMS House of Delegates.

For years (six to be exact) the last full week in September has been reserved by the Michigan State Medical Society for its Annual Sessions. This year two national medical groups (the American College of Surgeons and the American Roentgen Ray Society) arranged their conventions the same week as the MSMS Session in Detroit. What that conflict did to their attendance is not known—but the clash had no effect whatever on the grand total that gathered at the Sheraton-Cadillac Hotel for one inspired week in September, 1952! The total registration, including the ladies, was 3,605.

ATTENDANCE RECORD SMASHED AT 1952 MEETING

Total registration at the 87th Annual Session of the Michigan State Medical Society in Detroit, September 24 to 26, was 3,605, the largest total for MSMS!

The breakdown included:

Doctors of Medicine	2163
Guests	419
Exhibitors	507
Woman's Auxiliary Members	273
Medical Assistants Members	243
GRAND TOTAL	3605



AMA-MSMS Cooperation

Three presidents using a triple handshake symbolize the unity between the AMA and MSMS. Pictured *(left to right)* are Otto O. Beck, M.D., Birmingham, 1951-52 MSMS President; Louis H. Bauer, M.D., Hempstead, N. Y., AMA President; and R. J. Hubbell, M.D., Kalamazoo, 1952-53 MSMS President.

New Top Officers

R. J. Hubbell, M.D., of Kalamazoo *(right)*, 1952-53 President MSMS, congratulates President-Elect L. W. Hull, M.D. of Detroit. Dr. Hull was elected by members of the MSMS House of Delegates to assume the presidency on September 23, 1953.

New Honorary Members

(Right) Grins reward President Otto O. Beck, M.D., of Birmingham *(center)*, as he rehearses his presentation talk prior to Officers' Night ceremonies when he awarded MSMS honorary membership certificates to State Treasurer D. Hale Brake, Lansing *(left)*, and Paul de Kruif, Holland *(right)*.

Two thousand one hundred sixty-three (2,163) doctors of medicine heard lectures by twenty-four eminent teachers and clinicians, listened to AMA President Louis H. Bauer, M.D., of New York State, and heard an outstandingly vigorous Biddle Lecture presented by Paul de Kruif, Ph.D., of Holland, Michigan.

These Michigan doctors of medicine selected Sherman L. Loupee, M.D., of Dowagiac as Michigan's Foremost Family Physician for 1952, honored an additional eleven physicians with fifty years of practice, honored two Presidents during the Session—Otto O. Beck, M.D., of Birmingham, and also President-for-a-Day R. L. Novy, M.D., Detroit, who received this great honor from the House of Delegates on September 22, 1952. The doctors viewed ninety-nine interesting and instructive exhibits, attended eighteen additional meetings of special societies, alumni and auxiliary groups, named a President-Elect from Detroit, and incidentally had a wonderful time with old friends and new ones.

Every meeting room in the Sheraton-Cadillac Hotel was jampacked with activity. Suite 500 was one of the spots that buzzed during the two days of the MSMS House of Delegates meeting and during the three days of the scientific presentations. Everyday, top-notch reporters from Detroit papers and the wire services of Associated Press and United Press were on the job pouring out accurate, complete and widespread coverage; in one week's time, thousands of words were written and flashed all over Michigan as well as to many parts of the United States, about the great MSMS Annual Session of 1952.



"Cap" Potter's Work Recognized

William Bromme, M.D., Detroit *(right)*, Chairman of the MSMS Council, congratulates L. A. ("Cap") Potter, of the Michigan Department of Health, after Mr. Potter was awarded a scroll signifying honorary membership in MSMS.

PRESIDENT BAUER AFFIRMS AMA IS STILL FIGHTING SOCIALISM

One of the highlights of Officers Night, held in the Grand Ballroom of the Sheraton-Cadillac Ho-



NEW MEMBERS OF FIFTY YEAR CLUB

Representing 300 years of service to the medical profession, six members of the MSMS "Fifty Year Club" line up for their photograph before receiving the "Fifty Year Club" pins at Officers' Night ceremonies of the 1952 Annual Session. *(Left to right)* M. E. Danforth, of Detroit; W. J. Jend, M.D., of Detroit; J. E. Cooper, M.D., of Battle Creek; A. L. Robinson, M.D., of Burr Oak; M. J. Uloth, M.D., Ortonville; and H. A. Herzer, M.D., Albion. Other 1952 members of the "Fifty Year Club" not pictured are: W. A. Grant, M.D., Milford; G. P. Raynale, M.D., Birmingham; W. E. Keane, M.D., Detroit; Edgar T. Morris, M.D., Nashville, and B. L. Franklin, M.D., Remus.

tel on Wednesday evening, September 24, was the address of Louis H. Bauer, M.D., of Hempstead, L. I., President of the AMA and Secretary of World Medical Association. Dr. Bauer decried the published reports that the AMA was finished with its fight against socialism. He stated defi-



PRESS CONFERENCE AND COFFEE

Detroit science writers interviewing guest essayists in the busy Press Room at 1952 MSMS Annual Session.



MRS. MACKERSIE ACCEPTS WOMAN'S AUXILIARY GAVEL

Mrs. Robert S. Breakey, Lansing, retiring President of the Woman's Auxiliary to MSMS, presents the symbol of office to incoming President, Mrs. William G. Mackersie, Detroit. The Auxiliary held its 26th Annual Convention concurrently with the 1952 Annual Session in Detroit. *(Left to right)* Mrs. Russell T. Costello, Detroit, President, Wayne County Woman's Auxiliary; President Mackersie; Mrs. Harold H. Gay, Midland, Financial Secretary, MSMS Woman's Auxiliary; Mrs. Breakey; Mrs. A. F. Milford, Ypsilanti *(in background,)* First Vice President; Mrs. Walter S. Stinson, Bay City, President-Elect.

nitely and vigorously that the AMA never would let down in its battle against the forces of bureaucracy. Dr. Bauer's powerful address will be published in a later issue of JMSMS.

The Biddle Lecture of Paul de Kruif was a masterly delineation by a powerful moulder of



THE TECHNICAL EXHIBIT

A corner of the ever-busy Technical Exhibit during the 1952 MSMS Annual Session.

SCHEDULE OF TALKS DURING ANNUAL SESSION

Telecasts

L. Fernald Foster, M.D., Bay City Arch Walls, M.D., Detroit	WJBK-TV	Sept. 14
W. S. Jones, M.D., Menominee G. W. Slagle, M.D., Battle Creek R. W. Shook, M.D., Kalamazoo	WJBK-TV	Sept. 21
House of Delegates Newscast	WJBK-TV	Sept. 22
John R. Rodger, M.D., Bellaire	WXYZ-TV	Sept. 22
R. J. Hubbell, M.D., Kalamazoo S. L. Loupee, M.D., Dowagiac	WJBK-TV	Sept. 23
S. L. Loupee, M.D., Dowagiac	WWJ-TV	Sept. 23
L. Fernald Foster, M.D., Bay City R. A. Johnson, M.D., Detroit R. H. Baker, M.D., Pontiac	WJBK-TV	Sept. 24
E. F. Sladek, M.D., Traverse City S. L. Loupee, M.D., Dowagiac	WXYZ-TV	Sept. 24
Mrs. Wm. Mackersie, Detroit Mrs. A. F. Milford, Ypsilanti	WJBK-TV	Sept. 28

Radio Broadcasts

William Bromme, M.D., Detroit	WJBK	Sept. 22
R. J. Hubbell, M.D., Kalamazoo	WJR	Sept. 23
R. J. Hubbell, M.D., Kalamazoo	WKZO	Sept. 23
Stuart V. Smith, Wyeth, Inc., Phila. Harvey Merker, Parke Davis & Co., Detroit Mrs. George L. Stokes, Flint	WWJ	Sept. 23
R. J. Hubbell, M.D., Kalamazoo L. W. Hull, M.D., Detroit R. L. Novy, M.D., Detroit	WWJ	Sept. 24
J. E. Livesay, M.D., Flint	CKLW	Sept. 24
Otto O. Beck, M.D., Birmingham	WWJ	Sept. 25

Service Club Talks

H. B. Zemmer, M.D., Lapeer	Central Kiwanis	Sept. 22
Hugh W. Brenneman, Lansing	Kiwanis	Sept. 23
Otto O. Beck, M.D., Birmingham	Lions	Sept. 30

public opinion. Dr. de Kruif, roving Editor for *Reader's Digest,* cleverly covered in thirty minutes a wide area of both scientific medicine and its social and economic problems. Dr. de Kruif's masterpiece appeared in the October number.

THE BIG EXHIBIT WAS LIKED

The ninety-nine exhibits were terrific and each seemed to provide inspiration and impact. In some respects, this year's exhibits were as interesting and desirable to doctors of medicine as the papers presented in the meeting room; the exhibit section brought tangible values to the many hundreds who inspected it. Michigan M.D.'s found there's always something *new* in the MSMS exhibit.

Ubiquitous Hosts did a masterful job of making the guest speakers feel "at home" in Michigan. The following doctors of medicine placed themselves at the disposal of the visiting guest essayists who were on the program of the Annual Session—they demonstrated the meaning of Michigan hospitality to the eminent speakers from other parts of the United States: Otto O. Beck, M.D., Birmingham; G. B. Saltonstall, M.D., Charlevoix; W. W. Babcock, M.D., A. E. Catherwood, M.D., W. C. C. Cole, M.D., Edward Conner, M.D., P. J. Connolly, M.D., W. B. Cooksey, M.D., J. D. Fryfogle, M.D., E. S. Gurdjian, M.D., G. E. Hause, M.D., Benjamin Jeffries, M.D., S. J. Joyce, M.D., C. R. Lam, M.D., J. E. Lofstrom, M.D., G. T. McKean, M.D., R. M. McKean, M.D., W. G. Mackersie, M.D., J. G. Molner, M.D., H. V. Morley, M.D., R. L. Novy, M.D., E. A. Osius, M.D., J. P. Ottaway, M.D., P. S. Peven, M.D., R. P. Reynolds, M.D., F. S. Ryerson, M.D., A. E. Schiller, M.D., E. J. Shumaker, M.D., E. D. Spalding, M.D., C. N. Swanson, M.D., C. E. Umphrey, M.D., Wadsworth Warren, M.D., J. E. Webster, M.D., all of Detroit; and J. D. Miller, Grand Rapids.

THE COUNCIL MEETS THREE TIMES DURING ANNUAL SESSION

The twenty-five members of The Council held three meetings during the days of the MSMS Annual Session in Detroit. Elsewhere in this issue is a summary of the actions taken by The Council at the September Session. The Council placed upon its minutes a sincere vote of hearty thanks to all who helped in any way to make successful the record-breaking Annual Session of the Michigan State Medical Society in Detroit, September, 1952.

Report of Special Committee

The Joint Committee of Michigan State Medical Society and Michigan Hospital Association to Survey Medical and Hospital Facilities at the State Prison of Southern Michigan has submitted the following report to the Michigan Correction Commission.

Because of the excellent improvement made in the health program at Jackson Prison in the past five years, it is with considerable pleasure that the present report is submitted. It is of note that three of the four members of this Committee were members of the same committee which inspected the prison hospital facilities in 1947. A very detailed report was submitted at that time and many criticisms and recommendations were made. The present report omits many of the details describing the physical setup contained in that report and is more in the nature of a follow-up, plus a general inspection. The inspection was made May 7, 1952.

I. Population—May, 1952

The hospital serves an inmate population of approximately 6,500—an increase of 700 inmates over the 1947 population of 5,800. This is in excess by almost 1,000 inmates of the number for whom the prison was originally built. This overcrowding shows itself in every facet of prison life and is especially noticeable in the hospital facilities in that such facilities which might reasonably be used for the segregation of sex perverts, psychiatric inmates and tuberculosis patients are utilized for general prisoner care to the detriment of any definite and objective care and rehabilitation of the above-mentioned groups.

II. Inspection of Prison Hospital Physical Plant

A detailed description of the hospital is contained in the previous report and is omitted here. A comparison of 1947 and 1952 is astounding and a very great improvement is noted:

(1) it is now clean and sanitary; (2) records are well kept, accurate and complete; (3) patients' diets are posted on each cell door—special diets for diabetics and other inmates needing dietary are obtainable; (4) x-ray and laboratory facilities are excellent; (5) dental setup and program is clean and adequate; (6) eye clinic well run and adequate; (7) Pharmacy—well kept and clean—records good, excellent control of narcotics, barbiturates, and other special drugs.

It is almost impossible to believe so much progress has been accomplished.

Especially worthy of mention are the blood donations of 3,375 pints of blood to the Armed Forces and 1,753 pints to ill prison hospital patients.

III. Personnel and Service

There are now four full time physicians employed at the prison. Only Dr. R. L. Finch, head prison physician, was interviewed although the qualifications of the others were reviewed. All seemed adequate and a marked improvement in organizational work and defined allocations of duty were noticed.

Some 10,000 formal consultations were noted in the different medical specialties and of worthy mention is the fact that in spite of a marked population increase, the number of hospital deaths has not changed. Particular praise should be given to the University of Michigan Hospital which regularly sends physician teams or individuals to perform surgery of all kinds and consult in all of the medical specialties including allergy, dermatology, et cetera.

There is no question but what the acute hospital care of prison inmates is greatly improved over that of 1947. This good work is sincerely applauded by the Committee and it is their earnest hope that it will be continued. There is, however, still much room for improvement in several important areas and a special section is devoted to a discussion of them with criticism and recommendations. The six are as follows:

1. *Overcrowding.*—This is basic and is a matter of record of every lay and medical investigating committee of the last five years. Its influence on the whole penal system cannot be overstressed and it has stifled reform and progress of any sort. Segregation of psychiatrical patients, sexual perverts and tuberculosis patients is fundamental to good prison care and discipline let alone good hospital care which is impossible under present conditions.

2. *Psychiatric facilities and personnel.*—Undoubtedly the psychiatric set-up is the weakest and poorest of the entire prison medical make-up. It should be remembered that every prisoner is a potential psychiatrical problem. He would not have committed crime if he had been mentally adjusted. Prisoners should be screened on admittance to see if they are psychiatric cases. If so, they should be segregated and psychiatric rehabilitation started immediately. Instead there is no psychiatrist, no examination, no segregation and no attempt at psychiatric rehabilitation. The situation is pitiful. Prison officials acknowledge the presence of 1,500 sex perverts, over 100 bad psychotics and another 100 mild or chronic psychotics. They also state freely if there had been proper segregation there probably would have been no riot. The remedies are obvious—

(1) Immediate hiring of at least one and preferably two psychiatrists. To attract a psychiatrist he must be paid at least what psychiatrists are paid at state mental institutions and veterans facilities. (The present scale is below these levels.)

(2) Segregation of psychiatric patients.

(3) Screening program for entering inmates and rehabilitation program for those needing same.

(4) Addition of psychiatric therapy facilities.

The prison has three psychologists, and their work was only superficially scanned. No attempt was made to

evaluate their work or function. It is a fact known to all however that they are not physicians and in a situation such as exists in a prison facility they should be members of a psychiatric team under the specific direction and guidance of a psychiatrist instead of working alone.

Our state has a hospital for the Criminally Insane at Ionia. Yet only thirteen patients were transferred from Jackson to Ionia in 1951, and in turn Jackson received thirteen milder mental patients from Ionia. Ionia is itself badly overcrowded. However it is overcrowded because persons are admitted from state civilian institutions such as Kalamazoo, Pontiac and Traverse City. If Ionia is properly going to perform its function as an institution for the criminally insane, the state institutions should not be allowed to slough off their undesirable patients. This condition should be studied and made a matter of concern and definite policy by the proper governmental authorities.

3. *Tuberculosis.*—The prison hospital on inspection had sixty-nine patients with active tuberculosis on the second and first floors. There is a great need for additional space for the care and segregation of such tuberculosis patients as a means of keeping the active and convalescent cases away from other inmates and patients. Isolation for an inmate with tuberculosis at the present time amounts to practically solitary confinement and is a great hardship in maintaining his morale.

To properly care for the inmates who are infected with tuberculosis a separate building must be constructed. The State Tuberculosis Commission should seriously consider providing such a building out of the funds of five million dollars voted by the people of Michigan. Inmates having tuberculosis are not released from prison when their disease is arrested, but rather when their term expires or they are paroled. The release of an inmate with active tuberculosis is as great a hazard to the people of this state as the repetition of a crime. Every effort should be made to bring their disease under control.

4. *Nursing Care.*—Nursing care of prison hospital patients is solely in the hands of prison inmates. They are paid twelve and seven-tenths cents per day. This is below the scale paid in the prison industries and factories. It is felt their work is as important and that they should be paid a wage comparable to other prisoners.

Knowledge of proper nursing care is a hand-me-down from prison hospital attendant-inmates to their successors over the years. Bad and improper care as well as good is therefore passed on year after year. It is suggested that in the hospital budget, allocations be placed for the possible hiring of several civilian male nurses. The function of these male nurses to be that of instructing and teaching prison hospital attendants proper care of sick people.

This likewise performs the very worthwhile function of teaching inmates a profession and rehabilitating them for a job once they can be released.

5. *Geriatric Problem.*—An increase is noted in the number of inmates who are purely a geriatric (old age) custodial problem. Their numbers include those with plain old age senilities, those partially paralyzed from cerebral accidents (stroke), patients with old prostate and urological disorders, amputees and those with blood vascular changes. Legally they are as much a prisoner as anyone else because of their crime, but it is felt study should be given to this problem and some disposition made of them other than frank hospitalization.

6. *For the future planning* of new prison facilities in Michigan, the Committee is of the opinion that serious thought should be given to the classification of inmates as to moral character. Many prisoners are determined to return to society after their term expires and live useful lives. Being forced to live with the very dregs of society and be subjected to the most humiliating and degrading demands by some of their fellow inmates is unjust and unfair. We understand that our judges have the power to classify, but that they are helpless to do so because of the overcrowded prison population. We feel that this can only be accomplished with more and smaller prisons. To live with less fear and dread of fellow inmates would promote better mental and physical health.

The committee again wishes to commend Doctor Finch and his associates for the improvements that have been made and we sincerely hope that our further recommendations can be consummated.

Respectfully submitted,

For Michigan State Medical Society
Philip Riley, M.D.
Otto O. Beck, M.D.

For Michigan Hospital Association
Glen Fausey
Kenneth B. Babcock, M.D.

THE USE OF ORAL AND TOPICAL CALCIUM PREPARATIONS IN PRURITUS

(Continued from Page 1446)

appearance of lesions during period of time covered in this report.

3. Total of twenty-six patients were treated with the ointment and ointment base, and no instances of local sensitivity were observed.

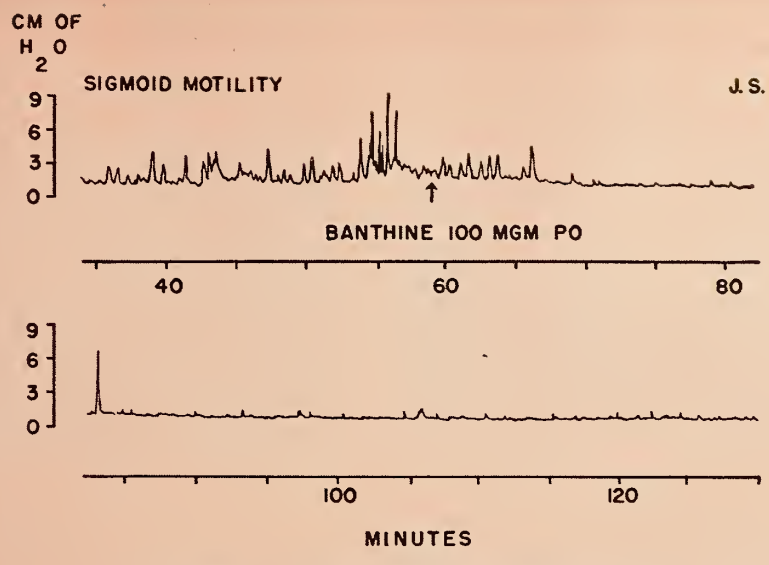
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3. Schoch Letter: Current News in Dermatology and Syphilology, (Nov.) 1950.

4. Tobias, N.: J. Invest. Dermat., 10:229 (Apr.) 1948.



The effect of 100 mg. of Banthine on sigmoid motility. The contractions did not return during the experimental period.[1]

In Intestinal Hypermotility—Banthine®

"...has a prolonged inhibitory effect on human gastrointestinal motility....
The duration of its action is striking,...."[1]

It has also been observed that definite retardation in gastrointestinal transit time in individuals with hypermotility was attributable to the therapeutic effect of Banthine.[2]

BANTHINE® Bromide (brand of methantheline bromide)—a true anticholinergic—is available for oral and parenteral use.

1. Kern, F., Jr.; Almy, T. P., and Stolk, N. J.: Effects of Certain Antispasmodic Drugs on the Intact Human Colon, with Special Reference to Banthine (β-Diethylaminoethyl Xanthene-9-Carboxylate Methobromide), Am. J. Med. *11*:67 (July) 1951.

2. Lepore, M. J.; Golden, R., and Flood, C. A.: Oral Banthine, an Effective Depressor of Gastrointestinal Motility, Gastroenterology *17*:551 (April) 1951.

ACCEPTED COUNCIL ON PHARMACY AND CHEMISTRY AMERICAN MEDICAL ASSOCIATION

RESEARCH IN THE SERVICE OF MEDICINE **SEARLE**

Say you saw it in the Journal of the Michigan State Medical Society

Michigan's Department of Health

Albert E. Heustis, M.D., Commissioner

POLIO PEAK LATE AND DECREASE GRADUAL

The third week of September appears to have been the peak week in reported polio cases for the United States in 1952. Only four times during the past twenty-five years has the peak occurred this late, or later.

Michigan's peak week was apparently the third week of August. The decrease in reported cases following the peak was much more gradual than in previous years.

FIFTEEN PUBLIC HEALTH WORKERS ON FELLOWSHIPS

As a part of the intensive statewide plan of recruiting and training workers for the public health field, fifteen engineers, public health nurses and laboratory workers from Michigan's state and local health departments began advanced study in September on fellowships granted by the Department from federal funds allocated for that purpose.

Five engineers are attending the School of Public Health of the University of Michigan. Five public health nurses are enrolled at Wayne University and three at the University of Michigan. Two members of the staff of the laboratories of the Department are doing graduate work, one at Iowa State College and the other at Kansas University.

BIRTHS STEADILY INCREASING

Provisional statistical reports for the second quarter of 1952 show a steady increase in live births in Michigan. During the first quarter of 1952, a total of 39,530 babies arrived, 2,728 more than during the same period in 1951. For the first six months of 1952, the total was 82,287, a gain of 1,524 over the same interval in 1951.

NEW HDA SIGNS BEING POSTED

The new HDA signs marking health department approved resorts were distributed to departments in the western part of the state in time for the autumn color tours. The green and gold signs with HDA in the center oval, carrying both state and local health department approval, are replacing the black and white "Sanitation Approved" signs that have designated safe resorts for many years.

HEARING CONSERVATION PROGRAM BEGINS TENTH YEAR

With the opening of schools this fall, the department began its tenth consecutive year of co-operating with local health departments, medical societies, schools and community agencies in planning and carrying on programs to detect and facilitate correction of hearing losses in school children. So far this year, programs have been organized in twenty-five counties.

In the past nine years, over a million school children have been screened in Michigan's hearing conservation program. Thousands of them now have improved or even have normal hearing as a result of corrective measures undertaken upon discovery of hearing losses. Over 70 per cent of the children found to have hearing loss who had medical attention had their hearing improved—half of them had normal hearing restored.

Out of every hundred children tested, it has been found that three require medical attention, two need classroom adjustments to compensate for hearing loss and one needs special instruction in lip reading or to be assigned to a room for the hard-of-hearing or to go to a special school for children handicapped in hearing.

The Department now has five consultants assisting communities in conducting hearing conservation programs. Equipment is provided, in addition to consultant service.

DIRECTOR OF ENGINEERING DIVISION LEAVES STATE SERVICE

John Hepler, for twelve years Director of the Division of Engineering of the Department and for nearly thirty-four years a member of the staff of the Division, resigned on November 1, to accept assignment as Chief Sanitary Engineer at Santiago, Chile, with the Institute of Inter-American Affairs. Willard F. Shephard, Chief of the Division's Section of Sewage and Sewage Treatment, was appointed to succeed Mr. Hepler as Director of the Division. Mr. Shephard has been with the Department for thirty years.

EDWARD DUNBAR RICH SERVICE AWARDS

Awards honoring twenty-five years of service in the water works field were given to eighty-three persons at the meeting of the Michigan Section of the American Water Works Association. This brings to 800 the number of awards presented to Michigan men and women since the plan was established in 1946, commemorating the long service to the state of the late Colonel E. D. Rich.

HEALTH OFFICER CHANGES

Douglas H. Fryer, M.D., became director of the Lansing-Ingham County Health Department on October 13 Dr. Fryer was with the Bureau of Local Health Service of the Michigan Department of Health in 1944-45.

F. I. Van Waougnen, M.D., was appointed acting director of the Jackson City Health Department to serve until a full-time director is appointed.

Orlen J. Johnson, M.D., has been appointed acting director of the Bay City and Bay County Health Departments to serve until a full-time director is appointed

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Correspondence

Wilfrid Haughey, M.D., Editor
Battle Creek, Michigan

Dear Dr. Haughey:

I have been keenly interested in Blood Banks, as are all medical men, and especially those who are veterans of World War I and II. Sad to relate, the veterans themselves donate more blood than do the civilians, who seem only to pursue the almighty dollar. At least such is my experience.

Men are drafted for the army and navy. If that can be done, why not set up another corps, and draft those who are exempt from actual military service, the four Fs, et cetera, for the blood bank service, to be called when there is need. The giving of a pint of blood would be no hardship, and in no sense equal the sacrifice of being drafted.

ARCHE E. HALL, M.D., F.A.C.S.
Am.M.S., U.S.A.

To the Editor:

The American Diabetes Association offers a $250.00 prize to *medical students* and *interns* for a paper on any subject relating to diabetes. The paper can be a report of original studies, a biographical or historical note, a case report with suitable comment, or a review of the literature.

This incentive is particularly apropos in the field of diabetes, since Dr. Paul Langerhans made his studies of the pancreas, describing the islets that bear his name, while he was an undergraduate student in Berlin in 1869; and Dr. Charles H. Best, while a graduate student, was co-discoverer of insulin in 1922.

Manuscripts must be submitted on or before April 1, 1953, to the Editorial Offices of *Diabetes:* The Journal of the American Diabetes Association, 11 West 42nd Street, New York 36, New York. The papers will be reviewed by the Editorial Board, which will take into consideration the value of the material and method of presentation in selecting the best paper.

The award of $250.00 has been made possible through the generosity of the St. Louis Diabetes Association, an Affiliate of the American Diabetes Association.

Sept. 30, 1952 AMERICAN DIABETES ASSOCIATION

THE TATTERED DOLLAR

The old dollar bill, she ain't what she used to be. Showing how the dollar has declined in purchasing power, the *New York Journal of Commerce* points out that it buys only 44 cents of the 1939 value in food, 49 cents in clothing and 74 cents in rent. The manufacturer's dollar has only 40 cents of its 1939 purchasing power in labor, 43 cents in construction, and 30 cents in raw materials.

Say you saw it in the Journal of the Michigan State Medical Society



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. NEWS MEDICAL

MICHIGAN AUTHORS

Arnold Wollum, M.D., and **H. Marvin Pollard, M.D.**, of Ann Arbor, are the authors of an article, "Medical Management of Chronic Ulcerative Colitis" published in the *American Practitioner Digest of Treatment,* September, 1952.

Ernest H. Watson, M.D., of Ann Arbor, is the author of an article, "Immunization of Children," which was condensed from the *Journal of the Arkansas Medical Society,* March, 1952, published in the *American Practitioner Digest of Treatment,* September, 1952.

F. Bruce Fralick, M.D., Ann Arbor, is the author of an article, "The Orbit-Annual Reviews," published in the *Archives of Ophthalmology,* September, 1952.

Laurence S. Fallis, M.D., and **James Barron, M.D.**, of Detroit, Michigan, are the authors of an article, "The Billroth I Gastrectomy," published in *The Journal of the Oklahoma State Medical Association,* September, 1952.

Laurence S. Fallis, M.D., and **James Barron, M.D.**, of Detroit are the authors of an article, "Gastric and Jejunal Alimentation With Fine Polyethylene Tubes," published in the *Archives of Surgery,* September, 1952.

J. H. Hertzler, M.D., and **William M. Tuttle, M.D.**, of Detroit are the authors of an article, "Experimental Method for an Everting End-to-End Anastomosis in the Gastrointestinal Tract," published in the *Archives of Surgery,* September, 1952.

Robert H. Clifford, M.D., of Detroit is the author of an article, "Evaluation of Three Methods for Finger Tip Injuries," published in the *Archives of Surgery,* September, 1952.

James E. Cousar III, M.D., and **Conrad R. Lam, M.D.**, of Detroit are the authors of an article, "Rectus Sheath Grafts in Vascular Repair," published in the *Archives of Surgery,* September, 1952.

J. L. Wilson, M.D., of Ann Arbor, Michigan, is the author of an article, "Relationship of Tonsillectomy to Incidence of Poliomyelitis," published in *The Journal of the American Medical Association,* October 11, 1952.

F. H. Top, M.D., of Minneapolis, Minnesota, formerly of Detroit, Michigan, is the author of an article, "Occurrence of Poliomyelitis in Relation to Tonsillectomies at Various Intervals," published in *The Journal of the American Medical Association,* October 11, 1952.

* * *

The Interstate Postgraduate Medical Association of North America met in Cleveland, Ohio, November 10, 11, 12, 13, 1952.

Cyrus C. Sturgis of Ann Arbor, President, gave an address at the Assembly dinner on "The Changing Medical Scene."

Other Michigan essayists were:

Dr. H. Marvin Pollard, Professor of Internal Medicine, University of Michigan Medical School, Ann Arbor, Michigan, "Evaluation of Present-Day Treatment of Peptic Ulcer."

Dr. Fred J. Hodges, Professor of Roentgenology and Chairman of the Department of Roentgenology, University of Michigan Medical School, Ann Arbor, Michigan; Address: "Common Errors in X-ray Diagnosis."

Drs. Claire L. Straith and Richard E. Straith, Straith Clinic-Plastic Surgery, Detroit, Michigan; Address: "The Treatment of Facial Injuries and Deformities."

Dr. Cyrus C. Sturgis, Professor of Internal Medicine, Director of Simpson Memorial Institute and Chairman of the Department of Internal Medicine, University of Michigan Medical School, Ann Arbor, Michigan; President, Interstate Postgraduate Medical Association of North America; Clinic: "Evaluation of Some Recently Introduced Therapeutic Agents in Hematology."

Dr. Winthrop N. Davey, Assistant Professor of Internal Medicine, University of Michigan Medical School, Ann Arbor, Michigan; Clinic: "Treatment of Pulmonary Tuberculosis."

Dr. John M. Sheldon, Professor of Internal Medicine, University of Michigan Medical School, Ann Arbor, Michigan; Clinic: "Place of Antihistaminics in the Treatment of Allergic Disorders."

Dr. William D. Robinson, Associate Professor of Medicine, University of Michigan Medical School, Ann Arbor, Michigan; Clinic: "Present-Day Treatment of Arthritis."

* * *

The AMA Committee on Pesticides is undertaking a toxicological study of cases of poisoning resulting from the use of insecticides, rodenticides, fungicides, weed killers, fumigants, repellents, and related types of chemicals used in agriculture and in the home. The committee is enlisting the aid of physicians in submitting records on fatal cases and nonfatal poisonings from pesticides. This information will be used to expand its permanent file of such cases for use by physicians and allied medical personnel. Summary data on the pertinent facts of the poisonings and the circumstances of their occurrence will be sufficient for the committee's use.

* * *

The United States Civil Service Commission has announced a Medical Officer examination for filling the positions of Rotating Intern, Psychiatric Resident, and General Practice Resident in St. Elizabeth's Hospital in Washington, D. C.

The Rotating Intern positions pay $2,800 a year,

Psychiatric Resident, $3,400 to $4,200, and General Practice Resident, $3,400 to $3,800 a year. Education and training is required. No written test will be given. The maximum age limit is thirty-five years (waived for veterans).

Full information and application forms are available at most first and second-class post offices, and at the U. S. Civil Service Commission, Washington 25, D. C. Applications will be accepted until further notice by the Executive Secretary, Board of U. S. Civil Service Examiners, St. Elizabeth's Hospital, Washington 25, D. C.

* * *

Ten Detroit Doctors have been named to a Medical Advisory Board for the new Sinai Hospital.

The Board of Trustees also announced the selection of department heads for the hospital, which is under construction on Outer Drive between Whitcomb and Lauder.

Board members are Dr. Harry Saltzstein, chief of staff; Dr. Sol. G. Meyers, vice chief of staff; Dr. I. Jerome Hauser, secretary, and Drs. Harry August, Bernard Bernbaum, Samuel Bernstein, Herbert Bloom, Saul Rosenzweig, Peter Shifrin and David J. Sandweiss.

The department heads are Dr. Saltzstein, surgery; Dr. August, psychiatry; Dr. Bernstein, pediatrics; Dr. Bernbaum, pediatrics consultant; Dr. Bloom, oral surgery; Dr. Hauser, eye, ear, nose and throat; Dr. Sidney Kobernick, director of laboratories, and Mrs. Ruth B. Edelson, director of nursing.

Dr. Julien Priver is director of Sinai Hospital, first hospital in Detroit under Jewish auspices. It is expected that the first patient will be admitted early in 1953. —*Detroit Free Press,* Oct. 2, 1952.

* * *

A. C. Furstenberg, M.D., of Ann Arbor, will be one of the lecturers of the seventh Annual University of Florida Midwinter Seminar in Ophthalmology and Otolaryngology at Miami Beach, January 12 to 17, 1953.

* * *

At the meeting of the Michigan Rehabilitation Conference, at Lansing, Michigan, Michigan State College, the following participated: A panel on Rehabilitation is Everybody's Business was moderated by Dr. Max Karl Newman, Detroit. The participants were James Rae, Jr., M.D., Francis Sweeney, M.D., Frederick House, M.D., and Nila Covalt, M.D. The importance of the physician, auxiliary help, vocational rehabilitation and the voluntary agencies was discussed. The date of the meeting was September 30, 1952.

* * *

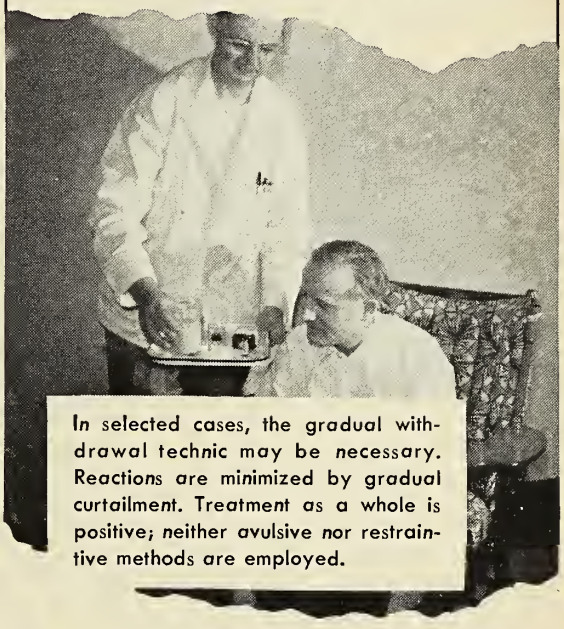
Max Karl Newman, M.D., spoke at the Sixth Annual National Employ the Physically Handicapped banquet, Ypsilanti, Michigan, October 6, 1952. The topic of discussion was "The Defense Mobilization Need and the Handicapped Person."

* * *

Postgraduate Study.—The following members of the Michigan State Medical Society are now attending postgraduate courses at the Cook County Graduate School of Medicine: Milton W. White, M.D., Detroit; William L. Bird, M.D., Greenville; Arthur L. Benedict,

Doctor..

You Have Patients with ALCOHOLISM



In selected cases, the gradual withdrawal technic may be necessary. Reactions are minimized by gradual curtailment. Treatment as a whole is positive; neither avulsive nor restraintive methods are employed.

We can help you in caring for this type of patient—often described as the "Problem Drinker."

At The Keeley Institute we have the facilities and the specialized experience for outlining and carrying through a comprehensive, coordinated plan of therapy.

From the initial physical and laboratory investigations until the final evaluation prior to discharge, every step in the management of the patient is under the supervised control of full-time physicians.

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Migraine In Children

"Migraine may appear during the first years of life. The presence of subjective signs, such as headache and flimmer scotoma, is often difficult to determine in young children. The true nature of the symptoms frequently remains obscure for years."

Vahlquist, B. and Hackzell, G.: Acta Paediatrica *38*: 622 (1949).

NO. OF CASES	SEX	AGE AT ONSET	CYCLIC VOMITING	DURATION OF ATTACK	INTENSITY
31	8 ♀ 23 ♂	3 yrs. (mean)	3 out of 31	2½ hrs.	severe in all cases

TABLE CONT'D

NO. OF CASES	UNILATERAL HEADACHE	NAUSEA	FLIMMER SCOTOMA	VERTIGO	HEREDITY
31	18 out of 31	31 out of 31	12 out of 31	6 out of 31	20 out of 31

(reference given above)

In a study of 400 adult migraine patients, it was revealed that 34% had suffered attacks before the age of 15.* These investigators concluded that childhood migraine was a much greater clinical problem than was previously believed and that psychodynamic mechanisms played an important part in the disease.

These criteria are useful in diagnosis:

Headache attacks with symptom-free intervals plus (at least two of the following) nausea, scintillating scotoma, hemicrania, and hereditary predisposition.

For symptomatic relief in these cases, Cafergot®, N.N.R. (ergotamine with caffeine) may be administered orally. For best results, give adequate dosage promptly.

For children within the age range 7 to 12 years—Cafergot® is administered, one tablet when the attack appears imminent followed by one additional tablet within 30 minutes. Not more than two Cafergot tablets should be administered to children within this age range.

In the adolescent age group, 12 to 18 years of age, the dosage may gradually be increased as necessary up to the usual adult dose, i.e., two tablets when the attack appears imminent followed by one tablet doses at half hour intervals until the attack is aborted. *(Total maximum dose for adults: six tablets for each attack.)*

* Katz, J., Friedman, A.P., and Gisolfi, A.: New York State J. Med. *50*: 2269 (Oct.) 1950.

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M.D., Muskegon; James W. Nunn, M.D., Highland Park; Lee E. Kelsey, M.D., Lakeview, and Harvey I. Kelsall, M.D., St. Joseph.

* * *

Harry F. Becker, M.D., of Battle Creek, is the new field secretary of the Michigan State Medical Society Medical Advisory Committee to the Michigan Hospital Service. W. S. Reveno, M.D., is chairman. Dr. Becker served for three years on the Board of Trustees of Michigan Hospital Service, resigning to go into military service where, as a Colonel in the Medical Corps, he commanded a casualty hospital in Southern England during the invasion.

* * *

Paul de Kruif, Ph.D., Holland, Michigan (Biddle Lecturer at the 1952 MSMS Annual Session) forwarded a $100 check to MSMS President Otto O. Beck, M.D., of Birmingham for the Beaumont Memorial fund.

Dr. de Kruif is tremendously interested in the project of Michigan's doctors of medicine to build on Mackinac Island a shrine to Dr. Beaumont, one of Dr. de Kruif's "heroes."

Dr. de Kruif also forwarded a check for $100 to Earl I. Carr, M.D., President of the Michigan Foundation for Medical and Health Education, as his contribution to this fund which is aiding senior medical students, interns and residents with scholarships, to attract them to practice in rural areas of Michigan.

* * *

The American Academy of Obstetrics and Gynecology will hold its first annual clinical session at the Palmer House, Chicago, December 15-17, 1952. For program, write Ralph A. Reis, M.D., 116 S. Michigan Avenue, Chicago 3, Illinois.

* * *

The Board of Trustees of the Baraga County Memorial Hospital at L'Anse, Michigan, dedicated the new hospital at 770 North Main Street on October 12.

Congratulations and best wishes to the trustees and staff of the Baraga County Memorial Hospital!

* * *

The Board of Trustees and the Woman's Auxiliary of the United Memorial Hospital, at Greenville, dedicated their new hospital at 615 South Bauer Street on September 24.

Congratulations to the trustees, staff and Woman's Auxiliary of Greenville's new and beautiful United Memorial Hospital!

* * *

William Henry Gordon, M.D., Detroit, has been appointed a member of the Committee of the Regional Health Services Advisory Committee, Federal Civil Defense Administration. Dr. Gordon is Chairman of the MSMS Committee on Emergency Medical Service.

Congratulations, Dr. Gordon!

* * *

"SRO" was the sign that the Kellogg Center of East Lansing hung out on November 17-18! Standing room only was the experience of the late comers at the sixth annual autumn postgraduate clinic of the Wayne County and Michigan Academies of General Practice.

Reason: a wonderful and stimulating scientific pro-

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gram with speakers disseminating important medical information and advice.

The chronological list of speakers included:

Joseph Meites, Ph.D., of Michigan State College; George C. Thosteson, M.D., Detroit; Sidney Friedlaender, M.D., Detroit; Duncan A. Cameron, M.D., Detroit.

G. H. Stollerman, M.D., New York City; Russell T. Costello, M.D., Detroit; R. P. Reynolds, M.D., Detroit; Robert B. Greenblatt, M.D., Atlanta, Ga.; George S. Fisher, M.D., Detroit; Lester Bauer, M.D., Detroit; J. H. Curhan, M.D., Detroit.

E. S. Beneke, Ph.D., of Michigan State College; Dan W. Myers, M.D., Detroit; Arthur E. Schiller, M.D., Detroit; Kathryn McMorrow, M.D., Detroit; Gaylord S. Bates, M.D., Detroit.

Charles E. Dutchess, M.D., New York City; E. D. Spalding, M.D., Detroit; Samuel D. Jacobson, M.D., Detroit; George J. Moriarty, M.D., Detroit.

Daniel Shaw, Jr., M.D., Philadelphia; Sibley W. Hoobler, M.D., Ann Arbor; Paul S. Barker, M.D., Ann Arbor; Lloyd T. Iseri, M.D., Detroit; Carl F. List, M.D., Grand Rapids.

The banquet was under the chairmanship of F. P. Rhoades, M.D., Detroit, with J. S. DeTar, M.D., Milan, as toastmaster. The speaker was Russell Barnes of the *Detroit News.*

This very successful conference was under the direction of E. Clarkson Long, M.D., Detroit, President of the Michigan Academy of General Practice, and John H. Schlemer, M.D., Detroit, President of the Wayne County Academy of General Practice.

The Catholic Physicians Guild of Michigan announces its autumn and winter program as follows: *November 13, 1952*—Annual Fall Meeting, David Whitney House, Detroit, Michigan. Speaker on subject of Catholic Moral Ethics, followed by afterglow, courtesy of Drug Industries through Jim Bechtel.

December 12, 13, 14, 1952—Annual Retreat at Maneresa.

March 15, 1953—Annual Mass and Communion Breakfast followed by speaker at Sacred Heart Seminary.

All Catholic out-of-state doctors of medicine are cordially invited to attend all of the above indicated meetings. For further information, write Eugene H. Quigley, M.D., Secretary, 22340 Michigan Avenue, Dearborn, Michigan.

* * *

The AMA Council on Medical Service reported at a recent meeting at AMA headquarters that mediation committees have been set up in each of the forty-eight states, the District of Columbia, and Hawaii, marking a major milestone in the medical care program for the United States.

The council also heard that voluntary health coverage continues to gain both in quality and quantity. The Council predicts that 90 million persons will be covered by some form of protection against the costs of illness, accident, and hospitalization in 1953.

Also reported was that community health councils have increased from forty-eight local health councils in 1943 to 1190 in 1951.

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The new WELCH ALLYN instrument case that offers you far greater

- DURABILITY
- CLEANLINESS
- COMPACTNESS
- BEAUTY

The Sandura Case is molded in reinforced material to stand great shock or abrasion, with tarnish-proof soft rubber lining which protects instruments from shock. The entire case can be washed or sterilized with alcohol.

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OF DETROIT

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Approximately 600 emergency call programs are now in operation throughout the United States.

A report on physician placement services was presented to the Council by Ralph A. Johnson, M.D., Detroit, who stated that thirty-seven states have established such services.

* * *

RESOLUTION ON THE LATE A. S. BRUNK, M.D.

WHEREAS, The Conference of Presidents and other Officers of State Medical Associations suffered a great loss in the death of our friend and Executive Committee member, Andrew S. Brunk, M.D., Detroit, Michigan, and

WHEREAS, Dr. Brunk was one of the organizers and served as the first President of the Conference and was untiring in his efforts on behalf of the organization, and,

WHEREAS, Dr. Brunk was an inspiration to others and was ever willing to help in efforts to improve the science and art of medicine; therefore be it

RESOLVED, That the officers and members of the Conference of Presidents and other Officers of State Medical Associations at the annual meeting on June 8, 1952, have a deep sense of regret at this untimely loss, and be it further

RESOLVED, That a copy of this resolution be spread upon the records as a token of esteem to the memory of Andrew S. Brunk, M.D., and be it further

RESOLVED, That a copy of this resolution be transmitted to his family with the sincere sympathy of the Conference of Presidents and other Officers of State Medical Associations.

Adopted by the Conference of Presidents and Other Officers of State Medical Associations, June 8, 1952.

* * *

The AMA Board of Trustees has reiterated its previous stand that doctors everywhere should take a more active interest in the affairs of the American Legion. Physicians who are members of the Legion were urged specifically to attend meetings of their posts since the policies of the Legion, like those of the AMA, are decided at the grass roots level.

The Board's expression came after it had studied a report on health matters which were discussed at the Legion convention in New York a short time ago.

Legion delegates adopted a resolution opposing ILO procedures that would socialize medicine by international treaty, and they turned down another resolution which would have mandated the Legion to urge the Veterans Administration to give special recognition to chiropractors. This would have permitted veterans to choose chiropractic treatment at government expense. A similar resolution for optometry was also defeated. The chiropractor resolution, coming from eight state departments of the Legion, resulted in one of the bitterest battles on the floor of the convention. The fact that it was defeated was remarkable since such large delegations as Illinois, New York, Pennsylvania and Texas voted solidly for the chiropractor resolution.

Several Legion officers explained that such strength is generated at the local level. That is why more doctors should attend meetings of their local posts where health proposals originate.—ORLANDO F. HULL, M.D., Secretary's Letter, September 24, 1952.

* * *

Louis P. Groos, M.D., of Escanaba, is the new President of the Upper Peninsula Medical Society. The

Secretary is N. L. Lindquist, M.D., of Escanaba. Congratulations, Doctors Groos and Lindquist!

The 1953 U.P. meeting will be held next July in Escanaba.

* * *

The "ubiquitous hosts" at the State Society meeting were observed hurrying and scurrying hither and thither trying to catch up with the guest essayists. In case you don't know what an ubiquitous host is—it's a person designated by the State Society to meet all trains, planes, buses, streetcars and trailers—to look for an academic phantom orator and otherwise to apprehend a stranger in town who always carries a briefcase, wears glasses, baggy pants—and otherwise might be mistaken for a doctor—or as they are so whimsically referred to—as guest essayists.

This phantom figure, called a guest essayist, is usually brought under scrutiny by the ubiquitous host at an airport or railroad station where the essayist is observed walking in circles looking for the ubiquitous host, or the powder room, or the barber shop, or a place to mail postcards. The ubiquitous host has only the faintest idea what the man looks like but he has been told to get his man—and escort him to the hotel—and if necessary show the dazed, wandering essayist to his hotel room—in case he has one.

After the ubiquitous host has expressed his regrets to the ubiquitous guest for his tardiness at the station, he leaves the essayist to himself in solitary confinement in his hotel room—to freshen up a bit—and also to allow the essayist to spend some time in front of the mirror practicing the speech he is about to present to the academic assembly.

The guest essayist finally gives his speech, during a lull when one of the slides is inserted upside down and the lights are out, and the ubiquitous host puts on the disappearing act—because he also must freshen up a bit, you know. By the time the ubiquitous host returns to the ubiquitous hall the ubiquitous essayist has already finished his talk—and the entire assembly is out viewing the exhibits and filling their pockets with samples—so the ubiquitous host scampers into the noisy current of human traffic trying again to find his man—but he has already absconded.

To be a good efficient ubiquitous host you must be tolerant, kind, patient and courageous—and not umbrageous.—JJL, "Rant and Rave," *Detroit Medical News,* Oct. 6, 1952.

* * *

The International Academy of Proctology announces its award contest for 1952-53 for the best unpublished contribution on proctology or allied subjects. For information write the Academy at 43-55 Kissena Blvd., Flushing 55, N. Y.

* * *

Clarence Manion, LL.B., MSMS Biddle Lecturer of 1951, announces his association with the legal firm of Doran & Manion in South Bend, Indiana. Dr. Manion recently resigned as Dean of the College of Law of the University of Notre Dame.

* * *

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Laboratory Fees in Hospital	5.00	10.00	15.00	20.00
Operating Room in Hospital	10.00	20.00	30.00	40.00
Anesthetic in Hospital	10.00	20.00	30.00	40.00
X-Ray in Hospital	10.00	20.00	30.00	40.00
Medicines in Hospital	10.00	20.00	30.00	40.00
Ambulance to or from Hospital	10.00	20.00	30.00	40.00
COSTS (Quarterly)				
Adult	2.50	5.00	7.50	10.00
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venereal disease were recently announced by Theodore J. Bauer, M.D., Chief of the Public Health Services, Division of Venereal Disease, Washington, D. C. The courses, to be conducted at the Venereal Disease Research Laboratory in Chamblee, Georgia, begin in January, 1953, and are open to senior technicians and to laboratory directors throughout the United States. For further information on these courses that run from January 12 through December 18, contact Dr. Bauer, Box 185, Chamblee, Georgia.

* * *

The Michigan State Medical Assistants Society elected at its September, 1952, convention in Detroit the following officers: President, Cary Guthaus, Bay City; President-Elect, Elizabeth Peck, Detroit; Recording Secretary, Noreen Nuechterlein, Saginaw; Corresponding Secretary, Margaret Schultz, 1110 David Broderick Tower, Detroit 26; Treasurer, Marion Horning, Grand Rapids.

* * *

James L. Wilson, M.D., Ann Arbor, is the author of an original article "Relationship of Tonsillectomy to Incidence of Poliomyelitis" which appeared in JAMA of October 11, 1952.

* * *

The Michigan Supreme Court ruled on September 5, 1952, that the 1951 charter amendment permitting osteopaths and dentists to sit on the Bay City's Board of Health was null and void.

The Supreme Court's decision stemmed from the fact that the charter amendment was submitted at the February primary of 1951, contrary to State law requiring that such proposals submitted by initiatory petitions be voted upon only at regular municipal or state elections.

* * *

"An Assignment to India" was the subject of a talk by Abraham Stone, M.D., Vice President of Planned Parenthood Federation of America, Inc. at the 21st Annual Meeting of the Michigan League for Planned Parenthood, in Ann Arbor, on October 21.

Palmer E. Sutton, M.D., Royal Oak, is Chairman of the Medical Advisory Committee of the Michigan League.

* * *

Herman F. Albrecht, M.D., Detroit, recently announced that he has retired and closed his office at 2686 West Grand Blvd. in Detroit, as of October 15, 1952.

* * *

The Wayne County Medical Society Council, at its meeting of October 3 in Detroit, voted to establish a Telephone Message Exchange. This Exchange will be inaugurated with an initial roster of 300 members.

Congratulations, practitioners of Wayne County!

* * *

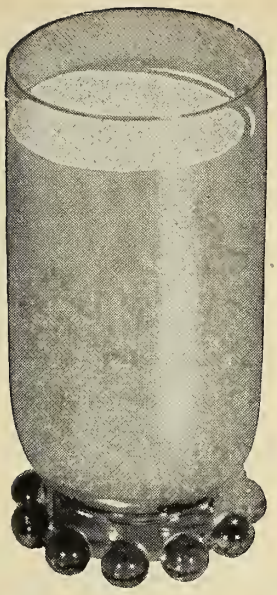
An interesting article, "Doctors are Generous Givers," appeared simultaneously in the June issue of *Modern Hospital* and the June issue of *Medical Economics*. The article, written by George Radcliffe, Senior Campaign Director, Ketchum Inc., Pittsburgh, indicates that contrary to the opinion of many, figures on more than 1,000

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hospital campaigns in 245 United States cities in the last thirty-three years reveal that the highest per capita contributions came from the doctors on their staffs. The recent survey of six major hospital campaigns shows that $928,661 was contributed by only 601 doctors. Analyzing these 6 appeals it was found that the doctors had contributed almost 8 per cent of the total. The average gift was $1,545.

* * *

The United Cerebral Palsy Association is widening the scope of research into more of the mysteries surrounding cerebral palsy through seven new research and training grants totalling $23,350. In addition, $66,922 have been allocated for renewal of previously authorized grants for research or the training of skilled personnel; two new grants for $19,423 for training of personnel also were approved, according to an announcement by Charles F. McKhann, M.D. of Philadelphia, National Medical Director for United Cerebral Palsy.

James L. Wilson, M.D., of Ann Arbor, is vice chairman of the UCP's Medical Executive Board.

One of the grants in the amount of $2,000 was given Richard J. Allen, M.D., of Ann Arbor, on the subject: "Basic neurology with view to a career in academic medicine with special interest to brain-damaged children."

* * *

The National Foundation for Infantile Paralysis announces the availability of a limited number of additional postdoctoral fellowships to candidates whose interests are research and teaching in medicine and the related biological and physical sciences. The fellowships cover a period of from one to five years and range from $3,600-$7,000 a year. For full information write: Division of Professional Education, N.F.I.P., 120 Broadway, New York 5, N. Y.

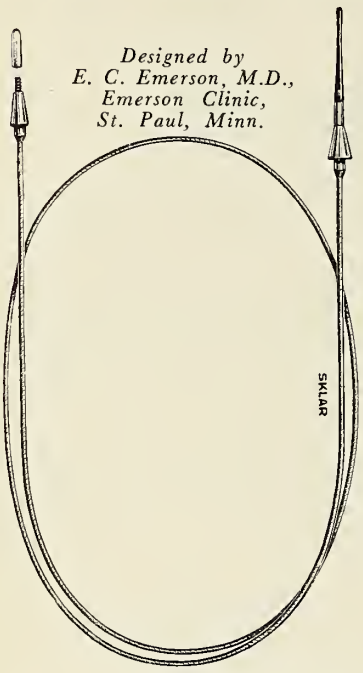
Tuberculosis morbidity is not declining as rapidly as tuberculosis mortality. This fact is pointed up in a study of five countries for which adequate records of reported cases and deaths are available—a study reported in an article entitled "Whither Tuberculosis?" by G. J. Drolet and A. M. Lowell and published in the May 1952 issue of *Diseases of the Chest.*

The same trend is seen in Michigan's record, which shows a tuberculosis death rate of 32.3 in 1946 reduced to 17.6 in 1951. However, the rate of new cases reported in Michigan was 97.2 in 1946 compared with 93.9 in 1951. This is a reduction in five years of 45.2 per cent in death rate and only 3.4 per cent in case rate.

MICHIGAN TUBERCULOSIS ASSOCIATION

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Following the Fourth Michigan Heart Day Program of the Michigan Clinical Institute on Friday, March 13, 1953, the annual meeting of members of the Michigan Heart Association will be held at 5:00 P.M. at the Sheraton-Cadillac Hotel. The Michigan Heart Association Board of Trustees meeting will follow.

* * *

This story was told by one of our nurses, who was privileged to witness it. It happened in a nearby city The surgeon was overworked, consequently irritable and often profane. An emergency had played havoc with the doctor's schedule. The atmosphere in the operating room reflected the doctor's tension and irritability. The anesthetist murmured assuringly to the dainty young woman on the operating table. "Breathe naturally and count slowly." She wondered if the lovely girl, so relaxed and smiling knew what a serious operation she was facing. "I would rather say the Twenty-Third Psalm, if you do not object." The doctor's face reflected surprise and sudden interest. "Yes, say it. I need to hear the Twenty-Third Psalm this morning, too." The quiet of the operating room was broken only by the confident voice of the girl. "The Lord is my Shepherd, I shall not want." Peace and serenity had suddenly filled the operating room. In that strange setting, nurses and the doctor listened to the simple beauty of that glorious old Psalm as if they had never heard it before. "Yea, tho I walk thru the Valley of The Shadow of Death, I will fear no evil, for thou art with me. Thy rod and Thy staff, they comfort me." Her voice was growing softer; she spoke more slowly. "Hold it," the doctor said to the anesthetist, "I want to hear all of it." "Surely, goodness and mercy shall follow me all the days—of—my — life." Her voice trailed off and then all was still. Misty eyed but apparently refreshed in spirit, the doctor nodded and the operating room sprung into action. The patients, who are admitted to the hospital, need not only skilled medical and surgical care but frequently psychiatric understanding. The doctor who allowed the little patient to repeat the Twenty-Third Psalm, instead of just counting, sent his patient into the etherized unknown, calm, serene and comforted.—*Michigan Hospital Association News,* October, 1952.

* * *

OLDSTERS TAKE NOTICE

Vanderbilt at eighty added more than a hundred million to his fortune. Wadsworth earned the Laureateship at seventy-three. Thiers at seventy-three established the French Republic and became the first president. Verdi wrote "Falstaff" at eighty. Gladstone became Premier of England for the fourth time at eighty-three. Stradivarius made his first violin after sixty. And Sir Walter Scott was $600,000 in debt at fifty-five, but through his own efforts paid this amount in full and built a lasting name for himself.—*Capital Cogs,* Albany.

In Memoriam

Charles R. Walsh, M.D., of Detroit, died September 8, 1952, at the age of sixty-five.

Dr. Walsh had practiced medicine in Detroit for forty years before giving up his practice four years ago because of failing health. He was graduated from the University of Louisville School of Medicine in 1908 and interned at Grace Hospital, Detroit, in 1910. He was on the staff of Grace Hospital for many years.

Dr. Walsh is survived by his wife, Florence; his father, Patrick J. Walsh, of Detroit; two sisters, Mrs. C. A. Ellington, of Lake Orion, and Mrs. W. J. Ferguson, of Miami, Florida.

THE USE OF AN ANTISEPTIC SYNTHETIC DETERGENT FOR LOCAL HYGIENE IN PRURITUS ANI

(Continued from Page 1448)

tients have so uniformly appreciated the feeling of cleanliness and the early relief which they have obtained, that the method deserves a wider trial.

Conclusions

1. Proper local hygiene is an important therapeutic aid in the treatment of pruritus ani.
2. PHisoderm with hexachlorophene, 3%, (pHisoHex®), a commonly used surgical scrubbing agent, is an effective and practical preparation for this purpose.
3. The results of a seven months trial period in forty-five cases have indicated that the method described is a useful adjunct in the therapy of this annoying condition.

References

1. Kallet, Herbert I.: The clover leaf operation for pruritus ani. Trans. Am. Proc. Soc., p. 240, 1946.
2. Chisholm, T. C., Duncan, T. L., Hufnagel, C. A., and Walter, C. W.: Disinfecting action of pHisoderm containing three per cent hexachlorophene on the skin of the hands. Surgery, 28:812 (Nov.) 1950.
3. Freeman, B. S., and Young, T. K. L.: Clinical studies of the use of a synthetic detergent combining 2,2-dihydroxy-3,5,6-3′,5′6′hexachlorodiphenylmethane ("G-11") for disinfection of the skin. Surgery, 25:897 (June) 1949.
4. Guild, B. T.: Cutaneous detergents. Arch. Dermat. & Syph., 51:391 (June) 1945.

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Acknowledgment of all books received will be made in this column, and this will be deemed by us as full compensation to those sending them. A selection will be made for review, as expedient.

ESSENTIALS OF DERMATOLOGY. By Norman Tobias, M.D., Associate Clinical Professor of Dermatology, St. Louis University; Assistant Dermatologist, Firmin Desloge and St. Mary's Hospitals; Visiting Dermatologist, St. Louis State Hospital; Fellow, American Academy of Dermatology and Syphilology; Diplomate, American Board of Dermatology and Syphilology; Visiting Physician in the Department of Dermatology at the St. Louis City Hospital. Fourth Edition. Illustrated. Philadelphia: J. B. Lippincott Co., 1952. Price $6.00.

In this fourth edition of Essentials of Dermatology, Tobias has revised his book to include recent discoveries in etiology and advancements in therapy up to 1952. Some of the newer knowledge in virus cutaneous diseases is included. The discussion of each of the many skin diseases is outlined as to clinical description, etiology, pathology, differential diagnosis, prognosis, treatment, et cetera. This makes for easier reading and study by students. The compactness makes it a valuable book. While details could not be included in a book of this type, all important items are. While not a reference book for Dermatologists, this book is very good for medical students and general practitioners. It contains, as the title indicates, the essentials of Dermatology.

H. E. A.

A METHOD OF ANATOMY, Descriptive and Deductive. By J. C. Boileau Grant, M.C., M.B., Ch.B., F.R.C.S. (Edin.) Professor of Anatomy, University of Toronto. Fifth Edition. Baltimore: The Williams & Wilkins Co., 1952. Price $7.00.

This book endeavors to leave less to the effort of memory and more to the underlying principles of anatomy so that the readers will learn to reason anatomically. It is reminiscent of an old Gray's anatomy of the last century, where only the arteries and veins were colored, except in this instance there is no color at all in the drawings; and despite the fact that the schematic and diagramatic illustrations are excellent, the absence of color lessens the value of the work. The absence of color is very noticeable in those diagrams where bone and muscle are portrayed, and it is particularly difficult to gain a good idea of the abdominal viscera without color. Portions of the book have excellent phraseology, while other parts are terse and uneven, and the meaning is not quite as clear as it might be. The explanation of the mechanics of bone and muscle is excellent and should make the text appeal to all those interested in orthopedics. The description of the result and the traumatic sequence of various types of falls is also very good. Descriptions such as: "The clavicle is a strut that forces the scapula laterally and backwards," make the text interesting as well as the inclusion of various anatomical anomalies, particularly those of the kidneys, ureters, bile ducts, nerves and ribs. X-rays also add to the text, and a chapter on advice to the dissector following the preface is good.

Unfortunately, certain terms are used apparently in

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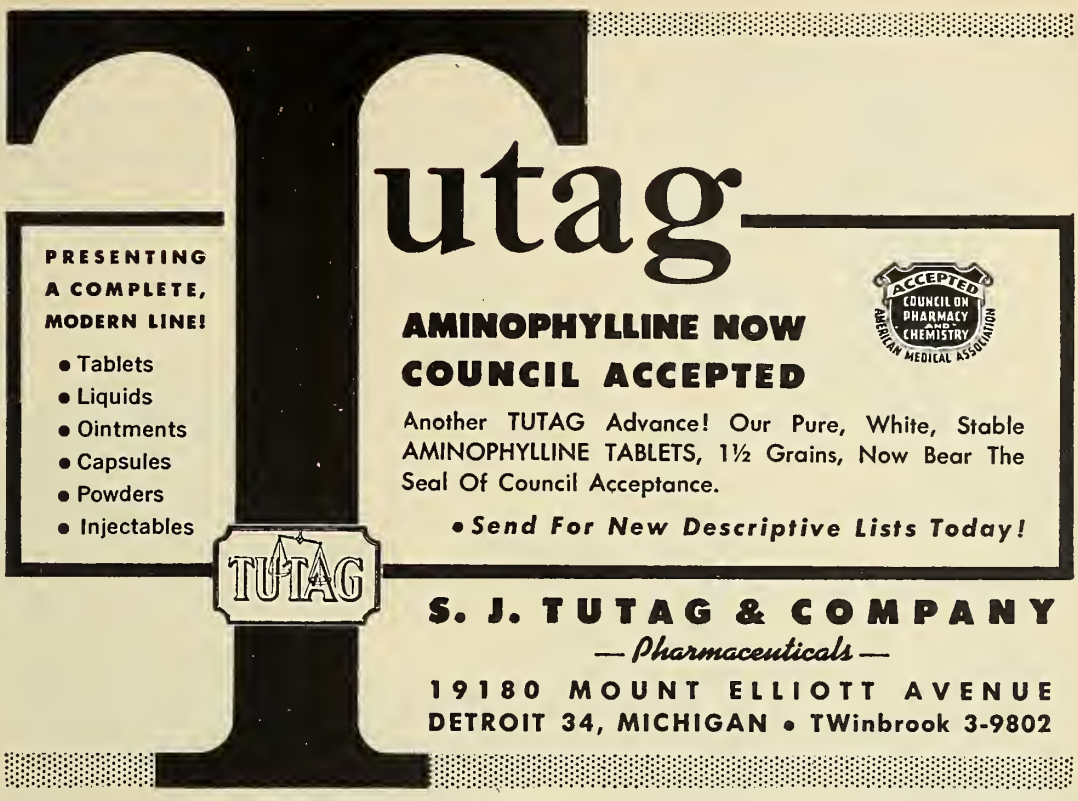
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an effort to attain simplicity, an example being that the apocrine glands are not mentioned as such, but are called "disintegrating sweat glands," or "sexual skin glands." It goes into considerable detail about the growth of the nails but completely fails to mention the neuromyoarterial glomus of the skin, although it describes its function. It enters into the physiological background of anatomy, which in most texts is not included, but here one wonders whether it should have been included, a particularly egregious example being the description of adrenal function.

Serious errors are present, such as assigning a life span of only six weeks to an erythrocyte. The author points out that he is ignoring topographical anatomy but, unintentionally, he also covers visceral anatomy and neurology very sketchily. The author is possessed of a wide and varied knowledge, this being particularly emphasized in the dissertation on the animal experimentation concerning the thoracic duct. The book is recommended as an ancillary text to those having another anatomy in their libraries. The book must be of some value since it has gone to five editions and eleven reprints. Its low price also recommends it.

A.A.H.

THE TREATMENT OF INJURIES TO THE NERVOUS SYSTEM. By Donald Munro, M.D., F.A.C.S., Surgeon-in-Chief, Department of Neurosurgery, Boston City Hospital; Associate Professor of Neurosurgery, Boston University School of Medicine; Assistant Professor of Neurosurgery, Harvard University Medical School. Illustrated, Philadelphia: W. B. Saunders Co., 1952. Price $7.50.

The author states that this book was primarily written for the general surgeon and general practitioner. Due to the numerous motor and other accidents of which many casualties involve a part of the nervous system this small volume appears timely and needed. The writer is gifted. He can adequately describe and inform without the use of unnecessary words. There is no theorizing or inconclusive advice. He presents his methods in a straightforward manner. He has been able to cover the entire gamut of diagnosis and therapy from the proper way to transport spinal cord injury cases to rehabilitation. The care of the genito-urinary tract includes tidal drainage, cystometry and bladder training. There are chapters on prevention and the overcoming of contractures. There is a listing of minimal instrumental and other equipment and operative procedures. To complete the book more fully there are forty-seven illustrations and nine tables for differential diagnostic and comparative purposes.

G.K.S.

LIVING WITH CANCER. By Edna Kaehele. New York: Doubleday & Co., Inc., 1952. Price $2.00.

An inspiring true story of a woman given six months to live who courageously decided to "outgrow" her cancer. She is alive and leading a full and busy life six years later, although she still has an active malignancy.

Mrs. Kaehele (rhymes with Bailey) writes principally for those who also have cancer. Suffering from a rapidly growing malignancy, she was treated with x-ray therapy, radium, gold seeds and radium chloride. At the

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The pathologist in direction is recognized by the Council on Medical Education and Hospitals of the A. M. A.

end of these treatments she weighed 90 pounds and no hope was held for her recovery. Because her family would not give up, and because she decided she was "more important than any growth occupying her body," she feels she continued to live. She suggests that those with cancer "search out the best cancer specialist you can find and make full use of the most advanced resources available. But do it hopefully, not fearfully. If at the end you come to the day when all has been done that can be done medically and you still have a cancer, do not be discouraged. Remember that while compromise may not be as good as victory, it is incomparably better than defeat. You may not be able to cure it, but you can *live* with cancer."

Any doctor who diagnoses or treats cancer could benefit by reading this book. He may not agree with all she says, but he will find her remarkably sensitive subjective approach illuminates the psychology of the patient, and in addition tells a readable human story. Most of his patients could take heart from this book and their families and friends would find it inspirational.

J.A.H.

THE LOW FAT DIET COOK BOOK. By Dorothy Myers Hildreth and Eugene A. Hildreth, M.D. Introduction by Francis C. Wood, M.D. Distributed by Grosset and Dunlap, New York: Medical Research Press, 1952. Price $2.95.

Mrs. Hildreth, consultant dietitian for the University of Pennsylvania Robinette Foundation, Heart Clinic, participated in research on the low fat diet with her husband, Dr. Eugene Hildreth, also associated with the University of Pennsylvania and a Fellow of the United States Public Health Service. Between them they have impressive experience to write this authoritative book.

Their cook book contains low fat (between 25 and 35 grams of fat daily) menus for a week, and over 200 recipes showing ways to cook appetizing low fat dishes. Included is information on the grams of fat per serving of all types of food, suggestions on menu planning, and a list of foods to be avoided. The Hildreths actually lived on this diet for some weeks, so the menus and recipes have authenticity.

This book could be very helpful to patients on a low fat diet. The recipes for low fat gravy and mayonnaise, and the many other practical suggestions, should make a real difference in mealtime pleasure for the patient with arteriosclerosis.

J.A.H.

POISONING—A GUIDE TO CLINICAL DIAGNOSIS AND TREATMENT. By W. F. von Oettingen, M.D., Ph.D., National Institutes of Health, U. S. Public Health Service, Federal Security Agency Bethesda, Md. New York: Paul B. Hoeber, Inc (Medical Book Department of Harper & Brothers) 1952. Price $10.00.

This book, by a most eminent authority, fills a very specific gap in today's clinical literature. Here is a comprehensive reference guide that will help the practicing physician quickly detect poisoning and institute effective treatment.



One section is devoted to signs and symptoms and they are classified by body systems and discussed one by one as they present themselves in the course of a clinical examination. Here we will look first, for under each sign or symptom we will find a list of toxicants which may be responsible for the change we have observed.

Next, there is the management of the case, including the rationale of treatment, the removal of the toxic agent, the elimination of the toxic agent, the detoxification of the absorbed poison, the symptomatic treatment, and lastly the general measures and treatment of the after-effects.

The final section, and the largest, offers an alphabetical index of the symptoms and treatment of the 461 types of poisoning. This is truly a comprehensive and worthwhile compilation of information and every physician should have it readily available.

G.W.S.

Permanent cancer cures are still achieved largely with surgery and/or external irradiation administered to patients with early lesions that have not yet metastasized widely.

* * *

The fact that cancer cells, like bacteria, are capable of developing resistance to therapeutic agents, accounts for the many failures in the drug therapy of cancer.

* * *

In the current preoccupation with specific therapy, sight is often lost of the fact that the patient as well as the cancer must be treated.

Cook County Graduate School of Medicine

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Surgical Technic, Surgical Anatomy and Clinical Surgery, four weeks, starting March 2.
Surgical Anatomy and Clinical Surgery, two weeks, starting March 16.
Surgery of Colon and Rectum, one week, starting November 17, March 2.
Bronchoscopy, one week, by appointment.
General Surgery, one week, starting February 9.
General Surgery, two weeks, starting March 30.
Fractures and Traumatic Surgery, two weeks, starting March 2.

GYNECOLOGY—Intensive Course, two weeks, starting February 16.
Vaginal Approach to Pelvic Surgery, one week, starting March 2.

OBSTETRICS—Intensive Course, two weeks, starting November 3, March 2.

MEDICINE—Intensive General Course, two weeks, starting May 4.
Gastroscopy and Gastroenterology, two weeks starting November 3.

UROLOGY—Two-week Intensive Course starting April 27.
Ten-day Practical Course in Cystoscopy starting every two weeks.

DERMATOLOGY—Intensive Course, two weeks, starting May 4.

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(Continued from Page 1436)

slide). Large calibre urethral strictures, No. 20-24 French, are frequent in the female and a common source of urinary complaints and infections, and may indeed cause abdominal or lumbar pain. Treatment by dilation with a Walther sound is usually very beneficial. It should be repeated once a week until No. 26-30 French is acquired and then the interval may be lengthened up to as long as six months. An instillation of Argyrol or weak silver nitrate (¼ per cent) is usually beneficial as an adjunct to the sound.

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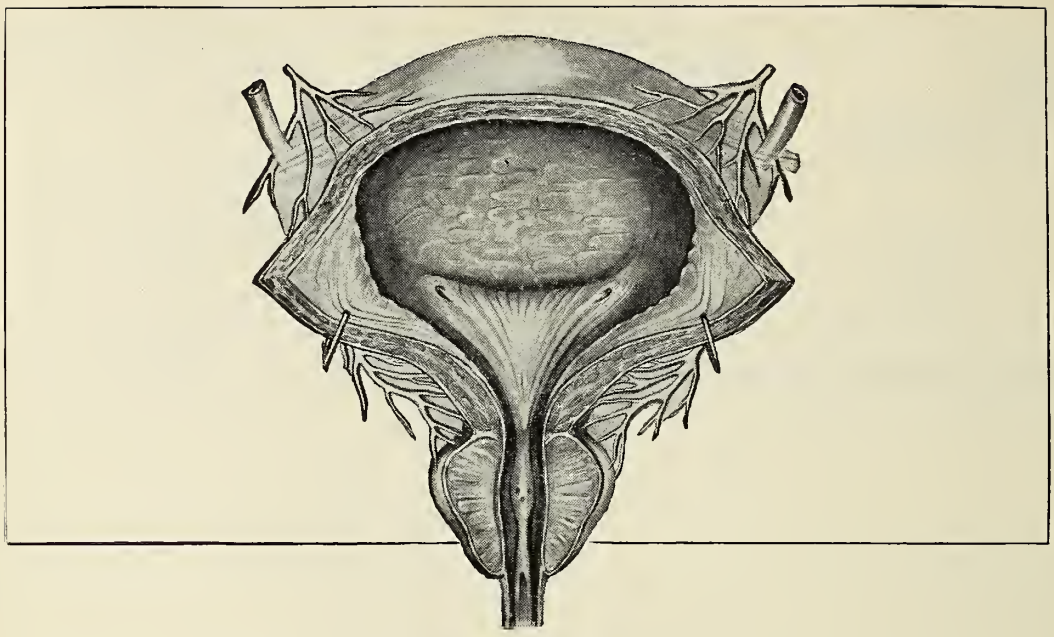
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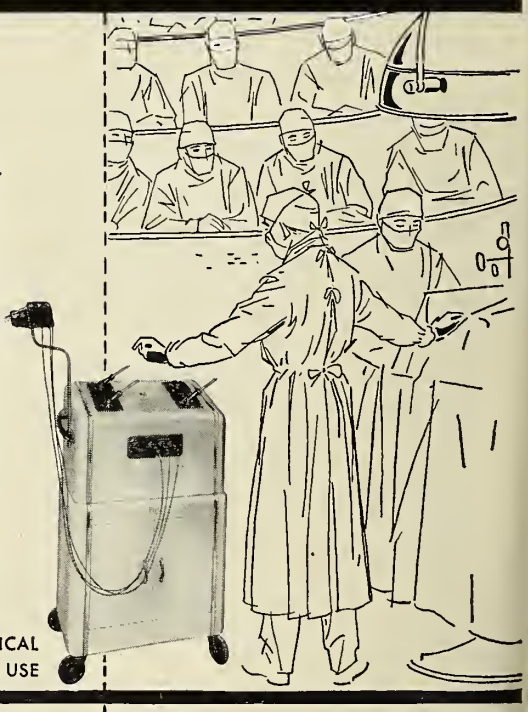
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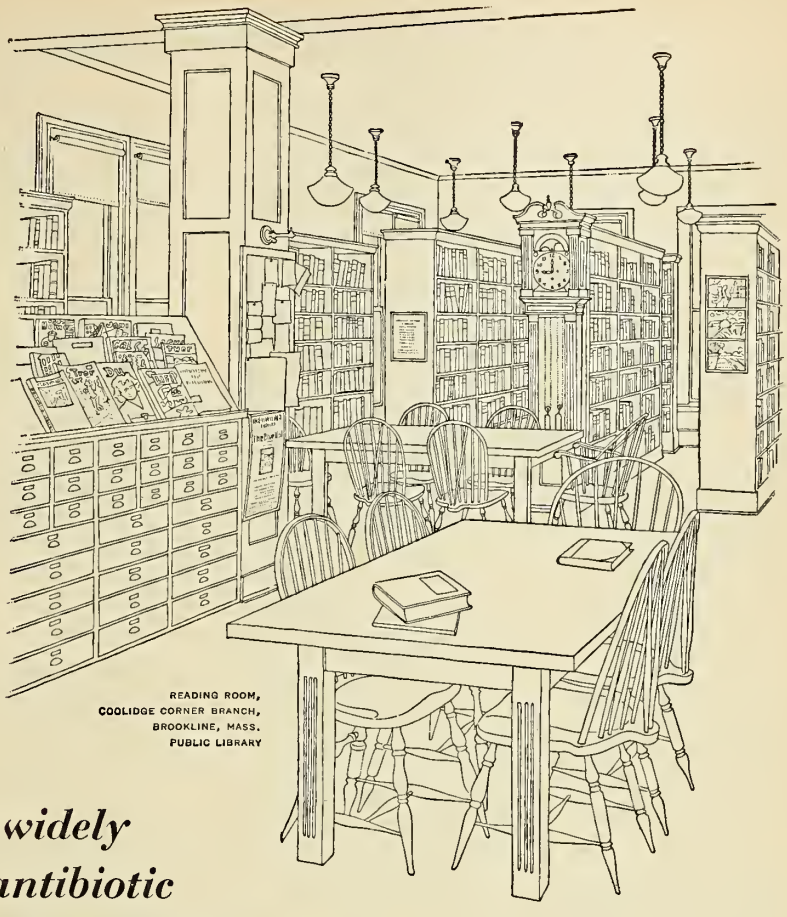
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L. E. Holly, M.D., *Chairman*.....878 N. Second, Muskegon

Subcommittee on Industrial Uses and Hazards of Atomic Energy

K. H. Corrigan, Ph.D., *Chairman*.....Harper Hospital, Detroit

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F. M. Doyle, M.D. 1001 American Natl. Bank Bldg., Kalamazoo
C. W. Oakes, M.D.....Harbor Beach
P. E. Sutton, M.D.....629 Wash. Square Bldg., Royal Oak

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Raphael Altman, M.D.....1052 Maccabees Bldg., Detroit
L. C. Carpenter, M.D.....604 Metz Bldg., Grand Rapids
E. H. Fenton, M.D.....15125 Grand River Ave., Detroit
J. T. Jerome, M.D.....105 State Bank Bldg., Traverse City
P. A. Riley, M.D.....500 S. Jackson, Jackson
R. D. Risk, M.D.....1160 Ransom St., Muskegon

You and Your Business

STRENGTHEN YOUR SUPPORT OF AMA

The Council of the Michigan State Medical Society, in its Annual Report to the House of Delegates, presented the following recommendation:

"The Council respectfully recommends that continued active tangible co-operation with the American Medical Association be maintained by every MSMS member who is urged to continue and strengthen his support of the AMA. Strength comes from unity and work, joined hand in hand. It flows from the roots to the trunk."

This recommendation of The Council was adopted by unanimous vote of the MSMS House of Delegates meeting in Detroit on September 22-23, 1952.

OSTEOPATHS TRY TO ENTER MUNICIPAL HOSPITALS VIA BALLOT BOX

The first attempt in Michigan, if not in the United States, to gain entrance into an accredited, registered city hospital, was boldly tried by osteopaths of Bay City through a proposed amendment to the city charter. This brazen bid for greater privilege and power, without the necessary background or education to back it up, was roundly defeated by the voters of Bay City who on November 4, cast 14,526 votes against the proposal, with only 5,633 in favor of the osteopathic scheme.

A review of this experience is being made and will be available upon request to any component society where a similar problem may arise.

The people of Bay City are to be congratulated on their wise decision to maintain the high standards of the Bay City General Hospital. The doctors of medicine of Bay City also are to be complimented on their unified stand in refusing to compromise with the Principles of Ethics of the medical profession.

NEW CANCER MANUAL DISTRIBUTED TO MICHIGAN HIGH SCHOOLS

"The Story of Cancer for High Schools," published by the MSMS Cancer Control Committee, with the co-operation and financial assistance of the Michigan Department of Health and the Michigan Division of the American Cancer Society, has just been distributed to all public and parochial high schools, junior colleges and county normal schools in Michigan.

Comments already received indicate its favorable reception. A few are:

"One of the truly real contributions to cancer education."

"A tremendously important step in cancer education has been taken."

"A very useful and interesting job and should help to clear up many of the misconceptions."

This Manual will provide science and health teachers with concise information regarding cancer. It also indicates a few ways in which cancer education can be integrated with other health teaching programs.

ENCOURAGE RECRUITMENT OF MEDICAL ASSOCIATES

The Medical Associates brochure, a pioneering development of the Michigan State Medical Society in 1947, has been revised and brought up to date. Copies are available so the brochure may be presented to teachers or vocational counselors of the young. For a supply, write MSMS, Box 539, Lansing. The Medical Associates Brochure has been highly praised in Michigan, as well as in other states, as an important instrument for recruiting the young into the health professional field, such as pharmacists, nurses, medical technologists, physical therapists, dietitians, x-ray technicians, medical librarians, medical ophthalmic associates, and others.

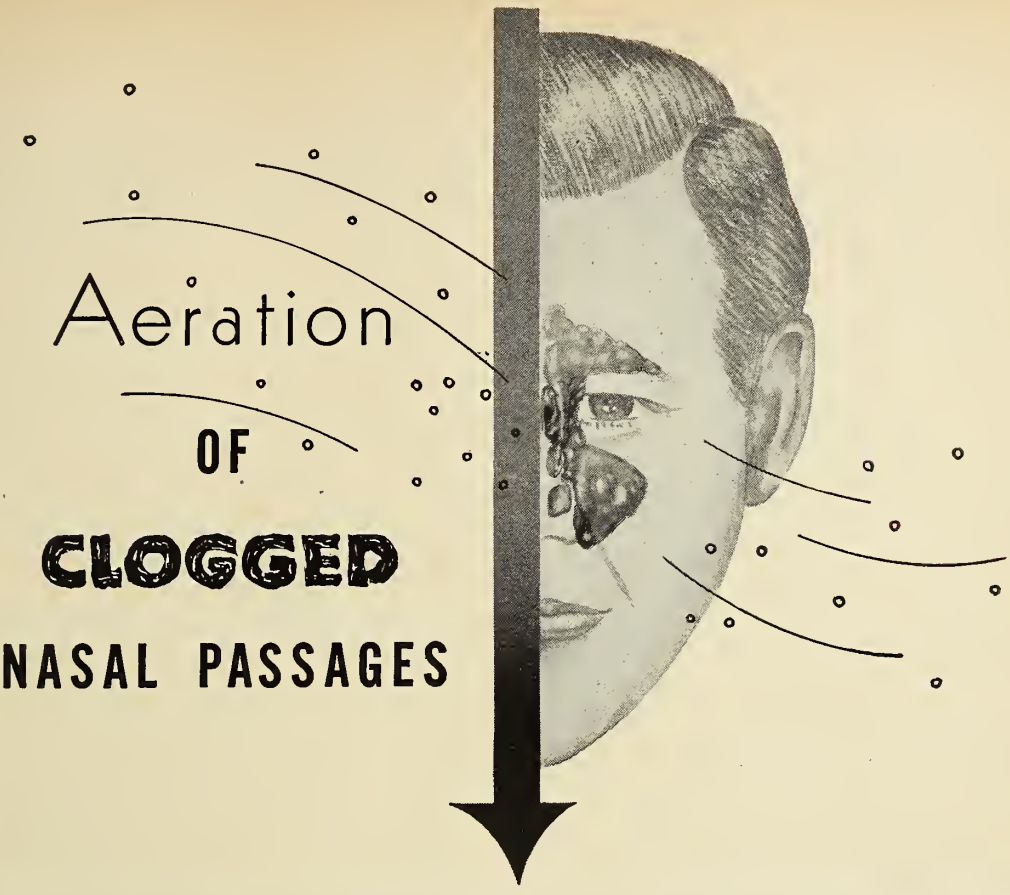
HIGHLIGHTS OF EXECUTIVE COMMITTEE OF THE COUNCIL

Meeting of October 23, 1952

Eighty-nine items were considered by the Executive Committee of The Council at its October 23 meeting in Kalamazoo. Chief in importance were:

- **Monthly financial reports** were presented and approved. Bills payable were inspected and payment was authorized.
- **Report** on the forthcoming battle of ballots to save Bay City General Hospital was presented; the Bay City experience seems to be a guinea pig in a national attempt to gain recognition through back-door methods by a certain group of healers.
- **Revision of Model Constitution and By-Laws for County Medical Societies:** personnel of the Special Committee as authorized by The Council on September 21 were approved: J. H. Schlemer, M.D., Detroit, Chairman; A. W. Allen, M.D., Ann Arbor; F. M. Doyle, M.D., Kalamazoo; C. W. Oakes, M.D., Harbor Beach, and P. E. Sutton, M.D., Royal Oak.

(Continued on Page 1506)



Breathing comfort as well as proper drainage and aeration of the sinuses during upper respiratory infections is assured by the swift and prolonged decongestive action of

NEO-SYNEPHRINE®

HYDROCHLORIDE

By shrinking the swollen mucosa, Neo-Synephrine permits drainage of purulent matter, restoring free breathing and relieving the headache caused by clogged passages.

RAPID AND PROLONGED ACTION Clearing of nasal obstruction follows within seconds after application of Neo-Synephrine and is unusually prolonged, so that comparatively few daily applications are necessary throughout the course of a cold.

WELL TOLERATED Neo-Synephrine is notable for its relative freedom from sting, virtual absence of compensatory congestion and also has been found relatively free from systemic side effects such as nervous excitation, cardiac reaction or insomnia even when tested on hypertensive, cardiac and hyperthyroid patients.[1]

NO APPRECIABLE INTERFERENCE WITH CILIARY ACTIVITY Neo-Synephrine not only restores nasal patency, but is compatible with ciliary action.

NO DROWSINESS Neo-Synephrine may be used by the ambulatory patient without danger of producing drowsiness or related sedative action. Applied topically, Neo-Synephrine confines its action to the upper respiratory passages.

SUPPLIED:

0.25% solution (plain), 1 oz., 4 oz. and 16 oz. bottles.

0.25% solution (aromatic), 1 oz. and 16 oz. bottles.

0.5% salutian, 1 az. bottles.

1% solution, 1 oz., 4 az. and 16 oz. battles.

0.5% water saluble jelly, ⅝ oz. tubes.

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Neo-Synephrine, trademark reg. U.S. & Canada, brand of phenylephrine

●

1. Van Alyea, O. E., and Donnelly, Allen: *Arch. Otolaryng.*, 49:234, Feb., 1949.

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Say you saw it in the Journal of the Michigan State Medical Society

HIGHLIGHTS OF THE COUNCIL

(Continued from Page 1504)

- **Beaumont Memorial:** The suggestions of Otto O. Beck, M.D., Birmingham, Chairman of the Beaumont Memorial Consultative Committee, that each MSMS Councilor be sent a list of those MSMS members who have contributed to the Beaumont Memorial, by counties, and that each Councilor visit the county medical societies in his District urging additional contributions so work on the Beaumont Memorial may be started in the Spring of 1953, were approved. Copies of the broadcast "The Strange Patient of Dr. Beaumont," given over Radio Station WWJ in Detroit on September 25, are to be made on phonograph records for those Councilors who desire to use same in their presentations to county medical societies; also copies are to be made available for individuals and groups contributing $100 or more to the Beaumont Memorial Restoration Fund.

- **Matters referred to The Council by 1952 House of Delegates:**

 (a) Study Committee on Fees for Surgical Assistants—the following personnel was appointed: B. M. Harris, M.D., Chairman, Ypsilanti; Raphael Altman, M.D., Detroit; L. C. Carpenter, M.D., Grand Rapids; E. H. Fenton, M.D., Detroit; J. T. Jerome, M.D., Traverse City; P. A. Riley, M.D., Jackson and R. D. Risk, M.D., Muskegon.

 (b) Appointment of Study Committee re Act 59 of the Public Acts of 1937—The personnel of this Committee was given prolonged consideration—appointments to be presented at November 12 meeting.

 (c) Resolution re simplified insurance reporting form—this was referred to Secretary Foster to contact the American Medical Association personally.

 (d) Resolution re repeal of "citizenship" in Medical Practice Act—a communication was ordered sent to the President of the Michigan State Board of Registration in Medicine asking him for a clarifying letter re the question raised by the 1952 MSMS House of Delegates.

 (e) Legislation re recalcitrant tuberculous patients: this matter was referred to the MSMS Legislative Committee, as per House of Delegates instruction.

- **Committee Reports.** The following were given consideration: (a) September 23, Detroit Hearing re President's Commission on Health Needs of the Nation—report of C. E. Umphrey, M.D., Chairman; (b) Medical Advisory Committee to Michigan Hospital Service, meeting of October 2; (c) Quarterly and also biennial financial reports of the Cancer Control Committee were presented and accepted.

- **Committees of The Council for 1952-53** were presented by Chairman William Bromme and approved.

- **A. E. Heustis, M.D.,** Lansing, was added to the MSMS Cancer Control Committee and B. B. King, M.D., Benton Harbor, to the Advisory Committee to the National Foundation for Infantile Paralysis, by President R. J. Hubbell, M.D.

- **R. J. Himmelberger, M.D.,** Lansing, President of the Ingham County Medical Society, was appointed as official MSMS representative to the dinner meeting of the State Division, National Foundation for Infantile Paralysis, to be held in Lansing, October 31.

- **A letter of thanks** to Horace Wray Porter, M.D., Jackson, for his two years' excellent work as Chairman of the MSMS Cancer Control Committee, was authorized to be drafted and sent by the Council Chairman.

- **The editorial "They"** as printed recently in the *Detroit Medical News* under the authorship of W. S. Reveno, M.D., of Detroit, was recommended for re-publishing in JMSMS, provided approval of the Wayne County Medical Society is given.

- **A special meeting** of the Michigan Health Officers Association during the 1953 Michigan Clinical Institute is to be recommended to the M.H.O.A. by the Executive Committee.

- **W. C. Beets, M.D.,** Grand Rapids, President of the Kent County Medical Society, in September, 1953, was appointed General Chairman of Arrangements for the MSMS Annual Session of September 23-24-25, 1953.

- **The Press Relations Committee** for the 1953 Annual Session, as confirmed by the Executive Committee of The Council, includes: R. H. Baker, M.D., Pontiac, Chairman; J. E. Livesay, M.D., Flint; L. Fernald Foster, M.D., Bay City; H. F. Dibble, M.D., Detroit, R. A. Johnson, M.D., Detroit, and C. A. Payne, M.D., Grand Rapids.

- **1953 Michigan Clinical Institute,** Detroit, March 11-12-13:

 (a) Assembly Chairmen were appointed:

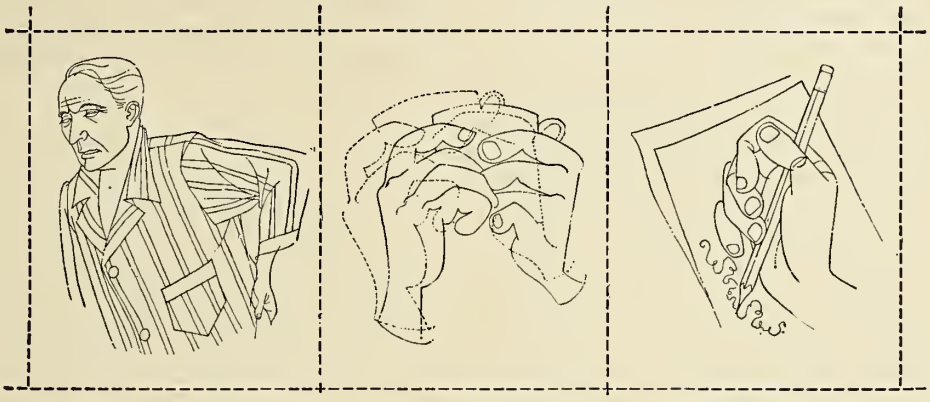
 Wednesday a.m.....R. A. Frary, M.D., Monroe
 Wednesday p.m.....A. B. Gwinn, M.D., Hastings
 Thursday a.m.....C. H. Keene, M.D. Willow Run
 Thursday p.m.....D. A. Cameron, M.D., Detroit
 Friday a.m.....H. L. Smith, M.D., Detroit
 Friday p.m.....J. D. Littig, M.D., Kalamazoo

 (b) Discussion Conference Leaders for the 1953 M.C.I. were appointed: W. H. Huron, M.D., Iron Mountain; F. A. Coller, M.D., Ann Arbor, and E. D. Spalding, M.D., Detroit.

 (c) "Ontario Day" during the 1953 Michigan Clinical Institute, with invitation to the Ontario Medical Association and all its county medi-

(Continued on Page 1508)

new uniform oral dosage



in muscle spasm of rheumatic disorders | **in acute alcoholism** | **in certain neurologic disorders**

The new, uniform oral dose for adults is 1-3 grams. This may be repeated 3-5 times per day.

The first dose prescribed should be at the lower end of the recommended dosage range *(an occasional patient may complain of side effects when* large *doses are given at the* start *of Tolserol therapy).* Subsequent doses may be adjusted to the needs of the individual patient. Whenever possible, Tolserol should be given after meals. When Tolserol is given between meals, it is desirable that the patient first drink ⅓ glass of milk or fruit juice.

Tolserol

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Tablets, 0.5 Gm. and 0.25 Gm., bottles of 100; *Capsules,* 0.25 Gm., bottles of 100; *Elixir,* 0.1 Gm. per cc., pint bottles; *Intravenous Solution,* 20 mg. per cc., 50 cc. and 100 cc. ampuls.

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HIGHLIGHTS OF THE COUNCIL

(Continued from Page 1506)

cal societies to co-operate, was authorized for the 1953 M.C.I., if approved by the Ontario doctors of medicine.

(d) Civil Defense Night, at the request of the Wayne County Medical Society, will be held on the evening of Wednesday, March 11, during the 1953 M.C.I.

- **National Society for Medical Research:** the Executive Committee of The Council felt that this organization was created for a very worthy purpose and recommended that Michigan doctors of medicine be urged to contribute to it.

- **Michigan Health Council:** at the suggestion of M.H.C. President J. S. DeTar, M.D., John R. Rodger, M.D., of Bellaire, and R. W. Teed, M.D., of Ann Arbor, were selected as Delegate and Alternate Delegate, respectively, from MSMS to the Michigan Health Council. The resignation of Dr. DeTar as MSMS Delegate to the M.H.C. was accepted with sincere regret and with thanks for his excellent work in this position.

- **Rheumatic Fever progress report** as presented by Co-ordinator Leon DeVel, M.D., was approved.

- **A progress report of the Legal Counsel** included (a) Review of the recent Court decision re Grand View Hospital, Ironwood; (b) Proposed revision of Constitution and By-Laws of Kalamazoo Academy of Medicine; (c) Answer to question re limitation of service, propounded by the Medical-Surgical Plan of New Jersey.

- **The Public Relations Counsel** reported (a) a distribution of approximately 27,500 copies of a reprint of the "Voter's Guide" from *Inside Michigan;* (b) that arrangements have been made to continue the MSMS radio program "Tell Me, Doctor" on a limited basis for the months of November and December, 1952; (c) preliminary program of the MSMS Public Relations Conference to be held February 1 in Detroit was presented.

- **Suggestion to hold a session of The Council in March.** This idea was thoroughly discussed with all the pros and cons being fully considered. The Executive Committee of The Council felt that due to added expense to MSMS for a March Session of The Council, it is inadvisable to hold a meeting during the M.C.I., which is only five to six weeks after the Annual Session of The Council.

- **Thanks to Dr. and Mrs. R. J. Hubbell** for their hospitality on this occasion was registered by standing vote.

PRESIDENT'S COMMISSION ON THE HEALTH NEEDS OF THE NATION

Problems of financing medical care, with emphasis on the issue of national *compulsory health insurance,* were argued before the President's Commission on the Health Needs of the Nation. Panel participants in the two-day sessions (Oct. 7-8) included several spokesmen long associated with the Truman-Ewing plan. Opposing their views were representatives of American Medical Association, non-profit and commercial health insurance organizations, hospitals, industry and the U. S. Chamber of Commerce.

There was agreement among participants on a number of points, particularly (*a*) that the country has an unprecedented health record for the last half century, *(b)* that the various types of voluntary health insurance have experienced a phenomenal growth in public acceptance, and (*c*) that better medical care should be extended to the undetermined number of people who are not now being cared for adequately.

But the discussion ended with continued disagreement on (*a*) exact or even relative number of Americans not adequately protected, by prepaid insurance or otherwise, (*b*) ability of the voluntary plans to expand rapidly enough, qualitatively and quantitatively, to meet the need, and (*c*) whether national compulsory health insurance is the answer.

Spokesmen for the non-profit plans insisted throughout that they would *be able to supply any coverage the public needs.* They said federal and state governments should co-operate by permitting Blue Cross and Blue Shield payroll deductions for their employes and by extending unemployment compensation to include payment of insurance premiums. It was also proposed that federal or state governments subsidize premiums for low income groups, possibly through a system similar to the Hill-Burton program.

Following are brief quotations from all participants, in order in which they testified:

Seymour E. Harris, Ph.D., Professor of Economics, Harvard: "The AMA can point with pride to the fact that the factory worker pays only half as large a part of his income for a doctor's visit as he did before the war. But we need to know more about the quality of the service. Does he (the doctor) give less time? Is he more tired and crowded?"

Frank G. Dickinson, Ph.D., Director of the Bureau of Medical Economic Research, American Medical Association: "It would take just 54 per cent of a week's wages in 1951 to purchase the same amount of medical care as a whole week's wages would have purchased in 1935-39 . . . Medical care costs as a whole are lagging well behind prices in general . . . All statistics show

remarkable improvement in maternal and infant mortality rates and startlingly longer life expectancy."

HARRY BECKER, Associate Director, Commission on Financing of Hospital Care and former Social Security Director for CIO: "If we accept the pattern of financing which establishes voluntary prepayment for the families of the currently employed and which, through government assistance, provides the same standard of care on essentially the same basis for non-wage and low income groups—we will close most of the existing gaps in financing care . . ."

HELEN HALL, Director of Henry Street Settlement, Chairman Subcommittee on Health Needs of the National Federation of Settlements: "Insurance for comprehensive care, with provision for preventive care, is what we need. Voluntary plans protect those in the least need of protection . . . I object to the whole idea of stabilizing such variable services as those offered by the voluntary plans."

WALTER F. PERKINS, Koppers Company, Inc., and Trustee, Johns Hopkins Hospital: "The sensible thing to do is to encourage the extension of hospital insurance so as to make it available at reasonable rates to all of our people. We must also develop reasonable and adequate medical, surgical and nursing care insurance plans. This will need the active leadership of the medical profession, which so far has been lacking . . . This is a problem that cannot be solved overnight. England thought so and you all know what happened there."

WILLIAM S. MCNARY, Executive Vice President and General Manager, Michigan Hospital Service: "Health service . . . is bringing into Blue Cross thought an increasing understanding of the importance of maintaining a balance between local or regional needs and the demands of the national economy. Where definite inadequacies exist, Health Service can step in and build up the benefits to the required uniform national levels. Thus . . . Blue Cross is raising national standards without imposing the hobbles of centralization."

DR. CHARLES G. HAYDEN, Executive Director, Massachusetts Medical Service: "Basically this (OASI) is a simple cash transaction and the recipient can do what he pleases with the money. Under federal compulsory health insurance, however, the federal government also proposes to collect the money, but instead of returning money to patients requiring medical care, it would undertake to provide the personal services of physicians. How this could be done without imposing controls on the medical profession I, as the administrator of a medical care plan, cannot understand . . ."

JOHN H. MILLER, Vice President and Actuary of the Monarch Life Insurance Co.: "One of the most significant developments . . . has been the growth in availability of protection against catastrophic medical expense . . . In 1951 benefits which either were or might have been used for medical care costs totaled $1.7 billion. with $768 million specifically paid for this purpose."

DR. GEORGE BAEHR, President and Medical Director, Health Insurance Plan of Greater New York: "The many extra charges that doctors are permitted to make under the limited plans deter families from availing themselves of the benefits of preventive medical services and . . . early disease detection . . . Voluntary insurance will not be accepted as the final answer . . . until it can provide comprehensive coverage to those who want it and should have it . . ."

I. S. FALK, Ph.D., Director, Division of Research and Statistics, Social Security Administrator, FSA: "Voluntary insurance plans . . . hinder at least as much as help the development of group practice required for advancement of quality of care . . . If we agree on the need for wider use of insurance . . . we find that voluntary insurance does not and cannot meet our needs . . ."

GEORGE W. COOLEY, Assistant Secretary of AMA Council on Medical Service: "The phenomenal growth of hospital, surgery and medical care insurance is evidence the American people have placed their faith in the voluntary system. In about ten years, hospitalization insurance coverage has increased 430 per cent, surgical protection 770 per cent and medical care 820 per cent."

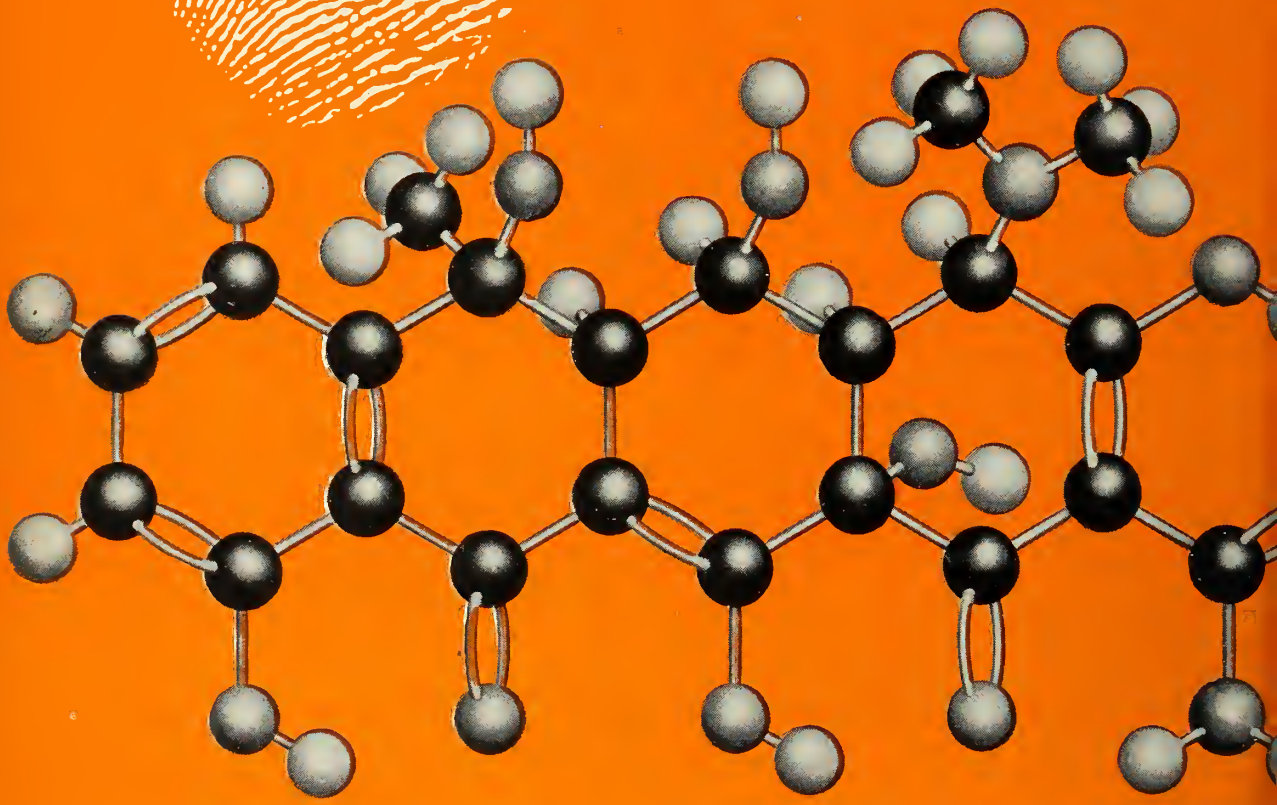
DR. VLADO GETTING, Commissioner, Massachusetts Department of Health: "The Commission has been spending too much time on how to finance medical care and not thinking enough about how to reduce the risks of poor health . . . The greatest need is nation-wide development of full-time local health departments."

DR. EDWIN L. CROSBY, Director, Johns Hopkins Hospital: "Efforts should be made to increase and expand Blue Cross on a voluntary basis . . . so as to narrow the gap between patients who have difficulty in paying their hospital bills and those who are entirely unable to pay."

DR. WARD DARLEY, Dean, School of Medicine, University of Colorado: "The recent activities of the National Fund for Medical Education and the American Medical Education Foundation in raising funds for medical schools are of significance not only in that they represent an effort to interest

(Continued on Page 1512)

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APPEARING REGULARLY IN THE J. A. M. A.

PRESIDENT'S COMMISSION ON THE HEALTH NEEDS OF THE NATION

(Continued from Page 1509)

the general public in contributing to the support of medical education but also in that these funds are to be given to the schools to be used in any way they think best . . ."

HAROLD M. GROVES, Professor of Economics, University of Wisconsin: ". . . the case for federal aid to medical education is strong and convincing . . . It should be our objective to devise a scheme of compulsory insurance . . . perhaps by a 2 per cent income tax for compensation of catastrophic illness."

MICHAEL M. DAVIS, Ph.D., Chairman, Committee for the Nation's Health: "For most of the American people, health insurance should be required by national law . . . Without a broad and positive national program, I anticipate a mixture of commercial and non-profit voluntary insurance which will be quantitatively insufficient and often qualitatively poor, plus the piecemeal but steady growth of directly tax-supported medical and hospital care . . ."

E. A. VAN STEENWYK, Executive Director, Associated Hospital Service of Philadelphia: "Solution of the problem of meeting the public's bill for medical care of the poor will require participation of government at all levels. Federal grants along lines of the Hill-Burton hospital program to state medical authorities for paying costs for the medically indigent should be tried."

LEON KEYSERLING, Chairman, President's Council of Economic Advisers: "During the next ten years, an additional $100 billion in goods and services may be expected, several billion of which could very well be used to expand health services. Steps should be taken to get these services to the people who need them most, particularly to those who are now unable to afford them."

EMERSON P. SCHMIDT, Ph.D., Director, Economic Research, U. S. Chamber of Commerce: "The enormous progress made by insurance programs in the last decade, covering more groups, smaller groups, higher ages, families and dependents, and features such as hospital, medical care, surgery and catastrophe, indicate what can be accomplished without coercion and compulsion."

NELSON H. CRUIKSHANK, Director, Social Insurance Activities, AFL, and Labor Advisor to Mutual Security Agency: "Organized labor and all wage earners are united in demanding a system of national health insurance for the benefit of all . . . Labor has tested the voluntary plans and with few exceptions has found them seriously wanting."

HAROLD S. VANCE, Chairman, Board of Directors, Studebaker Corp.: "The Company's employe-controlled medical program is receiving full co-operation from the local physicians and the medical society. 'Let us go as far as we can on the voluntary basis. It has worked for us and it can work for others.' "

The Commission reached no conclusions on the issues involved. It met in executive session on October 9 and will hold another three-day closed meeting later this month. Its report to the President is due by December 29.—*AMA Capitol Clinic,* Oct. 14, 1952.

HOW EISENHOWER AND REPUBLICAN PARTY STAND ON MAJOR MEDICAL ISSUES

Specifically as well as generally, the Republican administration should be found in fairly close agreement with American Medical Association on several major issues due to reappear before Congress in the next two years—issues on which the Association and the Roosevelt and Truman administrations were at odds continuously. The Republican platform and pre-election statements by General Eisenhower suggest that the following situation may be expected:

Socialized Medicine.—General Eisenhower has stated repeatedly that he is opposed to national compulsory health insurance or socialization in any other form. On this he is supported all the way by the Republican party's platform. In contrast, President Truman consistently advocated compulsory health insurance. This does not mean the end of the issue, but a safe assumption is that it will lie dormant for the next two years.

Aid to Medical Education.—General Eisenhower is determined that every effort be made to support medical education without resort to federal financial assistance; long before his nomination he was active in efforts to raise private funds to assist medical schools. AMA is in substantial agreement with his ideas on this subject; it believes States and private sources should accept responsibility for supporting the schools, with federal funds used only for "one time" construction and equipment grants where the need is clearly demonstrated.

Pension Plans for Self-Employed.—The General has indorsed extension of tax relief to self-employed persons to help them establish pension funds, a proposal which has the active support of AMA and a number of other national associations. He has stated: "There are over 10 million workers who cannot take advantage of tax relief provisions now offered to corporations and their employes . . . I think something ought to be done

(Continued on Page 1516)

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Ward, E., Slocumb, C. H., Polley, H. F., Lowman, E. W., and Hench, P. S.,
Proc. Staff Meet. Mayo Clin. 26: 361, Sept. 26, 1951.

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Heart Beats

THE FUNCTIONAL AND THERAPEUTIC CLASSIFICATION OF HEART DISEASE

The recent tremendous progress in the field of cardiology has been aided significantly by the almost universal employment by clinicians of a standard terminology, the adoption of definite criteria for the diagnosis of cardiac conditions and the practice of making accurate and complete cardiac diagnoses. The New York Heart Association has rendered a great service in publishing a manual entitled "Nomenclature and Criteria for Diagnosis of Diseases of the Heart," which has been adopted and distributed by the American Heart Association.* The present discussion is based upon this manual.

The attempt to make exact and complete diagnoses presents a challenge to the physician. It requires a fuller knowledge of heart disease as well as more thorough study of individual patients. The etiology, the anatomical changes and the alterations in cardiac physiology or mechanism are often recognized readily enough. The functional and therapeutic classifications, however, may present serious difficulties.

The functional status of the heart is determined by appraising the patient's capacity for physical exertion. There is no simple or accurate clinical test for measuring the functional capacity of the heart. It is estimated chiefly from the history, but sometimes in part from the physical examination. The estimate, obviously, is only approximate and at best represents no more than a well considered opinion. Histories are occasionally unreliable, and physical activity may be curtailed in the absence of abnormal physical signs. A patient may deny shortness of breath upon moderate exertion and become obviously dyspneic upon the slight exertion of disrobing or climbing upon the examining table. The physical findings may be normal in some patients who are incapacitated by angina pectoris or by paroxysms of cardiac arrhythmia. Usually, however, there are abnormal physical findings when the functional capacity of the heart is impaired. The most common causes of disability are cardiac insufficiency and the anginal syndrome. The degree of disability forms the basis for the following functional classification:

Class I.—Patients with a cardiac disorder without limitation of physical activity. Ordinary physical activity causes no discomfort.

Class II.—Patients with a cardiac disorder with slight to moderate limitation of physical activity. Ordinary physical activity causes discomfort.

Class III.—Patients with a cardiac disorder with moderate to pronounced limitation of physical activity. Less than ordinary physical activity causes discomfort.

Class IV.—Patients with a cardiac disorder unable to carry on any physical activity without discomfort.

The therapeutic classification is intended to serve as a guide in the management of cardiac patients. It should be helpful to nurses, teachers and others who need an indication of the amount of activity that a patient may be allowed. It may be found useful in vocational guidance and in the choice of occupation for adults or their placement in industry. It is to be distinguished from the functional classification and may indeed differ widely from it. There is often quite a difference between the amount of physical activity which a patient *can* undertake in terms of his functional capacity, and that which he *should* attempt with respect to the prevention of further cardiac damage and to the assurance of satisfactory improvement. The recommendations regarding physical activity form the basis for the following therapeutic classification:

Class A.—Patients with cardiac disease whose physical activity need not be restricted.

(Continued on Page 1516)

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CLASSIFICATION OF HEART DISEASE

(Continued from Page 1514)

Class B.—Patients with cardiac disease whose ordinary physical activity need not be restricted, but who should be advised against unusually severe or competitive efforts.

Class C.—Patients with cardiac disease whose ordinary physical activity should be moderately restricted, and whose more strenuous habitual efforts should be discontinued.

Class D.—Patients with cardiac disease whose ordinary physical activity should be markedly restricted.

Class E.—Patients with cardiac disease who should be at complete rest, confined to bed or chair.

The practice of making exact and complete diagnoses of cardiac conditions is to be recommended strongly. The diagnoses will have added meaning, will be generally understood by others and will be accepted in hospital, insurance, military and other records. Sound knowledge of heart disease, thorough examination of patients and much precise thinking will be required. The compensation will be large in the satisfaction of a job well done.

A chart of the Nomenclature for Cardiac Diagnoses is available, free of charge, from the Michigan Heart Association. The chart, which is a reprint from the manual "Nomenclature and Criteria for Diagnosis of Diseases of the Heart," covers the Etiological, Anatomical, and Physiological Diagnoses, as well as the Functional Capacity and Therapeutic Classification of cardiac patients.

Just complete and mail the coupon below for your free copy of the chart on Nomenclature for Cardiac Diagnosis.

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Please send me the chart NOMENCLATURE FOR CARDIAC DIAGNOSIS.

Name _____ M.D.

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EISENHOWER ON MEDICAL ISSUES

(Continued from Page 1512)

to help these people to help themselves by allowing a reasonable tax reduction for money put aside by them for their own savings."

Veterans' Medical Care.—The General promised a "firm assessment" of the Veterans Administration's medical care program, stating that charges of deterioration were "seriously disturbing" to him. He added: "I shall exert every appropriate effort to achieve a Veterans Administration program for proper maintenance of its many services and benefits, including the best medical care and facilities available. These matters . . . will be of primary concern to me."

The Republicans have pledged continued support of scientific *Research,* the "encouragement of improved methods of assuring health protection," and the maintenance of a program to stimulate development of adequate *Hospital* services. On *Social Security,* Gen. Eisenhower stated: "We must improve it and extend it . . . Security for old age, unemployment insurance, care for dependent children and widows . . . are moral obligations. But they also are a sound investment . . ."—*AMA Capitol Clinic,* Nov. 11, 1952.

COMMITTEE TO STUDY METHODS OF EVALUATING FEDERAL HEALTH PROGRAMS

At direction of the White House, an inter-agency committee has been formed and shortly will meet to decide what method is to be used to evaluate various health programs for federal employes. The long-range objective, according to T. Roy Reid, committee chairman and personnel director of the Agriculture Department, is "to see if the money we are spending for preventive health services for government employes is paying off."

Under the Randolph-Downey Act of 1946, each agency may set up health services for treatment (restricted to minor conditions, emergencies, or on-the-job injuries or illnesses), for referral to private physicians, and for promotion of education and preventive programs in health. Presently each agency must go to Congress annually to justify its case for funds. This has led, according to Mr Reid, to "heavy administrative red tape."

He said eventually the question should arise whether one central agency, such as the U. S Public Health Service, should be given full control over all federal employe health programs. Such a proposal has been advanced before, but until creation of the Reid committee no official step in that direction had been taken. Serving on the committee are representatives of PHS, Veterans Administration, Civil Service Commission, Post office Department, Army Medical Corps and Budget Bureau.—*AMA Capitol Clinic,* Nov. 1, 1952.

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COBALT	0.006 mg.	CHOLINE	200 mg.
*COPPER	0.7 mg.	FOLIC ACID	0.05 mg.
FLUORINE	3.0 mg.	*NIACIN	6.7 mg.
*IODINE	0.7 mg.	PANTOTHENIC ACID	3.0 mg.
*IRON	12 mg.	PYRIDOXINE	0.6 mg.
MAGNESIUM	120 mg.	*RIBOFLAVIN	2.0 mg.
MANGANESE	0.4 mg.	*THIAMINE	1.2 mg.
*PHOSPHORUS	940 mg.	*VITAMIN A	3200 I.U.
POTASSIUM	1300 mg.	VITAMIN B_{12}	0.005 mg.
SODIUM	560 mg.	*VITAMIN D	420 I.U
ZINC	2.6 mg.		

*PROTEIN (biologically complete)	32 Gm.
*CARBOHYDRATE	65 Gm.
*FAT	30 Gm.

*Nutrients for which daily dietary allowances are recommended by the National Research Council.

Cancer Comment

FOURTH MICHIGAN CANCER CONFERENCE

The Fourth Michigan Cancer Conference, held at the Kellogg Center, East Lansing, on October 9, 1952, drew an attendance of more than 300, by far the largest attendance of any of the conferences yet held. It was sponsored by the Cancer Control Committee, MSMS, and co-sponsored by the Michigan Department of Health and the Michigan Division, American Cancer Society which held its annual Training School at the same time and place.

R. J. Hubbell, M.D., president of the MSMS, welcomed the delegates and reviewed the Michigan cancer problem in some detail. He called for more lay education in order to reduce, if possible, the increasing death rate from this disease. He stressed that continuing education of both the laity and profession was necessary and stated that "as president of your state medical society I am urging the Cancer Control Committee to restudy the cancer problem in this state in co-operation with the two Michigan divisions, American Cancer Society and the Michigan Department of Health in order to see if a more effective program of cancer control cannot be developed."

Freddy Homburger, M.D., Director of Cancer Research, Tufts College Medical School, Boston, Massachusetts, reviewed many of the tests that have been offered in recent years for the diagnosis of cancer. He pointed out their unreliability for their intended purpose without further study of their nature and use. He stated that a few of them held promise of value for certain types of cancer after more study and refinement of technique and quality of product.

Dr. Homburger divided cancer tests into three categories, viz.: screening tests, to be adapted for use with asymptomatic groups; differential diagnostic tests for determining the nature (malignant or not) of any suspicious lesion or symptom; and tests for measuring tumor activity, the latter to specifically determine the extent of recurrence of treated neoplasms in order to gauge the effect to be expected from further therapy.

Dr. Homburger emphasized that any test offered in the cancer field must be reproducible, simple in procedure and of greatest sensitivity so as to produce a minimum of false positive or negative results. His conclusion was that no cancer test yet developed could meet the criteria just mentioned.

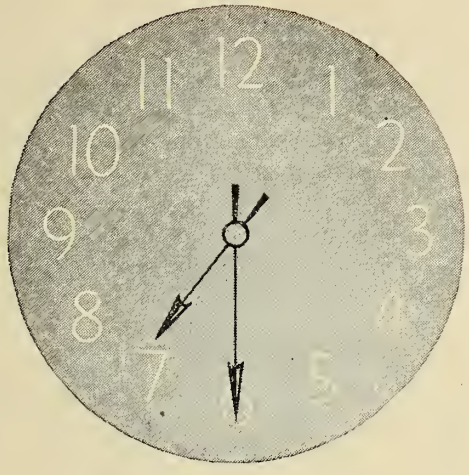
C. Allen Payne, M.D., of Blodgett Hospital, Grand Rapids, pointed to three criteria for proof that progress was being made in cancer control. He emphasized there was less delay between diagnosis and treatment now than formerly, the improvement often being as much as 50 per cent. The five-year survival rate is much greater now than formerly as is also the number of apparent cures. The third bit of evidence that improvements are being made in cancer control was presented from Connecticut statistics which have shown a rather consistent downward trend in the age-adjusted death rate for cancer in women in that state.

Dr. Payne stated that "the increase in incidence of cancer in many areas of the United States reflects the improvement in diagnostic and treatment facilities and must be looked upon as an encouraging sign rather than evidence that we are losing the battle. There are many incidents and experiences in the work of physicians that are convincing beyond doubt that definite progress has been and is being made against this important public health problem."

Otto K. Engelke, M.D., Health Officer, Washtenaw County, discussed the part the health department should play in the cancer control program. He defined the legally prescribed duties of health departments as "diagnosing and recommending treatment and prevention for community ills and health hazards much as a practicing physician diagnoses and recommends treatment and preventive treatment for a patient." He stated that effective planning for cancer control was handicapped by poor reporting of the disease. Without knowledge of the extent of the disease, no adequate control measures can be set up.

Dr. Engelke concluded that "the most productive health department effort in the entire cancer field, at this time, appears to be in public educa

(Continued on Page 1520)



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FOURTH MICHIGAN CANCER CONFERENCE

(Continued from Page 1518)

tion for early diagnosis and prompt, proper treatment."

The concluding paper was given by Miss E. Margaret Siebert of Lansing, representing the Michigan Federation of Business and Professional Women, Inc. Her subject, "Cancer Control—the Price and the Payoff," was directed toward the layman and her arguments were all centered on showing the intelligent layman what a small amount of time and expense was needed to give him much security against a fatal experience with cancer. She urged everyone to learn the seven danger signals of cancer and to consult his physician promptly if or when any one of them appeared. She urged further that everyone have a periodic examination for the added protection of early diagnosis such an examination would provide.

Miss Siebert emphasized that people give more attention to their motor cars than to themselves; that many women spend far more on cosmetics than they do on protection from cancer and other diseases. She stated that "an individual's cost to society up to graduation from college or until he gains maturity is at least $20,000.00." She said that "we care for our pets far more conscientiously than we do for ourselves." Her closing plea was "to take a little time and spend a little for the most precious thing in your life—your health."

The morning program was followed by a luncheon and question period directed at the morning speakers.

The papers given at this Conference will appear in the Cancer Number of THE JOURNAL MSMS early next year.

Discriminating medical writers avoid the phrase, "treat the cancer," and choose instead the expression, "treat the *patient* with cancer." This distinction is not so much one of rhetoric as one of philosophy. It is the *whole* patient for whom treatment is designed.

* * *

There is no evidence that careful incisional biopsy ever increases rate of tumor growth or incidence of metastasis.

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There is no reason to believe that publicity has increased the incidence of cancerphobia.

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There is no more reason to guess at the diagnosis of accessible tumors than to assume the treatment of bacterial diseases without using available diagnostic and specificity tests.



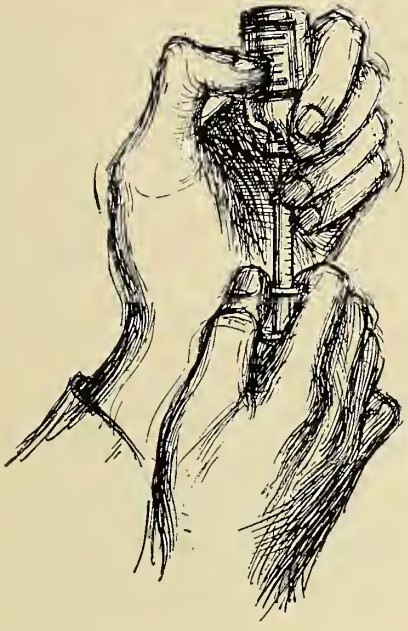
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July 14	L. A. Pratt, M.D., Detroit	Medical Associates
July 18	J. E. Croushore, M.D., Detroit	Tonsils
July 25	Frank Van Schoick, M.D., Jackson	Rheumatic Heart
August 1	O. C. Foster, M.D., Detroit	Pre-Natal and Post-Natal Care
August 8	O. D. Stryker, M.D., Mt. Clemens	Infectious Diarrhea
August 15	E. G. Merritt, M.D., Detroit	Home Nursing Programs
August 22	A. H. Whittaker, M.D., Detroit	Industrial Health
August 29	J. C. Montgomery, M.D., Detroit	Pre-School Clinics
September 5	J. I. Hauser, M.D., Detroit	Colds and Antihistamines
September 12	G. C. Thosteson, M.D., Detroit	Diabetes
September 19	Carleton Dean, M.D., Lansing	Crippled Children
September 26	Harold Henderson, M.D., Detroit	Fears of Pregnancy
October 3	A. T. MacGregor, M.D., Brighton	Value of Small Hospitals
October 10	J. J. Lightbody, M.D., Detroit	New Arthritis Theories
October 17	W. B. Cooksey, M.D., Detroit F. D. Johnston, M.D., Ann Arbor	Cardiac Catheterization and Surgery
October 24	Jack Rom, M.D., Detroit	Allergies
October 31	R. W. Waggoner, M.D., Ann Arbor	Emotional Factors and Diseases
November 7	J. S. DeTar, M.D., Milan	Michigan Rural Health Council
November 14	A. W. Strom, M.D., Hillsdale	Hillsdale Cancer Detection Plan
November 21	B. E. Brush, M.D., Detroit	Goiter and Iodized Salt
November 26	Gordon H. Scott, Ph.D., Wayne Univ., Detroit O. O. Beck, M.D., Birmingham	Funds for Wayne University
December 5	W. S. Reveno, M.D., Detroit	Modern Preventive Medicine
December 12	F. A. Weiser, M.D., Detroit	Problems in Living Longer
December 19	H. B. Zemmer, M.D., Detroit	Rural Medical Service and Health
December 26	E. J. Hill, Jr., M.D., Detroit	Plastic Surgery

1952

January 2	J. G. Molner, M.D., Detroit	Health in Detroit
January 9	E. D. Spalding, M.D., Detroit	Diet
January 16	A. E. Schiller, M.D., Detroit	Skin Diseases
January 21	L. W. Hull, M.D., Detroit	Urology
February 4	F. J. Fischer, M.D., Detroit	Care of the Feet
February 11	H. B. Fenech, M.D., Detroit	Surgical Rehabilitation
February 18	O. K. Engelke, M.D., Ann Arbor	Public Health and Preventive Medicine
February 25	F. D. Johnston, M.D., Ann Arbor C. R. Lam, M.D., Detroit R. F. Ziegler, M.D., Detroit	Heart Research in Michigan
March 3	H. W. Woughter, M.D., Flint	Veteran Amputees
March 10	R. H. Pino, M.D., Detroit	Doctors and Insurance Health Plans
March 17	J. L. Kubanek, M.D., Dearborn	Nervous Breakdowns
March 24	J. E. Livesay, M.D., Flint	Radiology
March 31	H. A. Price, M.D., Detroit	Underweight Patient
April 7	Carleton Dean, M.D., Lansing	Crippled Children's Commission
April 14	C. E. Umphrey, M.D., Detroit	Tumors
April 21	F. E. Ludwig, M.D., Port Huron	Mental Health of Youngsters
April 30	E. C. Long, M.D., Monroe	Appendix
May 7	H. L. Weston, M.D., Detroit	Care of the Eyes
May 14	L. G. Waggoner, M.D., Detroit	Bronchoscopy
May 21	J. E. Livesay, M.D., Flint A. L. Tuuri, M.D., Flint	Mott Foundation
May 28	E. A. Osius, M.D., Detroit	Hernia
June 4	D. H. Kaump, M.D., Detroit	What You Should Know About Your Blood
June 11	B. M. Harris, M.D., Ypsilanti Mr. Daniel E. Ford, Detroit	Gall Bladder
June 18	J. L. Posch, M.D., Detroit	Normal Hands
June 25	O. B. McGillicuddy, M.D., Lansing	Care of the Ears
July 2	R. J. Mason, M.D., Birmingham	Pediatrics
July 16	G. C. Penberthy, M.D., Detroit	First Aid
July 23	I. J. Hauser, M.D., Detroit	Smoking
July 30	D. B. Wiley, M.D., Utica	Safety in Childbirth

1952

August 6	L. Dell Henry, M.D., Ann Arbor	Care of Ears and Nose in Children
August 13	G. V. Conover, M.D., Flint	Cataract
August 20	H. M. Bishop, M.D., Saginaw	Liver
August 27	Henry Turkel, M.D., Detroit	Biopsy
September 1	FILM SHOWN	Lucky Junior
September 8	G. E. Millard, M.D., Detroit	Peptic Ulcer
September 15	C. A. Ludwig, M.D., Port Huron	Advancement of Medicine
September 22	J. R. Rodger, M.D., Bellaire	MSMS Annual Session
September 29	C. P. Mehas, M.D., Pontiac	Alcoholism
October 6	A. E. Palmer, M.D., Detroit	Care of the Skin
October 13	G. T. McKean, M.D., Detroit	Tuberculosis
October 20	Louis Jaffe, M.D., Detroit	Civil Defense Medicine
October 27	Arch Walls, M.D., Detroit	Do's and Dont's for Colds
November 3	R. J. Elvidge, M.D., Detroit	Gastro Disturbances of Alimentary Canal
November 10	J. B. Blodgett, M.D., Detroit	Heart Surgery
November 17	W. M. LeFevre, M.D., Muskegon	Detection of the Diabetic
November 24	Howard Lewis, Ph.D., Ann Arbor	Amino Acids

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*Hyman, H. T., "An Integrated Practice of Medicine," page 3082, W. B. Saunders, 1946

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Annual Session Echoes

MSMS REGISTRATION RECORD SHATTERED AT DETROIT SESSION

A new attendance record was established at the 1952 MSMS Annual Session, September 24-25-26, 1952. A total of 3,605 persons was marked up at the 87th Annual Session of the Michigan State Medical Society!

The breakdown of this all-time-high registration is as follows:

Doctors of Medicine	2,163
Guests	419
Exhibitors	507
Woman's Auxiliary members	273
Medical Assistants members	243
Grand Total	3,605

THANKS TO CONVENTION WORKERS

The Council of the Michigan State Medical Society, at its September 26, 1952, meeting in Detroit, placed on its minutes a vote of thanks to all who helped make the Eighty-seventh Annual Session in Detroit such an outstanding success. Deserving special commendation are: Arch Walls, M.D., Detroit, General Chairman of Arrangements; R. A. Johnson, M.D., Detroit, Chairman, E. C. Long, M.D., Detroit, W. S. Reveno, M.D., Detroit, A. E. Schiller, M.D., Detroit, and C. L. Weston, M.D., Owosso, who composed the hard-working Scientific Press Relations Committee; R. A. Johnson, M.D., Detroit, Chairman, R. H. Baker, M.D., Pontiac, H. F. Dibble, M.D., Detroit, L. Fernald Foster, M.D., Bay City, and J. E. Livesay, M.D., Flint, members of the House of Delegates Press Relations Committee.

Ubiquitous Hosts.—The ubiquitous hosts, whose names were listed in the November JOURNAL on page 1472, did a wonderful job proving to our guest speakers from all parts of the United States that Michigan is one of the most hospitable states in the Union and that its medical men appreciate the contributions to science made by our esteemed guest essayists.

Chairmen and Secretaries of Assemblies.—D. R. Boyd, M.D., Muskegon; P. S. Bradshaw, M.D., Muskegon; R. S. Breakey, M.D., Lansing; C. J. Courville, M.D., Detroit; R. L. Fitts, M.D., Grand Rapids; B. M. Harris, M.D., Ypsilanti; T. V. Hoagland, M.D., Detroit; L. W. Hull, M.D., Detroit; W. S. Jones, M.D., Menominee; A. H. Miller, M.D., Gladstone; J. G. Molner, M.D., Detroit; and Ralph W. Shook, M.D., Kalamazoo.

Discussion Conference Leaders.—L. J. Hirschman, M.D., Traverse City; W. S. Reveno, M.D., Detroit, and C. S. Stevenson, M.D., Detroit.

Richard A. Aubrey, Detroit, loaned by the E. I. du Pont de Nemours & Co., Inc., for the entire period of the Annual Session, rendered untiring service both day and night.

The MSMS public relations activities gained many aides during the convention including those who arranged for TV, radio and service club appearances. Special thanks are due the managers of the Detroit radio and television stations, who made special program time available and included reports of MSMS activity in regularly scheduled broadcasts: WJBK, WJBK-TV, WWJ, WWJ-TV, WXYZ-TV, WJR, CKLW, and of the Kalamazoo station, WKZO.

The generous supplies of notebooks distributed to registrants at the 1952 Annual Session were contributed by the Bruce Publishing Company of Saint Paul and the Michigan Medical Service, Detroit.

WHAT THEY THOUGHT OF THE 1952 MSMS ANNUAL SESSION

John J. Bonica, M.D., Tacoma, Washington (Guest Essayist): "I want to thank you most sincerely for a very enjoyable time during the recent annual meeting of the Michigan State Medical Society. As I mentioned to you at that time I think it is the best organized State meeting I have attended and the courtesies extended to guest speakers cannot be surpassed. Your entire organization should be complimented for a job very well done."

George Crile, Jr., M.D., Cleveland, Ohio (Guest Essayist): "I enjoyed the meeting very much. With best regards."

Ormond S. Culp, M.D., Rochester, Minnesota (Guest Essayist): "It was a great pleasure to return to Michigan and participate in the meeting

(Continued on Page 1526)

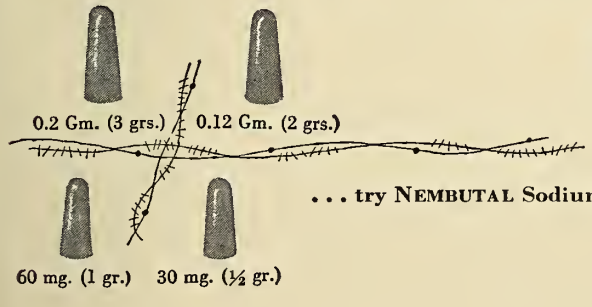
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WHAT THEY THOUGHT OF THE 1952 MSMS ANNUAL SESSION

(Continued from Page 1524)

of your State Society. As usual the hospitality of the organization was incomparable and I enjoyed my visit immensely. I thank you again for the invitation and best wishes to you and the Society."

Edwin J. DeCosta, M.D., Chicago, Ill. (Guest Essayist): "May I thank the Society for the fine hospitality shown to Mrs. DeCosta and to me, which we both appreciate."

Carl W. Eberbach, M.D., Milwaukee, Wisconsin (Guest Essayist): "Returning to Detroit to join and enjoy a visit with my friends there gave me more pleasure than a reunion back at Ann Arbor. I am deeply grateful to you for assigning me to Dr. Gene Osius as my 'ubiquitous host.' His gracious hospitality, together with an excellent program which I understand is routine under your direction, far exceeded anything experienced elsewhere at similar meetings. This opinion is also held by many other men who have had the pleasure of taking part in your programs. With kindest personal regards."

Milton I. Levine, M.D., New York, New York (Guest Essayist): "I want to you to know just how much I enjoyed my visit to Detroit as a guest speaker at your Annual Meeting. The visit was certainly one of the most pleasant experiences in my career. Dr. Glen Hause was a perfect host and everything was done to make the day in Detroit one I will not forget."

Roland P. Mackey, M.D., Chicago, Ill. (Guest Essayist): "I wish to thank you for your gracious hospitality and attention to me on my recent trip to Detroit. With all the guidance and help that I received both from Dr. Benjamin Jeffries and Dr. Edwin DeJongh there wasn't the slightest possibility that I could make any mistakes. It was indeed a pleasure to be with you in Michigan and to meet so many keen and interested physicians whose attention to my talks was both stimulating and flattering. With best wishes to you and all the others."

S. F. Marshall, M.D., Boston, Mass. (Guest Essayist): "I thoroughly enjoyed the meeting which I thought was very well handled. May I express my great appreciation for your kindness to me while in Detroit."

Earl R. Miller, M.D., San Francisco, California (Guest Essayist): "I thoroughly enjoyed my visit to Detroit and the opportunity to meet and speak before your Michigan State Medical Society. Again I thank you for asking me."

Emil Novak, M.D., Baltimore, Maryland (Guest Essayist): "I enjoyed the meeting immensely, and thought it was an unusually fine one. With thanks for the hospitality and courtesy extended to me during my visit."

Duncan E. Reid, M.D., Boston, Massachusetts (Guest Essayist): "I enjoyed my visit with the Michigan State Medical Society and appreciate having been asked to speak before such a fine group. Thank you again for making my visit so enjoyable."

David A. Rytand, M.D., San Francisco, California (Guest Essayist): "Please accept my thanks again for the superb organization relative to arrangements for your 87th Annual Session of the Michigan State Medical Society. You so successfully continue your impressive attention to detail. You should be very proud of the efficiency and hospitality exhibited by your colleagues. I shall always remember my pleasant visit to Detroit, and hope to renew our acquaintance."

Philip Thorek, M.D., Chicago, Ill. (Guest Essayist): "I want to take this opportunity to congratulate you upon the great success of your recent meeting. Speaking to this group was most stimulating to me and I sincerely appreciated their interest. With warmest personal regards."

Claude E. Welch, M.D., Boston, Mass. (Guest Essayist): "The meeting certainly appeared to be very successful to me and the audience very appreciative."

Hendrik De Kruif, M.D., Fergus Falls, Minnesota (guest): "I wish to express to you my most sincere thanks for your hospitality at the meeting September 24. It was nice of you to be so good to a poor out-of-stater and I assure you that I had a fine time even though my stay was short."

Mrs. William Mackersie, Detroit (President, Woman's Auxiliary to the Michigan State Medical Society): "Please convey to the Michigan State Medical Society my thanks and appreciation for the lovely orchid which I received during the Convention. It was worn with a feeling of pride

(Continued on Page 1528)



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WHAT THEY THOUGHT OF THE 1952 MSMS ANNUAL SESSION

(Continued from Page 1526)

and a hope that in the year ahead I may guide the Auxiliary in a manner worthy of my predecessors and that the Auxiliary may fulfill, in an ever-increasing degree, its purpose to be of assistance to the Michigan State Medical Society."

Louis J. Hirschman, M.D., Traverse City (Past President, MSMS): "Thank you for your note about the 'vote of thanks' from The Council for my slight service as moderator on September 24. I was quite pleased at the attendance and interest shown. Six of the eight speakers on the day's program were present, and all participated. It was a grand meeting. It stands out as one of the best organized, best conducted, and best attended medical meetings in the entire nation."

E. A. Osius, M.D., Detroit (Ubiquitous Host): "Let me tell you again how excellently the meeting was run and how many wonderful comments I had on the MSMS Annual Session and how it was handled. Guest Speaker Eberbach of Milwaukee was extremely impressed, particularly with the ubiquitous host idea."

Mrs. George L. Stokes, Flint (Beaumont's great-grand neice): "It was a great honor for me to be invited to unveil such a beautiful painting of Dr. Wm. Beaumont and to know that the Medical Society feels that Mr. Stokes and I fully co-operated with their plans. It really has made me feel like being with you in anything at any time or any place concerning Dr. Beaumont that will be of any service to your Society. The Medical Society will never know what this has all meant to me, something I shall never forget. Thanking you and the Medical Society for the lovely day and evening we were shown, everything was just perfect."

Homer D. Strong, Detroit (Executive Secretary, Wayne University Alumni Association): "May I express to you our deep appreciation for the assistance which Dr. Foster, Mr. Burns and Miss Schulte have given the Wayne University Medical Alumni during the MSMS Annual Sessions. Not only did they make the reservation for our alumni dinner and alumni headquarters, but they extended every courtesy to us during the meetings. It is indeed a pleasure to work with such friendly and efficient people. We had 110 at our alumni dinner in the English Room and registered over 400 alumni during the Sessions."

H. A. Berry, Armour Laboratories, Chicago (exhibitor): "I would like to take this opportunity to tell you how much I appreciated your courtesies at the meeting last week. Your special invitation to the Liaison Committee's dinner, pre-dinner festivities, as well as the exhibitors' grid-iron dinner was very nice and I certainly enjoyed being there. The entertainment was super! All in all, I believe it was one of the best Michigan State Meetings that I have ever attended as well as one of the best medical conventions I have been to. The reception and the response of the physicians was wonderful."

K. E. Brouwer, Armour Laboratories, Grand Rapids (exhibitor): "I would like to tell you what a wonderful meeting you arranged last week in Detroit. As an exhibitor I have always enjoyed the Michigan State meeting. This meeting was one of the best. I always look forward to your meeting. If I can ever be of any service please contact me."

W. C. Ayer, Brooks Appliance Company, Chicago (exhibitor): "Your State meeting at Detroit this year was very satisfactory."

S. S. Burnett, Brown & Williamson Tobacco Corporation, Louisville, Ky. (exhibitor): "Once again, as in the case of all Bill Burns' meetings, the Detroit session was a highlight of our schedule for 1952. In addition to being satisfactory, we have reason to believe that it was also profitable. As for the 1953 meeting to be held in Grand Rapids, let us assure you that we look forward with a great deal of pleasure to being with you again."

James T. Beers, The Coca-Cola Company, Atlanta, Georgia (exhibitor): "Congratulations on another fine Michigan State Medical meeting. We consider your meeting one of the best and will be looking forward to seeing you next year."

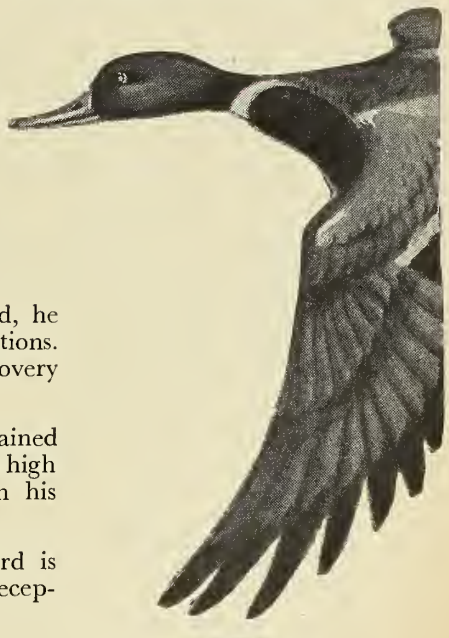
Frank M. Rhatigan of Davis & Geck (exhibitor): "Nothing but the highest praise for your September meeting—which I understand was the record-breaker—and I am very happy."





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Michigan Attracting Many New M.D.'s

Two Hundred Sixty-two Endorsed in Four Months

One hundred twenty-one doctors of medicine from other states were endorsed to practice medicine in the State of Michigan during the four-month period ending August 31, 1952, according to a report from J. Earl McIntyre, M.D., Lansing, Secretary of the Michigan State Board of Registration in Medicine.

Among doctors so licensed are:

William E. Avery *(Creighton)*; John W. Vincent *(Creighton)*; Freda A. Dunnam *(Louisiana State University)*; Robert G. Farris *(Southwestern Medical School)*; Henry L. Floyd *(Ohio State University)*; Peter J. Trinca *(University of Arkansas)*; Jerome S. Weingarten *(Medical College of Alabama)*; Ernest H. Jensen *(Jefferson Medical College)*; Robert E. Gunning *(University of Chicago)*; Philip E. Yunker *(Indiana University)*; Martin G. Vorhaus *(New York University)*; Arthur A. McMurray *(University of Texas)*; Owen W. Doyle *(Yale University)*; Richard M. Lott *(University of Rochester)*; Kenneth J. Moss *(University of Illinois)*; Andrew L. Hockstral *(University of Colorado)*; Stewart G. Belote *(University of Louisville)*; Nils O. Agneberg *(Northwestern University)*; Natalia M. Tanner *(Meharry Medical College)*; Mary K. Irving *(Syracuse University)*; George P. Graf *(University of Wisconsin)*; Raymond G. McDonald *(Creighton)*; Thomas B. Fitzpatrick *(Harvard Medical School)*; James L. Salomon *(Northwestern University)*; John B. Cleveland *(University of Chicago)*; Elihue B. Potts *(Howard University)*; Keene M. Wallace *(George Washington University)*; Rachel H. C. Boone *(Boston University)*; Robert C. Behan *(Long Island College of Medicine)*; Brita R. McLean *(Duke University)*; George H. Jennett *(Howard University)*; Jack Romascan *(New York University)*; Edwin G. Trytten *(Rush Medical College)*; Mary A. Guyon *(Marquette University)*; Howard A. Novell *(Ohio State University)*; David L. E. Reive *(Tulane University)*; Theodore E. Cox *(Western Reserve University)*; William W. Christeson *(University of Arkansas)*; Robert W. Gillespie *(University of Nebraska)*; Edward J. Sunday *(Meharry Medical College)*.

Francis X. Sweeney *(Temple University)*; Alfred Wascolonis *(University of Pennsylvania)*; Mark Nickerson *(University of Utah)*; John L. Wiese *(Northwestern University)*; Noah M. Dixon *(Northwestern University)*; Linn A. Campbell *(Northwestern University)*; William J. West *(Jefferson Medical College)*; Robert Rapp *(Temple University)*; Leon D. Comstock, Jr. *(University of Chicago)*; Ralph E. Carlson *(University of Illinois)*; John W. W. Epperson *(University of Maryland)*; Robert C. Hunter *(University of Maryland)*; Ernest W. Reynolds *(University of Oklahoma)*; William C. Prevette *(Bowman Gray School of Medicine)*; Trawick H. Stubbs *(Emory University)*; Robert W. Johnson *(University of Nebraska)*; Felix J. Lownick *(Loyola University)*; Carl A. Gardner, *(Syracuse College of Medicine)*; A. Burhan *(University of Istanbul)*; Eugene J. Agnone *(Hahneman Medical College)*; Josephine Y. Sullivan *(University of Virginia)*; Charles R. Marquardt, *(Marquette University)*; Henry A. Perlmutter *(Northwestern University)*; Arnold A. Michals *(College of Medical Evangelists)*; Sidney King *(Western Reserve University)*; Robert J. Horton *(Western Reserve University)*; Anna B. Grey *(University of Chicago)*; James W. Passino *(University of Cincinnati)*; Francis M. Murray *(Vanderbilt University)*; Myron W. Davis *(Washington University)*; David A. Krevsky *(Jefferson Medical College)*; Carl J. Olson *(Northwestern University)*; Wm. F. Jeffries *(Ohio State University)*; Ray R. Goding *(Medical College of Alabama)*; Winifred Oyen *(Temple University)*; Charles F. Thompson *(Indiana University)*; Francis J. Kruse *(University of Colorado)*; Sydney S. Schochet *(Tulane University)*; Douglas Ford, Jr. *(Meharry Medical College)*.

Rosemary M. Dykema *(Johns Hopkins University)*; Thomas H. Snider *(Loyola University)*; Victor R. Hanson *(University of Oregon)*; Billy J. Hill *(University of Nebraska)*; Eugene J. Keeffe *(Louisiana State University)*; Arnold J. Spanjers *(University of Minnesota)*; Joseph A. Cortez *(St. Louis University)*; Joseph L. Fleming *(University of Chicago)*; Lester E. Wolcott *(University of Buffalo)*; D. Kent Hassan *(Indiana University)*; Don C. Pates *(State University of Iowa)*; Oliver R. Hunt, Jr., *(University of Louisville)*; Bert D. Johnson *(Stanford University)*; Eugene I. Plous *(Chicago Medical School)*; Fred J. Hodges *(University of Wisconsin)*; Archie J. Dalgleish *(College of Medical Evangelists)*; Essex Monson *(Meharry)*; Leonard Leight *(Washington University)*; Paul M. Woodward, Jr. *(University of Cincinnati)*; Donald J. Davenport *(College o Medical Evangelists)*; George L. Reno *(St. Louis Schoo of Medicine)*; Archie R. O'Connor *(Northwestern Uni versity)*; Mark E. Heerdt *(University of Buffalo)*; Arthu W. Anderson, Jr. *(University of Nebraska)*; John M Lesesne *(Duke University)*; John M. Tracey *(George town University)*; Waldo L. Cain *(Meharry)*; Lowe J. Durham *(College of Medical Evangelists)*; Arthur M Clark, Jr. *(University of Iowa)*; Kenneth E. Pitts *(Wash ington University)*; Donald R. Schimnoski *(Universit of Minnesota)*; Craig E. Booher *(St. Louis University,* Robert C. M. Wickliffe *(University of Louisville)*; Gra Thorburn *(Columbia University)*; Mary S. Logan *(Joh Hopkins)*; Ahmad J. Majzoub *(University of Tennessee* Kenneth W. Saunders *(College of Medical Evangelists* Joseph D. Carlisle *(University of Minnesota)*; Robe H. White *(New York Medical College)*; Harry C. Geor *(George Washington University)*; David M. Weil *(George Washington University)*; Joseph C. Schael *(University of Wisconsin)*.

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One Hundred Forty-one Licensed After Medical Schooling in Michigan

Additional doctors of medicine, graduated from one of Michigan's two medical schools, who recently were licensed by the Michigan State Board of Registration in Medicine, include:

University of Michigan Medical School.—Drs. Albert D. Ruedemann, Albert G. Reynolds, Walter J. Jaracz, Yuan Mei S. Sun, Francis Fitzsimmons, Dean W. Seger, Wesley V. B. Mikesell, Richard K. Meinke, Charles W. Watson, James M. Fraser, William E. Nettleman, Thomas E. Nesper, Alfred D. Antilla, Richard T. Hammell, Thomas K. Buchanan, Gerald F. Barofsky, Ramon B. Lang, William G. Munich, Richard S. Murphy, John C. Ivanoff, Richard B. Michelson, Winton E. Stephan, Jerome H. Finkelstein, Albert M. Kinkella, Phyllis J. Wells, Richard W. Prior, Doyle E. Wilson, John P. Wicht, Edward R. Weddon, Coleman M. J. Rottenberg, Richard W. Stander, Mary E. N. Bentley, Gilbert W. Hague, Burt A. Parliament, Bruce C. Olsen, David S. Ruskin, Douglas A. Haddock, Robert D. McIntosh, William A. Kretzschmar, William O. Michel, Gloria Kozin, Herbert C. Cantor, Landis C. Stewart, Milton H. Goldrath, Robert C. Davis; Jack E. Portney, Morris Weiss, Max J. Garbert, James R. Marshall, Jr., Charles D. Fess, George E. Block, Marian A. K. Levai, Donald E. McGuire, Benjamin J. Stone, Alfred J. Vande Waa, Richard D. Richards, Jean L. Van Duzen, Thomas V. Hoyer, Robert H. Eich, Fern E. MacAllister, David E. Wile, Cecil W. Castor, Jr., Duane L. Waters, Verne E. Johnson, Nicholas A. Fotias, John T. Hayes, Seymour A. Vander, Martin Sharda, William W. Nicholls, Marvin J. Seven, Fernley Stoneman, Paul E. Doermann, John W. Berghuis, Donald R. Griffith, Douglas W. Erickson, Juliette L. Seelye, Martin D. Jaffe, Jerry K. Jacobsen, George P. Anderson, Arthur J. Rollins.

Wayne University College of Medicine.—Donald B. MacLean, Richard D. Budd, Nicholas Cherup, Elvin E. Olin, John H. Packer, Robert C. Bruder, Albert Boyajian, Robert G. Carrie, Joseph Dobkin, Donald H. Endean, Thomas Huffer, William W. Kitti, Robert A. A. Peterson, Albert H. Schrut, George R. Sewell, John W. Shriner, Donald P. Stratton, Samuel Trupiano, William Westrate, Jr., Richard E. Gibson, Walter C. Peltason, Thomas M. Flake, Edgar J. Gust, Jr., Roy A. Davis, J. Stanley Schultz, William H. Bond, Franklin H. Cox, Michael N. Zelenock, Richard S. Watts, Darwin F. J. Belden, Max Warren, John D. Pool, George H. Reye, David W. Lindner, Manual Sklar, John R. Jones, Paul E. Trudgen, Creighton A. Wagener, Tunis Vanden Berg, Albert Rizzo, Sidney Stone, Harold Wasserman, Ivan J. Mader, Myra J. Horning, Madeleine Lipson, Saul Brown, Roger V. Walker, Jr., George F. Newman, Victor J. Slominski, John H. Yff, Thomas Geoghegan.

Additional lists of doctors of medicine licensed to practice in Michigan will be published in JMSMS from time to time, through the courtesy of the Michigan State Board of Registration in Medicine in supplying lists of all recently licensed M.D.'s.

Cunningham Drug Company Foundation Launched

Founded one year ago, the Cunningham Drug Company Foundation is the most recent and, from the physician's point of view, one of the most interesting additions to the growing roster of philanthropic trusts now serving Michigan.

Deriving its support from Cunningham Drug Stores, Incorporated, which owns and operates 122 retail drug stores in thirty-three Michigan cities, the Foundation by its articles of trust is devoted to the improvement of medical and hospital care, nursing service and nurse education, and medical research.

Mark Neal Beach, since 1948 executive director of the Greater Detroit Hospital Fund, was named executive director of the Foundation last June; and Mrs. Mary Kelly Mullane, R.N., formerly assistant dean of the College of Nursing at Wayne University, became director of the Foundation's nursing program on September 1.

After a six months' survey of the health needs of this area, the Foundation determined that it could make its most important initial contribution in the field of nursing service and nurse education. The present critical nursing shortage, aggravated by the need to staff the many new hospitals soon to be opened throughout Michigan has particularly engaged the Foundation's attention.

As a part of its program to relieve that shortage, the Foundation has embarked upon a nurse-recruitment campaign in co-operation with the Detroit Council of Community Nursing designed to increase the enrollment in both professional schools of nursing and practical nurse training centers.

Trustees of the Foundation include Nate S. Shapero, president of Cunningham Drug Stores, Inc.; Charles T. Fisher, Jr., president of the National Bank of Detroit; Fred J. Kennedy, prominent Detroit attorney; and Ches B. Larsen and Sumner L. Prior, of the Cunningham drug chain.

Assisting the foundation in the formulation of its over-all plans for improvement of nursing service and nurse education is a newly formed advisory committee consisting of Julien Priver, M.D., director of Sinai Hospital, Detroit; Frank A. Weiser, M.D., director of education and research at Detroit's Grace Hospital; Katharine Faville, R.N., dean of the College of Nursing at Wayne University; Elizabeth S. Moran, R.N., director of nursing at Henry Ford Hospital; Emilie G. Sargent, R.N., executive director of the Visiting Nurse Association of Detroit; and Marion Wright, R.N., associate director of Detroit's Harper Hospital.



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AMA News Notes

ANNUAL CONGRESS ON INDUSTRIAL HEALTH

Improving health services of our nation's working force will be the over-all theme of the Annual Congress on Industrial Health, sponsored by the AMA's Council on Industrial Health. Workers, industrial leaders and medical men will assemble for this thirteenth annual conference January 21-22 at the Drake Hotel, Chicago.

Highlights of the Congress include sessions on small plant industrial health services, human relations, and aspects of occupational cancer. One important session will endeavor to answer the question—how can management, labor and medicine best help maintain the health of our national work force?

On Tuesday, January 20—the day before the Congress convenes—a joint conference will be held for members of the Council and chairmen of state society committees on industrial health. Tuesday afternoon's program will be devoted to round-table discussions stressing three main areas of industrial health—education, service and research. Gradie R. Rowntree, M.D., chairman of the committee on industrial health of the Kentucky State Medical Association, will preside.

AMA'S STORY OFF THE PRESSES

A new pamphlet—"The AMAzing Story"—prepared by the American Medical Association, gives the general public a brief summary of the ways in which the AMA serves an average American family. This booklet pictorializes the many ways the Association serves Mr. and Mrs. Joe Typical and family. The pamphlet will be distributed to all AMA members December 1.

NEW MEDICAL CARE EXHIBIT

The story of how local medical societies bring medical care and medical services to more and more American people is the subject of a new exhibit which is nearing completion by the AMA's Bureau of Exhibits. "You and Your Medical Care" exhibit, features emergency call services, voluntary health insurance, early detection and prevention of such diseases as cancer and TB, community health councils, grievance committees and sources of health education information.

A separate unit has been designed for each subject, making the exhibit suitable for showings in every community . . . any portion of the exhibit may be omitted if a state or county society has not yet developed a program on a certain subject. The exhibit will be available shortly after the first of the year.

STUDENTS READ "TODAY'S HEALTH"

"Today's Health" magazine is taking its place with regular textbooks on the college campus. More than 1,300 freshman physical education students at the University of Illinois at Champaign-Urbana are reading the magazine as part of their regular classroom assignment. A special supplementary study sheet called "Classroom Discussion Topics" is being supplied free of charge by the AMA's Bureau of Health Education as an aid to classroom discussion.

EXHIBIT CATALOG NOW AVAILABLE

If your medical society is anticipating displaying health exhibits at local fairs and meetings during the coming year, you'll be interested in the attractive new exhibit catalog prepared by the AMA's Bureau of Exhibits. This booklet carries pictures of twenty-five different health exhibits, with brief descriptions and such installation data as the minimum space and electrical requirements and shipping weights. All of these exhibits are available on a loan basis from the Bureau. The booklets are being mailed to secretaries of state medical associations for distribution to county societies.

"APPARATUS ACCEPTED" AVAILABLE

The 1952 edition of "Apparatus Accepted," a publication of the AMA's Council on Physical Medicine and Rehabilitation. will be available December 15. The sixty-page booklet includes a complete listing of diagnostic and therapeutic devices which have been accepted by the Council. Among other things, the booklet lists such items as audiometers and hearing aids, electrocardiographs, oxygen therapy apparatus, incubators, inhalers and resuscitators, and metabolism testing equipment. Copies may be secured on request through the Council.

STATE AMEF CHAIRMEN TO MEET

American Medical Education Foundation state chairmen will kick off the 1953 fund-raising drive with a meeting Sunday, January 25, at the Sheraton Hotel in Chicago. This second annual meeting will launch officially the medical profession's concerted effort during the coming year to raise voluntary funds to assist the country's medical schools. Keynote speaker will be L. D. McGuire, M.D., AMEF chairman for Nebraska.

Chief value of the meeting will be to exchange experiences and ideas on local fund-raising promotions. Representatives from every state will be on hand for the one-day session.


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HELICOPTER AMBULANCE UNITS FOR EVACUATION OF CRITICALLY WOUNDED

Helicopter ambulance units, designed to evacuate critically wounded patients from forward combat areas, have been authorized as an integral part of the organization of the Army Medical Service in the theater of operations, the Department of the Army announced today.

Helicopters have been used since early in the Korean conflict to rush severely injured soldiers from battalion aid stations or regimental collecting stations to mobile Army surgical hospitals and rear-area evacuation hospitals, but they have not previously been incorporated in formal Medical Service field-type units.

The new units will supplement rather than replace conventional means of evacuation, including litter jeeps and ambulances. All patients except those requiring emergency surgery or other definitive care will continue to be evacuated in vehicles where ground evacuation is feasible.

Helicopter ambulance units will include five two-rotor utility helicopters capable of carrying three litter patients or four ambulatory patients, together with a medical attendant and a pilot. The craft will be flown by Medical Service Corps lieutenants who have received training in basic aviation and helicopter operation at the Army's aviation flight training center at Fort Sill, Oklahoma.

Medical Service Corps officers are being encouraged to apply for helicopter training although precise starting dates for pilot classes cannot yet be given due to sweeping modifications now being made in the training program.

Applicants without previous military or civilian flying experience are being accepted for the program provided they are physically qualified for flight duty and have not passed their thirtieth birthday. Training will be conducted at Fort Sill alone, rather than being divided between Fort Sill and San Marcos Air Force Base, Texas, as previously planned. The first helicopter pilot class to include Medical Service Corps officers opened at Fort Sill October 6 for a nineteen-week session.

In addition to the five pilots, the new units will have a Medical Service Corps captain as commanding officer, an operations officer and twenty-one enlisted technicians. Maintenance personnel assigned to the unit include five helicopter mechanics, one aircraft welder, one airframe mechanic and an operational maintenance technician. Medical aidmen, supply specialists and administrative personnel will also serve with the organization.

The first helicopter ambulance unit is being activated at the Medical Field Service School, Fort Sam Houston, Texas, where it will be used for training purposes. Additional units will be formed in Korea and elsewhere as personnel and equipment become available.

PILOT PROGRAM OF MEDICAL EDUCATION FOR DEFENSE

All first-year students at the University of Illinois College of Medicine are participating this fall in a pilot program of Medical Education for National Defense. This long-range program is designed to be "an acceptable substitute" for the Reserve Officers Training Program in medical schools.

The University of Illinois has been allocated $15,000 by federal agencies to underwrite the costs of the program during this academic year. Similar pilot programs are being conducted at four other medical schools—University of Buffalo School of Medicine, Vanderbilt University School of Medicine, Cornell University Medical College, and the University of California School of Medicine.

An objective of the program is to enable medical students to gain a better understanding of the role of the physician in society, including the responsibility for the medical programs of the armed forces.

At the present time, first-year students are enrolled in a course in "Emergency Surgery" which is being offered by Dr. John Van Prohaska on Monday afternoons. In connection with this course, two medical students are assigned each evening to the emergency service at Cook County Hospital. There, they serve as observers on MEND clerkships.

Clinical sessions in anatomy, biological chemistry, and physiology also are integrated into the program. For example, the Department of Anatomy is devoting its regular one-hour clinical session each Friday to presentation of cases or examples of peripheral nerve injuries, burns, fractures, infections, vascular and corneal grafts, injuries to blood vessels, concussion, and cold injury. These clinical presentations are timed appropriately with the students' study of nerves, epithelium, bones, connective tissue, blood vessels, and the central nervous system, et cetera.

Dr. George V. Byfield, clinical assistant professor of medicine, is serving as co-ordinator of the University of Illinois' pilot program. Serving in an advisory capacity are Dr. Mark H. Lepper, associate professor in charge of preventive medicine, and Dr. William V. Whitehorn, associate professor of physiology.

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Editorial Comment

EFFECTS OF BASIC SCIENCE LAWS

In the editor's comprehension of the subject of the basic science laws, it has remained for Michigan to present a rather exhaustive study with arguments favoring the revocation of that state's basic science law as it applies to the legal practice of medicine in Michigan. The question of a basic science law for Pennsylvania has been raised occasionally, but has never been given serious consideration. Believing that some of our readers will be interested in a discussion that proposes the repeal of such a law by a state in which it has been effective for fifteen years, we will quote rather freely from the *Michigan State Medical Journal* of July, 1952, wherein we read that the most frequent question asked concerning the proposed repeal of Michigan's basic science law is: "Would not repeal open the gates to those of other schools of practice?"

Franklin L. Troost, M.D., of Holt, Michigan, answered this pertinent question as follows, at the same time developing information on a decrease in the number of doctors entering the practice of medicine in Michigan accompanied by an increase in the number of legal practitioners of osteopathy and chiropractic:

"The gates are wide open now. In 1940 there were 435 osteopaths registered in Michigan; in 1950 this has increased to 907, an increase of over 100 per cent in ten years, during which time the basic science law was in effect. Chiropractors registered in Michigan increased from 492 in 1940 to 747 in 1950, an increase of 50 per cent. There are some 11,000 osteopaths in the United States. On a population basis, we should have about 4 per cent of them. Actually we have between 8 and 9 per cent, and all this has come about with our basic science law in full effect. Does our law keep them out? Most definitely not. People will ask 'How do those of other schools get into the state, then?' A few come in by examination, most of them by reciprocity in basic science with Minnesota, Nebraska, and Arkansas —chiefly Minnesota. In 1949 Michigan issued 126 basic science certificates by reciprocity—only thirty-eight of these to medical doctors, the rest being to osteopaths, chiropractors, and unclassified. It must be granted that if our law were repealed we would probably have more than ever of the other schools for a short while. Soon, however, our state would secure enough medical doctors and the situation would take care of itself. Many people are cared for by non-medical men because there is no medical care available.

"States without basic science laws are not over-loaded with those of other schools. Illinois has 12,795 medical doctors and less than 500 osteopaths. Ohio has 9883 medical doctors and less than 500 osteopaths. Neither state has a basic science law. When there is enough medical care available, the other types of practitioners fade away to a large extent.

"Let no one think that basic science is popular throughout the country. While nineteen states and the District of Columbia have such laws, many of them are very small states. In 1950 there were 201,277 medical doctors in the country. Only 50,787 of them were located in the basic science states. In other words, when a young doctor wants to locate, there are three places out of four to which he can go without bothering with a basic science examination. No wonder they pass us by.

"In the last decade, Michigan's population was increased by 1,115,660 people. During this same period, Michigan's increase of physicians numbered only 575. That is only one new medical doctor to about 2,000 new citizens in our state. If we take the national average of one doctor to every 749 people, our physician increase should have been 1489.

"Where are we going to secure the 1500 doctors that we are now lacking? Where will the replacements come from for the 150 to 200 Michigan doctors who die or retire each year? Where will the 143 (one for every 749 people) doctors come from to serve the annual population increase of 110,000 a year? If we could secure 500 medical replacements a year for a period of ten years, we would finally get up to a national physician-population ratio. Of this 500 needed, we secured only 186 in 1950. The answer as to where the needed doctors are coming from is that they are not coming—not coming until we become realistic and repeal the basic science law."

In Rebuttal

In the same issue of the *Michigan State Medical Journal* appears a reply to Dr. Troost's article by Edward D. Spaulding, M.D., Detroit, Michigan, who maintains that the law fundamentally is a good one in which certain modifications should be made; furthermore, that the primary difficulties pointed out by Dr. Troost were not in the basic science law but in its administration on the one hand, and in the medical practice act on the other.

In the 1951 Michigan House of Delegates, after prolonged debate, a special study committee was authorized on the subject of revocation. After hearing this study committee's report, the House of Delegates voted against repeal and for modification of the Michigan basic science law.

Subsequently, Michigan's legislative bodies passed and the governor signed the amended basic science act, which has six changes, the most important of which are: (1) elimination of examinations in "hygiene and public health" (to be

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EFFECTS OF BASIC SCIENCE LAWS

(Continued from Page 1538)

in conformity with a number of other states); (2) not requiring re-examinations in those subjects previously passed; (3) not construing the act to apply to interns and residents in training in Michigan hospitals; (4) requiring the Board of Examiners to file with the Secretary of State each January a list of all those certified during the preceding year. (It should be noted that the state medical practice act was amended at the same time.)

The modification of these two acts does away with the basic difficulties previously encountered and leaves the law, with the proper restrictions, to operate as was the intent when originally passed. —Editorial, *The Pennsylvania Medical Journal,* September, 1952.

HEALTH INSURANCE PREMIUM WAIVER

Can the medical, hospital insurance policy holders be protected as to premium payments when he is unemployed or otherwise unable to meet his obligation?

It is being demonstrated daily that superior medical care can be delivered to the American people through the medium of the voluntary, prepaid plans, such as Blue Shield and Blue Cross. And, it is being done without resorting to mass care techniques, without dictation to the patient as to choice of doctor or without a waiting period for the decision of a bureau when a citizen wishes to "fire" his doctor or desires the services of a specialist. Both the patient and the doctor remain as free as thought, under our voluntary prepaid plans. And, the patient is pleased with the service he is getting and the way in which it is delivered to him. The steady increase in enrollment in the voluntary plan is the undeniable evidence of its success. This success is all the more remarkable because it has been achieved in spite of some justifiable worries that beset the policy holders. They worry about the day when unemployment may overtake them and protection is lost because the program, carried by the employer or the employe, lapses for non-payment of the premium or because the group advantage has become inoperative. They worry about being able to pay the premium when retirement comes; when income depends on a fixed pension or, worse still, on Social Security alone. And, such worries are well founded.

By paying a relatively small additional amount, it is possible to protect one's life insurance against periods of total disability—or it is possible to arrange premium payments in such a way that one need not pay beyond a stipulated number of years, e.g., a Twenty Pay Life policy. The premium of straight life insurance is great enough to build up cash values which automatically extend the protection, even after the policy holder discontinues payment.

We believe a careful exploratory study should be made to find out if the life insurance principle of protection can be applied to medical and hospital insurance policies so they can function when needed most by the policy holder—when he is out of money to buy his protection.—Frank A. Weiser, *Detroit Medical News,* Nov. 12, 1952.

JUDGE MEDINA CRITICIZES HUNT FOR SECURITY

Federal Judge Harold R. Medina of New York recently said that "every one seems to be looking for security." Boys just out of college ask personnel directors what the pension rights are and at what age they will be allowed to retire," he said at the summer commencement exercises of the University of Chattanooga. "Croakers abound everywhere telling us that everything is going to pot, that the world is plumb full of corruption and that nothing can be done about it.

"But the truth is that this do-nothing policy of playing everything safe is just about the worst thing that a person can do."

Turning to the Scriptural parable of the talents, in which those who traded and thus increased the number of their talents were commended while one who hid his talent in the earth was reproved. Judge Medina said that he believed this was a lesson "telling us don't be afraid, don't be cynical, don't be lazy, keep plugging away all the time with zest and enthusiasm." The talent was both an ancient weight and unit of money.—*New York Times,* September 3, 1952.

"THEY"

To a disgruntled few, any duly elected group of officers immediately becomes an evil foreign force that is referred to as "they." "They re-elect themselves year after year." "They run the Society to suit themselves." "They fatten their reputations at our expense," or "they give us little service in return for our dues." Nothing that officers or committeemen do is right, according to the jerry-built standards of these critics.

Any minor deviation is immediately tarred as the nefarious work of "they." No matter that the man in office is but one of the active members with recognized qualities of leadership who mirrors the thinking and expectations of those who elected him. Or that he seeks and needs help in his job and expects and welcomes constructive criticism. Scant notice is taken that when he speaks to or of the organization he refers to the membership as we, not as you or they; and when

(Continued on Page 1542)

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"THEY"

(Continued from Page 1540)

a successful job is done it is not I who did it, or if unsuccessful, you; it is we who did both. All of this seems to make little impression.

Officers do not expect full agreement among the members on all questions; only a sharing of duty and responsibility is sought, with no one set up as the whipping boy. Added responsibility without special privilege is their lot and they deserve more considerate treatment than that of outcasts called "they." Those who would thus separate them from the rest merely emphasize their own indolence and inability to become group participants.—W. S. Reveno, M.D., in *Detroit Medical News*, October 20, 1952.

CALLS STATE MEDICINE A FAILURE

England's experiment in socialized medicine has largely failed, according to the Rt. Hon. Lord Horder, consulting physician to the royal family. He spoke at the convocation of the International College of Surgeons in the Civic Opera House, Chicago.

The eighty-three-year-old physician said Britain's national health service plan, which places control of medical practice in government hands, failed because: Too much was attempted in too short a time. It was done by revolution rather than by evolution; it largely sidetracked the family doctor, and its cost far exceeded the budget.

Lord Horder warned American surgeons to "not put your faith in politicians, of whatever party."

"Stability is not with them, nor even tradition," he said.

"Politicians come and go but medicine goes on forever. Medicine is your trust, not theirs. It is not safe in their hands. See that you preserve it."—*Chicago Daily News*, September 6, 1952.

BRITISH HEALTH SERVICE OFFERS LOTTERY TO DRUGGISTS

Britain's Minister of Health has invited druggists, to whom it owes money under the state-run National Health Service, to take part in a "lottery" to recover their cash, the *Manchester Guardian* reported.

The newspaper said the Ministry has fallen behind in pricing the millions of prescriptions dispensed by druggists this year.

Under the health service, druggists hand over medicine and pills ordered and then forward the prescriptions to the Ministry for payment.

As a result of the delay, the Ministry, the *Guardian* said, is asking each druggist if he will allow medicines supplied between February and May this year to remain unpriced and instead accept a sum calculated on prescriptions he dispensed in the previous three months.

The Ministry estimates each prescription would be underpaid or overpaid by twopence (about three cents). But, the *Guardian* pointed out, as the prescriptions run into millions, the average druggist stands to win or lose around 50 pounds ($140). Druggists who decline to accept the gamble must continue waiting for their money.

The *Guardian* quoted the National Pharmaceutical Union as being "unable to recommend druggists either to accept or reject the scheme."

"Is this the way to play fast and loose with the taxpayers' money?" the newspaper asked.—*Detroit Free Press*, October 20, 1952.

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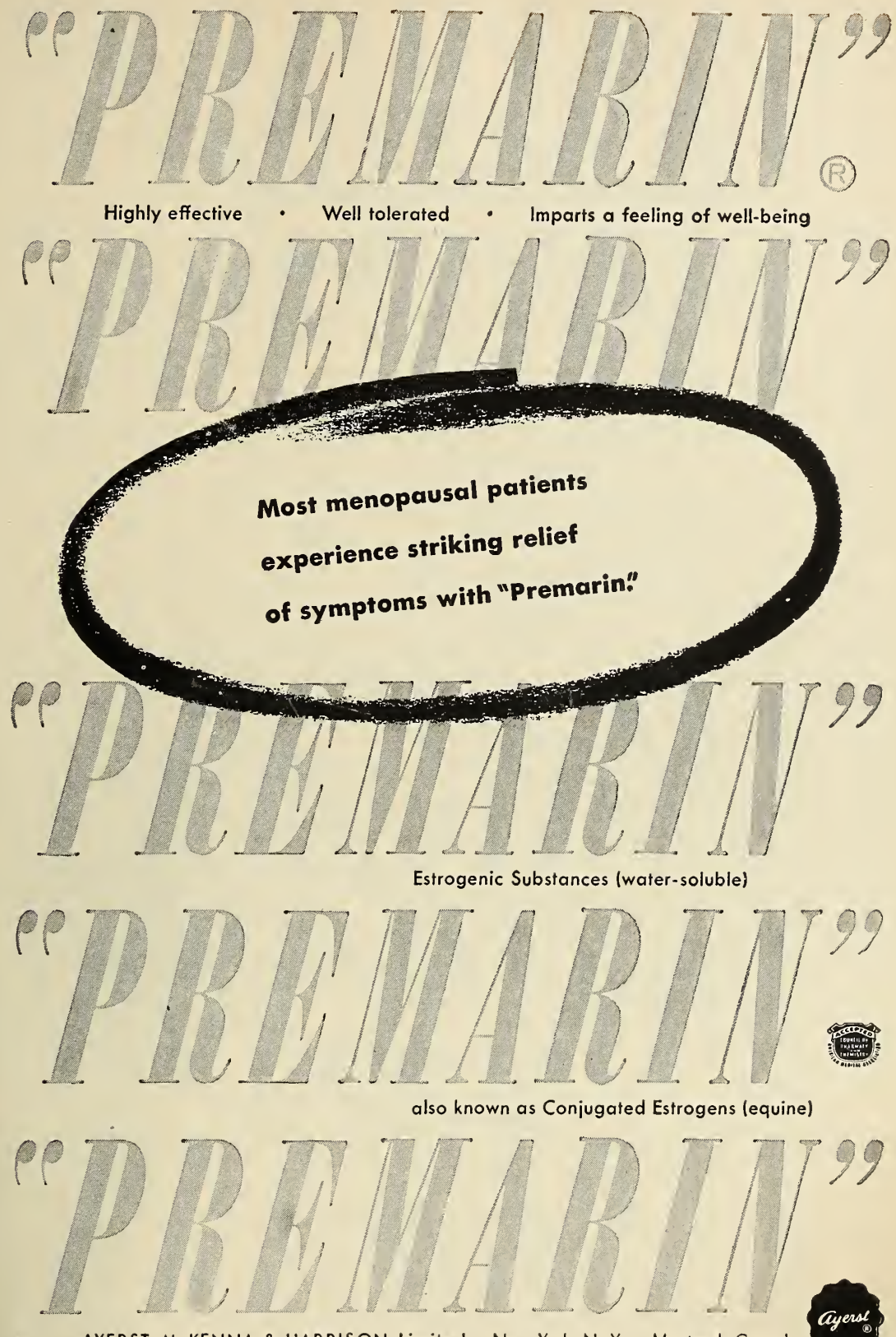
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Medical Management of Peptic Ulcer

By Solomon G. Meyers, M.D.; Hugh W. Henderson, M.D.; John Reid Brown, M.D., and Benjamin Juliar, M.D.

Detroit, Michigan

IT IS insufficient to diagnose peptic ulcer; one must determine if the ulcer is gastric or duodenal; one must inquire as to past complications such as perforation and bleeding. If bleeding has taken place, data should be obtained as to the number and severity of the hemorrhages. A review of the life cycle of the particular ulcer should also include duration of ulcer symptoms, frequency and severity of attacks, and amenability of the attacks to treatment.

The treatment of the ulcer attack is not a difficult matter as a rule. The intelligent patient who has been treated previously will often do a good job of treating a subsequent attack. The essential features are a bland diet, interval feedings of milk, or milk substitute, antacids and antispasmodics. The most popular antacids at the moment are aluminum hydroxide gels. These can be given in liquid or tablet form, as amphojel or creamalin. If these are constipating, they can be combined with magnesium as gelusil and maalox. The aluminum hydroxide gels do not provide the instant relief that one gets from sodium bicarbonate, and if the ulcer symptoms are severe much better results can be obtained from the use of Sippy powders which contain soda and magnesia, or soda and calcium carbonate.

Antispasmodics are important. Tincture of belladonna and atropine are useful. The newer anti-cholinergic blocking agents as Banthine are often effective when atropine fails. Banthine diminishes gastric secretion and decreases gastric motility. Nocturnal pain is often abolished by its use. An initial dose of 50 mg. every six hours may be tried, increasing the dose to 100 mg. every six hours, or decreasing it to 50 mg. two or three times daily, depending on the patient's tolerance. We have not been successful in getting patients to take the higher dosage. Undesirable effects as excessive dryness, blurred vision, dysuria and constipation may lead the patient to discontinue the use of the drug, or cut down the dose. A similar anti-cholinergic blocking agent called Prantal has recently become available which is better tolerated than Banthine because it does not cause dryness of the mouth as a side effect. Effective dosage consists of 100 mg. every six hours. If there is delayed gastric emptying, or prostatic disease with urinary retention, the use of Banthine is contraindicated. Sedatives as phenobarbital and bromides with nightly medicine for sleeping such as Seconal are helpful.

A discussion of any factor that gives rise to tension in the patient's emotional life such as a tough employer, a job unsuited to the patient or domestic difficulties may be productive of suggestions for improvement. Review of the patient's habits with regard to coffee, tobacco and alcohol may reveal that such stimulants are taken in excess.

If the patient is not immediately relieved by an ambulatory program, one should suspect that—(1) the diagnosis of ulcer is incorrect; (2) that some disease in addition to ulcer is also present, as cholelithiasis; (3) that some ulcer complication is present, or the ulcer is intractable.

From the Medical Service of Dr. Gordon B. Myers and the Surgical Service of Dr. Charles G. Johnston, Detroit Receiving Hospital and Wayne University College of Medicine.

Presented at the Sixth Annual Michigan Clinical Institute, Detroit, March 13, 1952.

If the ambulatory program fails to relieve the patient, it is wise to hospitalize him. This will accomplish a number of objectives, namely (1) it removes the patient from environmental factors that are disturbing; (2) a more accurate neutralization program can be carried out; (3) the use of gastric aspiration, nightly or more frequently is often the key to ending an attack.

Recognition and Treatment of Complications

Obstruction is one of the easiest complications to recognize and aspiration is the key to success in treatment. The patient may be aspirated morning and evening, or he may be put on continuous aspiration and parenteral intravenous feedings and a trial made to feed him after the stomach has been empty for a few days, or he may be put on a Wilkinson[5,6] regime with alternate aspiration and feeding. On any of these methods of treatment, the intravenous fluids should contain sodium chloride and potassium, the amounts needed being judged by the amount of aspirated material and frequent determination of blood sodium, potassium, chloride, non-protein nitrogen and carbon dioxide combining power. These chemical tests are necessary to determine the loss of salts and the presence of alkalosis and pre-renal azotemia which occur in obstructed patients treated by aspiration. If the obstruction does not yield to medical management, or if the clinical impression is that the patient is suffering from considerable scarring plus edema, surgical relief is indicated.

Treatment of Hemorrhage

In treating hemorrhage, the patient should be hospitalized at once. A patient who commences with mild bleeding may soon bleed massively, and blood transfusion is often life-saving. Confinement to bed, an injection of demerol to allay nervousness, and blood typing are done at once.

With regard to feeding, patients with mild or moderate hemorrhage are given a tenth day Sippy diet with soft foods as cereals, jello, custards, puddings, soft boiled eggs and cream soups with extra milk between meals. This is quickly advanced to a diet containing meat and fish. If the patient has bled severely, he is apt to be nauseated and is offered a glass of milk every two hours, with water as desired, and when the nausea disappears a 10th day Sippy diet is given, followed soon by the addition of meat and fish. If the patient vomits repeatedly, a Levine tube is inserted and suction applied. The important point about diet in bleeding ulcer is that no diet, not even the Danish diet, will stop the bleeding. The diet is important in keeping the patient hydrated and nourished until the bleeding stops, and if it does not stop, until surgery is instituted.

The crux of the treatment of hemorrhage centers about how much blood is lost. If the hemorrhage is mild, transfusion may be unnecessary. If the hemorrhage is severe, three or more pints of blood should be given in the first twenty-four hours after admission. This will usually bring the patient out of shock and start him on the road to recovery. However, if the bleeding continues, he may be given the "transfusion test." This consists of giving the patient three to four pints of blood in a short period. If repeated blood transfusion at this rate will not stabilize the blood pressure and keep the patient out of shock, then the blood is pouring out faster than it is being poured in and operation is imperative.

The treatment of bleeding peptic ulcer is best carried on by a team consisting of a medical man, surgeon, and "on the job" house staff. A surgeon who does good gastric surgery, preferably one who is conservative by nature, is hired immediately on admission of the patient whether the patient looks like he will require surgery or not. The surgeon can aid the medical man in the institution of a vigorous program to combat shock and hemorrhage, he can come to a mature judgment as to the necessity for surgery, and he is sure to be on hand if a surgical emergency arises.

Brown, Meyers, Posch and Deneen[1] have reviewed all cases of bleeding peptic ulcer entering Detroit Receiving Hospital over a nine-year-period. They found the following factors to be important in mortality.

1.—Age: Bleeding occurred at all ages from twenty to eighty years. About one-third of the patients who bled severely were under age forty. The mortality from bleeding is highest in the older age group, but young patients (twenty-one to thirty) can bleed to death from peptic ulcer.

2. Location of Ulcer: The mortality from bleeding duodenal ulcer was 9.4 per cent while that from bleeding gastric ulcer was 25 per cent. These findings are in agreement with those of Welch and Yunich[4] who found a 35 per cent mortality for bleeding gastric ulcer as contrasted with a 6 per cent mortality for bleeding duodenal ulcer.

3. Number of Hemorrhages: There is an appreciable incidence of deaths with the first hemorrhage.

4. Severity of Hemorrhage: This is the most important factor in mortality. When exsanguinating hemorrhage is present, the mortality from medical treatment is much higher than that from surgical treatment.

The indications for surgical interference in bleeding ulcer are:

All patients with exsanguinating hemorrhage resulting in severe sustained shock. By exsanguinating hemorrhage, we mean a patient who looks like he is going to die.

Patients with severe bleeding whose blood pressure cannot be stabilized and kept out of shock despite a vigorous program of blood replacement.

Patients with bleeding gastric ulcer.

Patients with a hemorrhage which stops after a hospital regime including transfusion and shortly starts up again. These patients do poorly on conservative management.

Patients who have had two or more previous hemorrhages.

Patients with hemorrhage plus some other ulcer complication as obstruction or penetration.

Acute and Subacute Perforation—Walled Off Perforation—Penetration

Acute perforation should be recognized at once and treated surgically.

Subacute perforation is difficult to prove in the absence of pneumoperitoneum. There is sudden severe pain with localized tenderness, and a low grade fever for twenty-four to forty-eight hours. The symptoms usually subside in three to five days.

There are some cases in which the perforation is walled off by adjacent organs as the pancreas or omentum as has been described by Ruffin.[3] In addition there are ulcers that penetrate the wall of the duodenum or stomach without perforation and these are clinically indistinguishable from the walled off perforated ulcers. In both of these conditions, there is a change in the usual ulcer pattern. The ulcer symptoms become more severe and there is now no relief from food and soda. Night pain is common. The pain becomes severe and boring and may radiate to the back, stimulating acute pancreatitis. Morphine may be necessary for relief. Physical examination is negative except for point epigastric tenderness. There is usually no leukocytosis. X-ray reveals the presence of ulcer but does not usually diagnose the penetrating nature of the lesion. Aspiration may give relief, after which relapses occur frequently.

TABLE I. COMPLICATIONS IN DUODENAL ULCER, PRESENT OR PAST

	86 Office Patients	95 Receiving Hospital Patients
Hemorrhage—one or more	27	31
Perforation	1	37
Penetrating pain	4	3
Retention and Obstruction	4	3
No complication	50	21
TOTAL	86	95

TABLE II. RESULTS OF MEDICAL TREATMENT FOR DUODENAL ULCER

	Patients	Per Cent
Good or Excellent	48	57
Fair	15	17
Poor	22	26
No follow up	1	
TOTAL	86	

This symptom complex which is characterized in the main by severe pain should be looked for and identified, as patients with this syndrome usually have intractable ulcer and will require surgery.

Intractable Ulcer

We have analyzed the complications occurring in ninety-five unselected patients admitted to Detroit Receiving Hospital for duodenal ulcer, and compared them with eighty-six patients seen in office practice. Table I shows a very high incidence of acute perforation in the Receiving Hospital group, otherwise the two series are comparable. Intractability is not listed as a complication here. The eighty-six office patients were surveyed as to results obtained from medical treatment, inasmuch as prolonged follow up was available in this group. The results are recorded in Table II. It will be noted that good and excellent results were obtained in only 57 per cent of the patients. One is misled by the ease with which a single attack of ulcer distress is improved. This table (Table II) shows what the results are in the long run.

The poor results to be obtained from medical

TABLE III. REASONS FOR POOR RESULTS IN ULCER THERAPY

1. Presence of complication as obstruction or repeated hemorrhage.
2. Penetrating pain.
3. Frequently repeated attacks; long or severe attacks.
4. Multiple hospitalizations; much time off work.
5. Abuses in food, alcohol and tobacco.
6. Unsuitable work; overwork.
7. Anxiety symptoms and emotional difficulties in addition to ulcer symptoms.

treatment are due to organic changes in the ulcer area (intractable ulcer) or failure or inability of the patient to co-operate in the medical regime (intractable patient), as described by Jordan.[2] The reasons for some of the poor results obtained in our patients are listed in Table III. These are the major factors in intractability.

A review of the life cycle of the particular ulcer and a size-up of the patient's psyche is necessary in deciding the question of intractability. How long has the patient been suffering from ulcer? How frequent and severe are the attacks? How many times has he bled and has he ever perforated? Has he co-operated with the medical treatment? Is the patient economically useful or is he a stomach invalid? Is he an overtly neurotic individual? The question of intractability cannot be answered categorically, but must be based on clinical experience and judgment. Decision that intractability is due to organic changes in the ulcer area implies that surgical relief should be advised.

Summary

In the diagnosis of ulcer, one should review the life cycle of the patient's disease, including duration of ulcer symptoms, frequency of attacks, duration of attacks, complications and amenability of the disease to treatment.

The treatment of the uncomplicated attack is a simple matter. If the patient's symptoms do not yield to treatment promptly, he should be scrutinized for the presence of complications.

In the treatment of hemorrhage, the best results are obtained from immediate hospitalization, transfusion, and team work on the part of the medical man, surgeon and housestaff.

Recognition of walled off perforation and penetration of the ulcer is emphasized.

Intractability often constitutes an indication for surgery but this cannot be categorically defined.

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GM TRAINING

On-the-job training is now being extended to medical students in General Motors' expanding program of industrial medicine. This summer, four medical students from the University of Michigan are spending their vacations working in GM plants with plant Medical Directors. In these plants, they will become thoroughly acquainted with the practical problems of occupational health before they return to their senior year studies at medical school.

This practical training is part of GM's broad program of improving the standards of industrial medicine. Throughout industry in general, employment health programs have lagged somewhat behind other phases. GM and other industries now realize the importance of prevention, diagnosis and treatment of industrial disease.

Under Dr. Max Burnell, GM Medical Director, the company has pioneered in industrial health at the University of Michigan. At the end of medical school, young doctors who intend to specialize in industrial medicine can enroll with GM for a further year's work at industrial health departments and in the School of Public Health.

In the "on-the-job" summer program, carefully selected students are given jobs in GM plants where they come face to face with actual conditions and work with plant Medical Directors in their day-to-day problems. Result is that the program is going a long way to stimulate interest among medical students in industrial medicine and to attract the highest type of young doctors into this formerly somewhat neglected but vitally important field.—*Iron Age*, August 21, 1952.

Duodenal Ulcer

A Continuing Challenge

By R. L. Mustard, M.D., F.A.C.S.
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THE TREATMENT of duodenal ulcer has gone through many phases in the past and unquestionably will pass through a great many more in the future. It is to be hoped that the summation of all the experience attained by the medical profession with this disease entity through these various phases of treatment will consolidate the knowledge of the past, and thus help lead to newer approaches and better methods of treatment in the future. With this idea in mind, it occurred to us that a report on 257 personally managed partial gastrectomies for duodenal ulcer, done over the past fifteen years, might shed some additional rays of light on this particular problem. The treatment of this group has been the cause of many trials and tribulations which may have helped temper the steel and mature the surgical judgment of the writer or possibly hurried him on to an earlier exodus. We look backward on these experiences with humility and forward with the hope that knowledge so painstakingly gained in the past may help prevent errors in the future. We offer no startling new discoveries or panaceas on the surgical management of duodenal ulcer. However, as a result of our experience, perhaps some tiny facet of information may be added to the structure of knowledge already attained on this particular subject. We rather humbly present this report of one surgeon's personal experience in practically living with 257 partial gastrectomies for duodenal ulcer over the past fifteen years. From this experience and by the slow process of evolution there has been welded a philosophy of management satisfactory to us but one which must constantly be subject to change.

Duodenal ulcer has been the subject of engaging interest not only to the gastroenterologist but also to the surgeon for many years. No final or crystal clear set of conclusions can be drawn on this particular entity as yet. Logical reasoning during the thirties had been pretty well consolidated behind partial gastrectomy when surgery was indicated. However, during the forties Dragstad,[1] with his advocacy of vagotomy, reopened the whole subject to a great deal of discussion and argument. Therefore, we have chosen the past fifteen years for our report inasmuch as this peiod of time has covered the earlier and rather clear cut partial gastrectomy as well as the later vagotomy phases of surgical management.

At the present time, there is little question as to the requisite indications for surgery regardless of whether the surgery is to consist of partial gastrectomy or vagotomy plus a drainage procedure. Approximately 90 per cent of all duodenal ulcer patients may be cared for successfully by medical treatment while the remaining 10 per cent must turn to surgery for relief. It is with the latter 10 per cent that we are particularly interested and this group is composed of the perforating, the obstructive, the hemorrhaging and the intractable ulcers. There is no longer any doubt as to the necessity for surgery in these four classifications.

Perforation demands immediate surgery to be life-saving and the operative procedure should be confined to suturing a piece of omentum in the perforation as quickly and gently as possible. This, necessarily, must be combined with cleansing of the abdominal cavity and administering the appropriate antibiotics and gastric suction postoperatively. A small number of surgeons have advocated conservative treatment confined to gastric suction and antibiotic therapy for these patients, but we have never agreed with the rationale of such management. During the past few years our viewpoint has changed considerably concerning the ultimate outcome of this group. We once believed that surgical closure of a perforated ulcer resulted in clinical cure for the vast majority and that only a relative few came to ultimate gastrectomy. However, we have long since reversed our position here and now believe that the largest part of this group must be subjected to partial gastrectomy relatively early when, under good medical management, signs of intractability appear.

Obstruction at the pyloric outlet may be due to edema or scar contracture or a combination of both. If due to edema, intensive medical therapy combined with gastric suction will eradicate the immediate pathology. However, if scar contracture is also present, conservative therapy will attain only a short respite. Afterwards the obstructive symptoms will reappear and operation at the earliest possible time should be advised.

Hemorrhage always has been and always will be a troublesome problem. No definite set of rules can ever be formulated for this particular pathology. While most clinicians prefer conservative management, there is a rather large number of men in the surgical field who favor the more radical and operative methods in dealing with this problem. We have always leaned strongly toward the conservative side and believe that here the closest possible co-operation is necessary between the internist and surgeon. Surgical mortality can be very vicious for this type of pathology hence we have always hoped to manage the majority of these patients as gently as possible. This management consists of bed rest, appropriate sedation, intravenous fluids and a very bland diet for a patient with mild or medium hemorrhage; in the case of a patient with massive hemorrhage, we prefer parenteral fluids exclusively along with constant gastric suction. We believe in plenty of blood with the amount varying from one-half up to two, or even three, liters a day. This amount is determined principally by the factors of blood pressure, red blood cell count, blood volume, pulse rate, and the severity of shock. Hemorrhaging patients should be in private rooms and under private nursing care whenever possible. Pulse and blood pressure readings should be taken every hour, red blood cell counts every four hours and blood volume determinations twice a day if feasible. The systolic blood pressure should be kept over ninety, blood volume over 60 per cent, pulse rate under 120 per minute and the red blood cells over 2.5 million. Under this regime the vast majority of these patients will recover. Lewison[4] reports 3,499 cases of hemorrhaging ulcer with a 4.5 per cent mortality in those treated medically and 19.5 per cent mortality in 460 cases treated surgically. However, if, in spite of conservative measures and mass transfusions, it becomes impossible to maintain adequate blood volume, red blood cell count, a systolic blood pressure over ninety and a pulse rate under 120 then immediate surgery is necessary. As a general rule, we strongly believe that surgery, when indicated for hemorrhage, should be carried out within forty-eight hours or not at all. Any operative procedure delayed longer than forty-tight hours is very apt to be fatal, although there always may be the exception to the rule. Once the decision for surgical intervention has been made, the patient should be massively transfused not only before he reaches the operating room but throughout the operative procedure. We prefer intratracheal nitrous ether as an anesthetic agent. Certainly never spinal anesthesia inasmuch as it is likely to drop the existing low blood pressure down to levels of greater shock. The abdomen is quickly opened, an incision is made in the lower anterior wall of the stomach and its contents quickly aspirated. Following this, the pylorus is slit anteriorly and a small pack placed against the hemorrhaging point in the ulcer. Partial gastrectomy may then be carried out routinely and it is very possible that such a patient may leave the operating room in better condition than when he entered. We have had occasion to use this procedure only twice during the past fifteen years and both patients lived. However, it is our considered opinion that conservative management of the hemorrhaging ulcer with adequate transfusions will show a much better mortality rate over the years than could possibly be attained by radical surgical therapy.

Intractability is the fourth and last major indication for surgical intervention. The criteria here, as to the proper time for intervention, have indeed been varied. At what point of time does the term intractability apply to the ulcer case? It would seem to us that the term should depend upon three principal factors: (1) the quality of medical management; (2) the economic status of the patient and (3) lastly his general physical condition. The quality of medical management is often more dependent on the patient than the attending physician. The most careful dietary and medical regime may be turned into a travesty by the careless patient or by one whose economic status does not permit regular meals or proper food and medication. Ulcer patients should not only have a proper diet with adequate medication and periods of relaxation, but, also should exclude smoking, alcohol, caffeine and such things as hot sauces, pickles, et cetera, from their regime. It has been our experience that most ulcer patients violate the no smoking and no caffeine rule. The economic factor is also very important, for a working man whose daily livelihood depends on continuing health certainly is not a candidate for ever recurring ulcer disability with its concomitant hospitalization, loss of time and medical expense. The point of time at which intractability occurs with him is necessarily much earlier than with the well-to-do patient who can afford such recurring

disability and expense. The third and last factor concerns the general physical condition of the patient. Certainly one would be very foolish to advise surgery where, because of physical infirmities, the operative risk might be greater than would the medical risk under conservative therapy.

During the past fifteen years we have definitely reached the conclusion that the diagnosis of intractability should be placed on the average duodenal ulcer patient much earlier than it has been in the past. Anyone doing this type of surgery cannot help but be impressed by the technical difficulties due to scar tissue, adhesions and deformities in long standing ulcers in contradistinction to the relative absence of these elements in ulcers of shorter duration. It is hardly possible to set a definite time limit as to when an ulcer may be called intractable where there are so many variables. Each patient must be judged on the merits of his particular case. However, for our own convenience, we have rather arbitrarily chosen a time limit of not less than six or more than twelve months of disabling symptoms under medical management after which we advise surgery. Naturally this time limit must be subject to rather wide interpretation, but if it can be determined that the patient has been co-operative and faithful in every way with his medical management and still has troublesome symptoms after six months of adequate treatment then we are strongly inclined to advise immediate surgery rather than permit long months to years of more or less constant and varying invalidism. In short, we wish emphatically to emphasize that surgery for intractability should be urged much sooner now than it was fifteen years ago and we firmly believe that this earlier surgical intervention has been one of the most important factors in our decreasing morbidity and mortality rate.

After surgery has been decided upon, the question arises as to the best type of operative procedure. Up to 1943, when Dragsted reintroduced the procedure of vagotomy, surgical opinion had become pretty well crystallized behind some type of resection. However, with the reintroduction of vagotomy in ulcer therapy, indecision as to the best type of operation again appeared in surgical thought. While it is true that complete section of the vagus fibers severs cephalic influence on gastric secretion and motility, it is also true that gastric and intestinal control of acid secretion remain untouched. Vagotomy, to be total, should be done through the chest unless the surgeon is a highly trained specialist on vagus dissection from below the diaphragm. The average good American surgeon is not such a trained specialist and it is our belief that he will not sever all the vagus fibers when working in his region. However, chest exposure permits no examination of abdominal pathology or performance of sidetracing procedures which are so necessary with vagotomy. Therefore, where vagotomy plus drainage procedures are executed, we believe three factors will intervene to prevent excellent long results, namely, (1) incomplete severance of vagus fibers; (2) return of autonomic control of motility, and lastly, (3) gastric and intestinal control of hyperacidity. Also it is our belief that with a concrete number of patients subjected to vagotomy in any given year the percentage of poor results will increase in proportion to the time interval away from that particular year. We cannot help but believe that a large percentage of patients now being subjected to vagotomy and gastroenterostomy will eventually terminate in marginal ulcer pathology. Furthermore the combined operations of vagotomy and gastroenterostomy form a combination which is only an infinitestimal distance behind partial gastrectomy insofar as morbidity, mortality and the major nature of the operation is concerned. Also while the disagreeable side reactions such as gastric stasis, foul eructations, abdominal distention, substernal pain and diarrhea are now fairly controlled by better postoperative care, these side reactions are still more serious than those found after partial gastrectomy.

These opinions have been substantiated by the recent report of the American Gastro-Enterological Association Committee for the study of peptic ulcer.[2] This report, based on a very exhaustive study, has rather conclusively proved that partial gastrectomy, where at least two-thirds of the stomach has been removed, is a far better procedure than the combination of vagotomy and gastroenterostomy. The percentage of patients clinically cured is much greater with partial gastrectomy and it is our opinion that this percentage will increase with the passage of time. While we have no wish to permanently condemn vagotomy, we must conclude that at the present time we are definitely not favorable to it except in three possible circumstances: if the patient is young, highly tense and has an intractable ulcer associated with tremendous hyperacidity; if the patient is young

and will not, or cannot, follow a sensible ulcer regime postoperatively with abstinence from smoking and drinking; or if there is a marginal ulcer following partial gastrectomy where two-thirds of the stomach has been removed. In the first two instances we favorably consider the advisability of vagotomy combined with partial gastrectomy and in the last instance, vagotomy alone. We have done this eleven times in the past six years with good results. However, when the three previous exceptions can be excluded, we firmly believe that partial gastrectomy with removal of two-thirds of the stomach is by far the best surgical procedure which has been designed to date for duodenal ulcer.

Morbidity and mortality figures for all types of major operations as well as partial gastrectomy are infinitely better today than they were fifteen or twenty years ago. This condition has been attained by the use of modern antibiotics, by better technical skill and lastly, and probably most important, by better pre- and post-operative care. The tremendous importance of the latter cannot be stressed too much. Hospitalization before operation is necessary for three to four days during which time the patient is given sufficient sedation to insure complete rest. All the essential blood, liver, cardiac and kidney tests are done. Anemia is corrected completely with sufficient transfusions. Blood chloride, non-protein nitrogen, prothrombin concentration, AG ratio and plasma protein values are corrected to as near normalcy as possible. Inasmuch as a low plasma protein is usually present in these patients it is well to place them on a high protein, high carbohydrate, low fat diet for two to three weeks prior to hospitalization. Twenty-four hours before operation constant gastric suction is instituted so that we may have a less edematous and congested stomach to work on.

The operation itself should be done gently, neatly, quickly, and with complete hemostasis. As a general rule the operating time should never be less than one and one-half or more than two and one-half hours. Operating times of more than two and one-half hours are liable to increase the morbidity rate markedly and the mortality rate to a lesser extent. Approximately two-thirds of the stomach is removed along with the pylorus and upper portion of the duodenum containing the ulcer. The removal of the stomach and pylorus is very necessary, but a long struggle over the removal of a deeply and dangerously situated duodenal ulcer is not worth while. It has been our impression over the years that the occasional ulcer not removed will always heal spontaneously once the acid contents of the stomach cease to flow over the ulcer area. We have no hesitation in opening the duodenum inasmuch as no self-respecting lethal germ can remain healthy in the acid stomach contents of these patients. This maneuver permits more accurate dissection in the difficult cases as the index finger of the left hand can be inserted into the bowel lumen, thus permitting easier dissection of the duodenum away from its surrounding delicate structures. We have utilized this method for the past fifteen years and postoperative wound infections have been practically non-existent in spite of working with the open duodenal stump. No crushing instruments of any type are ever used on the stump for such instruments rob the operator of a small portion of the cuff which is so very necessary for safe invagination. Bleeding points on the cuff are individually ligated with fine catgut to achieve complete hemostasis. This permits the first invaginating stitch to be entirely seromuscular. A second invaginating layer of interrupted silk stitches is then placed and a tag of omentum is sutured over the top of the stump. We agree with Lahey[3] and rarely suture the stump into the pancreas for fear of pancreatic injury with its possible resultant pancreatitis complicating the post-operative convalescence.

The anterior Hoffmeister type of operation is preferred and the anastomosis is made either iso or antiperistaltic depending on whichever way the jejunum lies naturally and without any torsion extending outward from the ligament of Treitz. The proximal jejunal loop is made as short as possible and its adequate length should be determined with the stump of the stomach lying naturally and without tension. It is very easy for an assistant to pull the stomach remnant downward under tension during the process of anastomosis. This can result in a proximal loop which the surgeon, to his dismay, may find much too short when the stomach is released at the end of the anastomotic procedure; thus giving rise to dangerous tension on the suture line and too much compression of the transverse colon. The size of the stoma has been decreased through the years so that at the present time it admits, on completion, the tips of two fingers snugly.

This unquestionably has lessened the incidence of the so-called dumping syndrome which was so much in evidence with the earlier Polya, large stoma, type of procedure. A careful check of the last 100 patients in this series reveals the fact that only six have had any symptoms of dumping, and, of these, five had symptoms so mild they disappeared within three months. The sixth had symptoms which persisted as somewhat of a nuisance for a year and then became relatively unimportant.

The anastomosis itself has been standardized, kept very simple and done openly. We have no pride when the safety of the patient is involved or where a technical procedure may be executed more easily. It has been our experience through the years that the actual anastomosis may be done much easier and more safely from the left side of the patient. From this position the operator faces naturally toward the infrahepatic region where suturing is the most difficult, hence we never hesitate to move around to the left side of the patient for the anastomotic part of the procedure. Only two layers of sutures are ever used, the outer being a continuous chromic 000 and the inner being locked posteriorly, but run anteriorly as a continuous whipstitch. In executing the posterior lock stitch it is very handy for the surgeon to sew away from himself. In this way the suture, after it has passed through both walls of the bowel, may be held firmly in the left hand and with just the proper tension which only the surgeon himself can judge accurately. Furthermore, this permits the most dangerous end of the anastomosis in the region of the lesser curvature and under the liver to be executed in the open while the anterior portion of the stoma is still open. A most careful effort is made to turn in as small a curtain of tissue as possible in order that postoperative edema with its resultant retention may be kept at a minimum. At this point it may be well to say that as much as possible of the transverse colon is pulled under the anastomosis and over toward the left side of the abdomen, in order that all possible postoperative colonic distention may be prevented. Perhaps one further point should be stressed; in obese patients we find it much handier to amputate a segment of omentum over the midportion of the transverse colon in order that the jejunum may be brought forward in front of the large bowel more easily.

Postoperatively, the principal attention is directed toward maintaining the blood elements important to recovery as nearly normal as possible. Daily chloride, potassium and plasma protein values are determined and corrected. Blood volume is maintained with adequate transfusions, and early ambulation is urged. The gastric suction tube is closed the morning after operation and opened over the next one to three days only when symptoms of distention appear and then only for a few minutes at a time. This procedure helps conserve the all important electrolytes in the gastric juice and in the vast majority of cases it is possible to remove the tube on the second postoperative day when no distressing symptoms of stomach distention appear after four hours of tube closure. Clear fluids are started on the day after operation and milk in small frequent amounts on the second postoperative day. Parenteral fluids necessary for proper electrolytic balance and caloric requirements are used until the patient can take sufficient nourishment by mouth. These patients are discharged from the hospital on an ulcer diet as soon as they become self-sufficient and urged to exclude smoking, caffeine, alcohol, hot sauces, condiments, et cetera, from their daily regime. After six weeks they are given the liberty of following a normal diet inasmuch as questionnaires sent to 100 such patients showed eighty-two disregarding any type of ulcer regime.

In the past fifteen years 257 partial gastrectomies for duodenal ulcer have been done by the author. Each of these patients has been personally managed from beginning to end and this management has included the pre and postoperative care as well as the actual operation. There have been six patients with postoperative eviscerations and two with leaking duodenal stumps. These complications occurred in the early part of this fifteen-year period before the tremendous importance of preoperative preparation was appreciated. The eviscerations on the six patients were repaired and they all lived. One patient who developed a leaking stump healed after considerable drainage and the other died. Altogether there have been seven deaths in this series. One of these was due to the leaking stump just mentioned and occurred in 1938. Two occurred from acute pulmonary edema, one in 1939 and one in 1940. Both of these might be prevented today by what we consider a better type of anesthesia, intratracheal nitrous ether. There was one death from bronchial

pneumonia which might now be prevented by our better antibiotics. There was one death in 1943 and one in 1944 from acute urinary suppression. With our present knowledge of the lower nephron syndrome it is possible that a more propitious end result might be attained in these two cases today. It is worthwhile noting that the last two patients had a cholecystectomy combined with the gastrectomy. We now consider this very bad practice and no longer undertake combined procedures. In the last six years there has been one death in 122 cases. This was due to respiratory failure which defied all efforts toward resuscitation not only on the operating table but during the following three hours. Thus for the first nine years there were six deaths in 135 cases giving a mortality rate of 4.4 per cent and in the past six years there has been one death in 122 cases, giving a mortality rate of .8 per cent.

Of the patients cared for over the midportion of this fifteen-year period 100 have been contacted. Eighty-two have completely disregarded their ulcer diet, sixty-one smoke, thirty-nine use alcohol in some form and thirty-eight drink coffee, in spite of instructions to the contrary on all of these items. Such is human nature. Ninety-one of this group consider themselves clinically cured, five definitely improved and four must be considered failures. Of these four, two developed marginal ulcers severe enough to warrant vagotomy, with resultant relief. The other two have all their previous symptoms with no present x-ray evidence of ulcer. Of the ninety-one who consider themselves clinically cured, twenty-seven have either lost some weight or at least failed to gain, but, inasmuch as they are without symptoms otherwise we feel thoroughly justified in placing them in the group of ninety-one clinical cures. Eight posterior gastroenterostomies have been excluded from this list as we intended to deal only with the subject of partial gastrectomy for duodenal ulcer. These gastroenterostomies have been done where advanced age or complicating physicial infirmities have made any heavier procedures hazardous. We are violently opposed to the exclusion type of procedure because of the high incidence of postoperative marginal ulcer development. Rarely is duodenal pathology so extensive that its immediate removal is dangerous from the standpoint of vital structure injury. However, in such cases one could be justified in using the exclusion procedure, as advocated by McKittrick.[5] Six to eight weeks after this procedure the pylorus and duodenal ulcer area may be removed safely and startling resolution of bowel pathology can occur in this short period. We have used this procedure once with an excellent end result.

Partial gastrectomy for duodenal ulcer should be approached cautiously by the younger surgeon. He should have plenty of assistancies in his background on this particular operation. He also should have done various parts of this procedure with the help of older experienced men. All of these various parts should add up to two or three completed operations in addition to his assistancies before he attempts the total operation alone. The surgical profession owes this much to the helpless patient not only with gastrectomy but with every other major operation. We should do to patients exactly what we would like done to members of our own family. No more. No less.

Summary

Two hundred fifty-seven partial gastrectomies for duodenal ulcer are reported.

Perforation, obstruction, hemorrhage and intractability, the four indications for surgery, are discussed.

The conclusion, that vagotomy plus a drainage procedure as compared with partial gastrectomy, does not attain as high a percentage of excellent end results for duodenal ulcer patients is reached.

The possible uses of vagotomy for duodenal ulcer pathology are discussed.

Much earlier surgery for intractable ulcers is recommended.

Preoperative and postoperative management plus additional points of surgical technique are expanded upon.

Caution on the part of the younger surgeon in this heavy type of surgery is urged.

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Prenatal Care: Its Aims and Value

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THE VALUE of careful supervision of the patient during the period of pregnancy up to the time of labor and delivery cannot always be demonstrated, yet it has been a distinct factor in the dramatic decrease in maternal deaths during recent years. The increasing safety of pregnancy and childbirth is shown in Table I. In 1944, in the City of Detroit, approximately two mothers died for every 1,000 babies born alive. In 1950 approximately one mother died for every 2,000 live births. This is a fourfold decrease in maternal deaths.

During the past ten years these deaths have been reviewed by the Maternal Welfare Committee of the Wayne County Medical Society. According to the information available, critical analysis suggested that certain of these might have been prevented. Of the 211 maternal deaths occurring from 1946 through 1950, the committee considered that in 134 the fatality might have been averted. Admitted that such reviews cannot appraise results with the desired degree of accuracy, they do suggest, however, some factors which warrant consideration. While the end-result might not have been altered, of the 211 deaths only seventy-two patients appeared to have received adequate prenatal care, while 103, almost one-half, probably would have benefited significantly by proper medical care during the course of pregnancy.

I should like to outline what I consider to be the principal aims of those of us who care for the pregnant woman. In the first place, we try to achieve the best possible physical health for the mother. Second, we attempt to discover abnormalities and complications as early as possible and to treat them promptly. Because we have the rare opportunity of seeing our patients over a period of several months, we can do much to prepare them for their subsequent years with their family. Through thoughtful appraisal of their problems as well as their fears, and by honest and kindly counsel, we can develop in our patients mature and healthy attitudes toward childbirth and family life. This is, I believe, the responsibility of the individual physician and should not be left to recommended books and courses of lectures. We strive to conduct labor and delivery always with the utmost safety for both the mother and her child. If these aims are realized, we are certain, finally, to return an efficient mother and a normal child to a well-adjusted family.

TABLE I. STILLBIRTHS, INFANT AND MATERNAL DEATHS
City of Detroit

Year	*Live Births*	*Still Births**	*Infant Deaths**	*Maternal Deaths**
1920	27,679	52.1	104.2	9.2
1930	32,634	42.0	64.7	6.6
1940	30,315	30.6	37.4	3.0
1945	36,136	25.6	36.6	1.55
1946	44,098	26.0	30.3	1.16
1947	50,234	37.6	31.7	0.94
1948	48,197	21.3	30.5	0.94
1949	50,384	20.6	29.6	0.73
1950	52,338	19.0	26.8	0.59

*Rate per 1,000 Live Births

Because most pregnancies proceed normally and are delivered without complications, the inherent hazards frequently are forgotten or overlooked. It must be constantly kept in mind that every obstetrical patient is, potentially at least, a major surgical risk. Fortunately, the obstetrician generally has adequate time as well as the most favorable circumstances to prepare his patient for the possibility of major surgery. This situation exists nowhere else in medical practice. During pregnancy and childbirth the death rate now is less than for any nine-month period in the same age group of non-pregnant women. It would appear that, given good obstetrical care, it is now safer for a woman to have a baby than not to have one.

If full advantage of prenatal care is to be obtained, patients should be seen early in pregnancy. Two to four weeks after the first missed menstrual period is not too early. At the initial visit a meticulous appraisal of the patient should be made. A complete history should be taken, a thorough examination done, and basic laboratory determinations made. Appropriate treatment should be directed toward whatever abnormalities are discovered. At this first visit the entire management of pregnancy should be outlined to the patient and detailed instructions regarding diet and hygiene should be given. Prompt notification regarding abnormal symptoms should be impressed upon the patient as should the importance of regular return visits.

Adequate prenatal care is built upon these es-

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sentials. Some brief comment may indicate their usefulness. A complete history is necessary. For example, if the last period was a week or two later than usual and scant or spotting rather than the customary flow, it should suggest the possibility of an ectopic pregnancy and direct a careful and cautious examination of the adnexae. Full details regarding previous pregnancies should be recorded. The weight of newborn infants usually increase with each increasing pregnancy. If moderate pelvic contraction is present, such increase may eventually produce a dystocia requiring cesarean section. There is a distinct tendency for premature labor to be repeated in following pregnancies. While it may not be possible to prevent such labors, at least we can be alert to their possibility and attempt to conduct them under the most favorable circumstances. Similar warning is given for stillbirths where a repetition can be expected two and a half times more than usual if the last pregnancy ended in a stillborn infant. Many medical diseases occurring previous to pregnancy, such as acute nephritis, rheumatic fever, essential hypertension, often have important residual organic changes which dictate differences in prenatal care and delivery. Significant data also can be found in the surgical and family history. It is obvious that the course of the present pregnancy be thoroughly known.

Details of the physical examination need but little comment. Ophthalmoscopic findings at the initial visit may become valuable in interpreting hypertension with or without retinal changes later in pregnancy. Carefully appraised posture may be valuable in evaluating abnormalities of the bony pelvis and may afford exploration and proper treatment of the chronic female complaint of backache. Precise and meticulous pelvic examination is essential. It can discover lesions which may become obstetrically significant. Recently the value of external pelvimetry has been questioned. However much we should like to have routine x-ray pelvimetry, such is not financially possible for the majority of patients. Thorough clinical examination of the obstetric pelvis will indicate those patients for whom x-ray pelvimetry at term would be useful. The pelvic outlet can be measured clinically with an accuracy equal to x-ray studies. Routine vaginal and rectal palpation of the sacrum, coccyx, ischial spines and lateral pelvic walls will, in a surprisingly short time, develop an obstetrical astuteness that can be as reliable as x-ray studies in predicting probable dystocia.

Certain abnormalities can be detected only in the laboratory. Syphilis has become increasingly infrequent since the means of diagnosis and effective, rapid treatment have become available. There should be no congenital syphilis among the newborn. A blood count with hemoglobin and hematocrit determinations discovers the anemias which can be adequately treated during pregnancy. The urine specimen at the initial visit should be obtained by catheterization. In addition to routine examination, microscopic study of the stained, centrifuged sediment should be done. This can detect sub-clinical cystitis and pyelonephritis which are easily treated and which often are responsible for unreasonable lassitude and irritability in the patient. It is basic in any proper evaluation of the urinary tract. The blood type and Rh factor should be determined for all patients. Transfusion of whole blood is fundamental in any effective treatment for the leading complication at delivery, hemorrhage. Such can be started much more quickly if the blood type and Rh factor are known. There are many instances where this saved time has saved the patient. Rh negative women may have erythroblastic infants. In Rh negative secundigravidae it is imperative to determine the Rh factor of the father so that the possibility of erythroblastosis can be anticipated and proper precautionary measures taken at the time of labor. X-ray examination of the chest is very desirable, but it adds considerably to the medical bill. For screening purposes, those examinations sponsored by public health agencies may be utilized.

After examination, the patient should be returned to the consultation room, placed at her ease, and reassured as positively as possible regarding her pregnancy. Unless there is definite evidence to the contrary, she should be told that her pelvis is normal and definitely adequate to deliver the baby. She should be told that her general health is good, that no physical abnormalities were found, that she is fully capable of carrying the pregnancy through an uncomplicated labor, and that her baby should be normal. Should abnormalities be present, these must be carefully weighed and all doubts regarding their effect upon the pregnancy or delivery must be completely resolved in the mind of the physician before they are presented to the patient. She should be given ample opportunity to ask questions. These should be answered frankly and as completely as possible.

Any fears which she may have should be brought out, discussed openly, and either refuted convincingly or effectively minimized. At return visits, questions concerning labor, delivery and anesthesia should be answered directly and honestly. Such will develop the rapport between the patient and her physician which can make pregnancy a significant and desirable experience.

Regular visits at definite intervals must be made. Through the twentieth week these should be every four weeks, every three weeks through the thirty-second week, and every two weeks through the thirty-fourth week. From the thirty-fourth week until delivery the patient should be seen once each week. Whenever abnormalities or complications are present, she should be seen at least weekly, more often if necessary, until such are under proper control.

Certain examinations are to be done at each visit. The patient is to be weighed and her blood pressure taken. Sudden and unusual gain in weight during the third trimester might be an early manifestation of toxemia. The scale, it will be found, is the best deterrent to gains due to uncontrolled eating. If the physician will weigh the patient himself, he will be able to make timely, appropriate comment which is amazingly effective. During the second trimester a decrease in blood pressure is normal, yet this may hide an actual hypertension. For example, a blood pressure of 122/72 mm. Hg at twenty weeks which at thirty-four weeks has increased to 130/80 mm. Hg may discover a patient with underlying vascular disease. She must be evaluated and watched carefully. Whenever proteinuria is found, a catheterized specimen should be examined to eliminate vaginal secretion as the source. With a positive urine sugar, blood levels should be determined, since many diabetics give their first evidence of the disease during pregnancy.

At repeat visits it takes but little time to examine the patient. Measurement of the height of the fundus, determination of fetal presentation, position, and heart rate are important and give useful information. Often such routine examination will detect a multiple pregnancy and thereby avoid an embassassing announcement at delivery. Early in pregnancy, disproportionate uterine size in relation to the length of gestation may point to a missed abortion or hydatidiform mole. Rectal examinations are to be done after the thirty-sixth week. In certain circumstances a sterile vaginal examination might be valuable. Engagement and station are thus determined and potential dystocia discovered. Effacement of the cervix indicates approaching labor. When present, it affords an excellent opportunity to instruct the patient about what she may expect and to support her further against the unknowns of labor and delivery. A red cell count and hemoglobin should be done in each trimester. It is advisable to prescribe supplemental iron at least during the final eight weeks; it is insurance against the demands of delivery and will effectively reduce the number of postpartum patients with anemia.

From time to time the patient should be questioned about the foods she actually eats. Whether the diet includes adequate proteins, proper minerals and sufficient vitamins can be quickly discovered. Discussion of specific foods to be included and nonessentials to be avoided makes correction of an improper diet more certain. Moreover, the value of essential foods can be stressed. Usually, abnormal gains in weight come from an unbalanced diet in which the necessary proteins, minerals and vitamins are inadequate.

Every physician should always take time to listen to his patients' complaints, and he should do so without impatience. The complaints should be sought out, they must be evaluated, and each one must be treated. Many merely need the explanation of being a normal, or at least not uncommon, occurrence in pregnancy. Some require active treatment, others are managed by appropriate medication. Fears and phobias must never be casually dismissed or completely disregarded. They must always be convincingly resolved. For some unknown reason, every pregnant woman seems to become a target for horror stories. Well-meaning friends and relatives constantly report incidents, most of which are misinterpretations, obstetrical rarities, or persistent old wives' tales, apparently for their gruesome implications. However informed and intelligent the patient may be, she still allows them some validity. The untruths must be constantly and emphatically refuted.

By careful supervision of their prenatal course, we can bring our patients to labor and delivery in the best possible physical health; by sincere and honest interest in them and their problems and our competent management of them we can instill justified confidence and a sense of security. By these means we can make more certain the achievement of our aims as obstetricians.

Problems of the Newborn

By C. G. Jennings, M.D.
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THE PROBLEMS of the newborn infant originate from three general sources. The first is development, for the newborn is a rapidly developing individual. The second is environment, which changes suddenly from intrauterine to extrauterine. The third is the birth process itself. All three enter into each specific problem to some extent. Taken together they add up to a stress and readjustment which makes the newborn period perhaps the most critical in the individual's life.

There are certain general principles in the prevention and management of neonatal difficulties. The first of these is skillful management of pregnancy and labor, which conserves fetal health and development and reduces to a minimum the dangers of anoxia, narcosis and physical trauma.

In the newborn period itself there are six principal adaptations to extrauterine life which may give rise to difficulty. First is the establishment of respiration. Second is the re-establishment of normal body temperature. Third is the re-establishment of normal osmotic and electrolytic balance. Fourth is the establishment of digestion. Fifth is the encounter with the agents of infection. And sixth is the establishment of a relationship between the mother and the new infant which will help him to develop towards a full and healthy individuality.

Several current trends in the management of these adaptations deserve mention. There is less emphasis on positive pressure inhalators and tracheal catherization, and more on the treatment of shock and exhaustion. A more liberal use and gradual withdrawal of oxygen are recommended. The management of salt and water balance is receiving intensive study. Terminal sterilization of formula has become an almost universal practice in hospitals. Smaller nursery units and greater participation of the mothers in the infants' care is continuing to receive wider attention.

In discussing specific problems of the newborn, much will have to be omitted. Such topics as prematurity, congenital anomalies, erythroblastosis, hemorrhagic disease, tetany, hypoglycemia, neonatal sepsis and epidemic diarrhea can only be mentioned. The two which I wish to emphasize are brain injury and personality development.

There are many causes of neonatal brain damage. Even normal birth is somewhat traumatic, though recovery is usually complete within two or three days. Some individuals stand this trauma less successfully than others. The infant's susceptibility may be increased by depressant drugs as well as by prematurity and the specific diseases of the newborn. There must also be some fetal factors which are still unknown. On the other hand, trauma is increased by the accidents of labor and by forcible delivery. Trauma may also occur after birth. These causes may occur alone or in any combination.

There are two mechanisms by which these primary causes produce brain damage: physical trauma and anoxia. Physical trauma includes laceration of the cerebral envelope, which causes massive hemorrhage, and concussion-like injuries due to sudden pressure changes, which cause cerebral edema and capillary hemorrhages. These primary brain injuries are apt to result in central respiratory depression, with anoxia and further injury.

Primary cerebral anoxia may begin before or after birth. The fetus distressed by interference with oxygen supply is usually born in a state of shock and depression which impairs his ability to breathe. He may also have aspirated amniotic fluid. Anoxia beginning at birth is usually due to narcosis. Anoxia beginning after birth may be caused by many factors. It not only injures nerve cells, but also blood vessels, again causing cerebral edema and capillary hemorrhages.

Atelectasis and aspiration pneumonia are probably never the primary causes, but rather the results of brain injury. One pulmonary condition, the so-called "Hyaline Membrane Pneumonia," may sometimes be a primary cause of anoxia.

In spite of the complex causation of neonatal brain damage, its treatment is relatively simple. Where resuscitation is necessary, the value of the forceful administration of oxygen must be balanced against the resulting shock. In general, I feel that the former is of little value. The airway must be gently cleared, and mild physical and pharmacological stimulation may be used. If res-

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pirations do not begin shortly, rest, warmth, and the provision of an oxygen rich atmosphere give the best chance of recovery.

After respiration is begun, the objective of treatment must be support and the avoidance of shock and exhaustion. Artificial heat is often necessary. Oxygen is of great value, and should not be too suddenly discontinued. The air passages should be gently cleared when necessary, and vitamin K should be given. Stimulant drugs are indicated only for selective depression of the respiratory center. Carbon dioxide is not of value as a respiratory stimulant. Sedation should be used only for central convulsions. Transfusion is indicated only for anemia and hemorrhagic disease. Lumbar puncture should be used only when accurate diagnosis is essential. The administration of fluids by any route should be delayed until cerebral or generalized edema are subsiding, and feeding may be delayed as late as the third or even the fifth day. Naturally, the ordinary nursery routines should be postponed until they are safe.

Initial mild reversible brain injuries may become severe and irreversible because of the vicious circle of brain damage and anoxia. When every effort has failed to prevent a brain injury, much may still be gained by skillful intervention in this vicious circle. Thus the proportion of children with the severe sequellae—epilepsy, cerebral palsy, mental deficiency—may certainly be reduced.

Birth is to personality development approximately what implantation of the ovum is to physical development—the crucial beginning. The fetus spends nine months in quiet, sheltered growth. Suddenly he must endure, with whatever strength and competence he has gained, a dangerous expulsion from the uterus. Suddenly he finds himself in the outside world, where he must do some things for himself, and must demand those things which he cannot do.

The newborn infant's greatest need is for the re-establishment of as much of his lost security as may be possible under the new circumstances. It is only through a sense of security that he can begin to discover and employ his own capacities for growth and independence. The source of this security is his mother, and the ideal is to maintain as close a relationship as possible between them. Since this relationship depends almost entirely on the mother, she is the key to the mental hygiene of the newborn period.

The mother must accept as fully as she can the dependency of her new baby. Her ability to make this adjustment depends on many things. Her own childhood determines important limitations and attitudes. She has prior relationships with her husband and family. There are social and economic realities. And she must recuperate from the stresses of pregnancy and labor.

In helping the mother to make a good start with her new baby, the most helpful things are understanding and a flexible attitude towards circumstances, needs, and capabilities. She needs relief from anxieties about herself, her baby, and the family at home. She needs as much participation in the care of her baby as circumstances and her own abilities permit. She needs protection at first, and confidence for the day when she will be on her own. And she needs help in getting to know and understand the individual needs of her baby, especially in the method and frequency of feeding. There is no simple system by which all mothers may be instructed in the details of their job. The best results will come from helping each to do the best that she is able.

A POINT OF VIEW

Psychosomatic medicine essentially is not a specialty but a point of view, and an approach which applies equally to medical and surgical problems. It is basic medicine which has needed re-emphasis. The compassionate aspect of medicine has perhaps been rather overshadowed by the rapid growth of techniques of investigation and by the present abundance of specific remedies.

The best physicians and surgeons have long regarded their patients as individuals with backgrounds which may influence their illnesses. Some medical men, because they have been too hurried or too poorly trained, may have tended to think only in terms of the immediate disease process and have not had a sympathetic understanding of the patient's problems.

There is no doubt that many patients benefit merely from the taking of a detailed history at leisure and in privacy, and the unburdening of their story, often untold to others, may save many weeks of attendances at outpatient departments or surgeries. But "psychosomatic" is an unnecessary term, and the sooner it is dropped from the current literature the better.—*Connecticut State Medical Journal,* March, 1952, quoting an Editorial in *British Medical Journal.*

Treatment of Blood Diseases of the Newborn Infant

By Wyman C. C. Cole, M.D.
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FIRST OF ALL, I want to make it clear that I am not an authority on the blood diseases of the newborn infant. My excuse for dwelling on this very complex and imperfectly understood subject is purely from the point-of-view of a physician who has had an opportunity to see a good many babies, to tell you how we are currently treating these conditions, and perhaps to be of some practical help to you in the handling of these rather frequent problems in your every-day work. Symptoms indicating some disturbance in the infants' blood are very common. So, whether we understand all of the causes and basic pathology of these diseases or not, we are obliged to deal with them, and to take immediate and positive action. Fortunately, although the nature of the pathology may not always be clear, we do have methods of treatment which in a majority of cases are effective and result in a cure of the patient.

To attempt to cover the wide range of pathologic conditions which may cause these symptoms in the space allotted is obviously impossible so this paper will be confined to two or three of the more common diseases, with special emphasis on treatment.

There are certain symptoms which point to some abnormality in the baby's blood. These are hemorrhage, anemia, jaundice, and edema. These often occur in combination but any one of them may be an indication of serious trouble and calls for prompt action.

The three subjects which I will outline briefly are, Hemorrhagic Disease of the Newborn, Hemolytic Disease or Erythroblastosis, and infection.

Hemorrhagic Disease is a much confused term. In its pure sense it applies to spontaneous hemorrhage, occurring in any part of the body but most commonly in the gastro-intestinal tract, and is associated with some dysfunction of the coagulating mechanism. This pure form is a rare disease, probably occurring in only about one out of every 2,500 babies. But many times the term is loosely used to include any form of bleeding. Intracranial hemorrhages from trauma, vomiting of bloody mucus, vaginal bleeding, oozing from the cord, mild melena, and cephalhematoma are often diagnosed as hemorrhagic disease. If all of these conditions are included, the symptom of bleeding occurs very often and it becomes important to distinguish between mild, self limiting conditions and serious bleeding.

The cause of pure hemorrhagic disease is not fully understood. The coagulation and bleeding time together with the prothrombin content of the blood are normally reduced in all infants between the second and fifth days, but in only a few does spontaneous hemorrhage occur. It was thought for a time that abnormal reduction of the amount of prothrombin was the cause of this disease, but that is not so certain, because hemorrhage takes place sometimes in cases which show higher prothrombin values than in many babies which do not bleed. Also simply building up the prothrombin level is not always sufficient to control the bleeding. It appears that some other unexplained factor must also be operative, perhaps something to do with vessel wall permeability.

It is interesting that this condition seemed to be much more common twenty-five years ago than it is now. This may be due to many cases formerly being diagnosed as hemorrhagic disease that we now recognize as something else, but it is probably also true that improved prenatal care and better maternal diets and hygiene have had something to do with this decrease.

Characteristically true hemorrhagic disease does not appear before the second day nor after the fifth. It is unassociated with other symptoms, the only sign being sudden, profuse, and frequently exsanguinating hemorrhage. It may cause death simply through blood loss or by bleeding into internal organs, particularly the adrenal gland.

Fortunately this disease responds spectacularly to treatment. A single blood transfusion of 60-100 cc. stops the bleeding immediately. It does not recur. If this is done promptly before other damage has been done the baby makes an uneventful recovery. Intramuscular injection of blood as formerly practiced, is not adequate, because the amount that can be given in this way is in-

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sufficient. It is too slow and the mode of action seems to be different. Under circumstances where facilities for giving a transfusion are not available, the intra-peritoneal injection of the same amount of citrated blood may be done in an emergency.

When the relationship of Vitamin K to prothrombin formation was learned a few years ago it was thought that the prophylactic administration of this substance would prevent hemorrhagic disease. This has proved to be unsatisfactory. The giving of Vitamin K to the mother before delivery has been shown to be useless in affecting the blood of the baby. A single injection in the amounts commonly used, to an infant at birth is ineffective and the rarity of the disease makes this needlessly expensive and impractical. Many hospitals have discontinued its routine use. Some are giving it only to prematures. This is on the theory that the premature does not begin to manufacture his own Vitamin K as soon as a full-term baby. If given on this basis it should be given repeatedly for several days. It may and probably should be used in treatment, however, in conjunction with transfusion. It is probably wise and certainly harmless to give Vitamin K to babies who show evidence of other types of hemorrhage of traumatic origin in order to prevent further bleeding, or where surgery is contemplated before the fifth day because of the normally prolonged coagulation and bleeding time at this period.

The discovery of the Rh factor some ten years ago did much to clarify a group of diseases which we previously did not understand at all. These had been called icterus gravis, hemolytic anemia, fetal hydrops, and various other names. Many of these are now at least partially explained.

The relationship between the different groups and subgroups of antibodies and agglutinins that have been described is exceedingly complex. Even those who are expert in this field do not entirely agree. It would be impossible for anyone engaged in active practice to keep in mind anything but the roughest idea of this relationship. Fortunately for practical purposes this is not necessary and a very satisfactory working basis for the handling of these cases can be had by keeping a relatively few things in mind.

The fundamental concept is that an Rh negative woman, who has been sensitized either by previous pregnancy or in some other way to Rh positive blood, has antibodies in her blood which have an antagonistic action on the blood of the fetus, if the fetus is Rh positive. This may vary widely in degree, sometimes causing fetal death and resulting in miscarriage or stillbirth, or in producing all grades of hemolytic disease in the newborn infant. There is still no satisfactory explanation of why the disease takes different forms in different cases. Why should in one case hemolysis be the outstanding feature, in another jaundice, and in yet another edema? Quite obviously there are still many things to explain about this disease.

Somewhere in the neighborhood of 15 per cent of all white women are Rh negative yet only about one baby in each 130 shows evidence of the disease. There are several reasons for this; usually it is because the mother is not sensitized to Rh positive blood. The fetus may also be Rh negative. The husband may be heterozygous so that only half or less of the offspring will be Rh positive. There are also certain Rh negative women who are incapable of becoming sensitized to Rh positive blood no matter how often they are exposed to it.

Accordingly, while in a busy obstetrical hospital these cases are seen frequently, an individual practitioner, even if fairly busy, might go for long periods without encountering one. That does not lessen the need for being alert to the possibility of the disease for many times these are especially important babies. They often occur in families who have lost previous children and this may well be the last opportunity to have a healthy child.

What are the things that should be done during pregnancy? At the first prenatal visit the woman's Rh should be determined. If she is Rh negative what is her previous obstetrical history? If this is her first pregnancy it is unlikely that she will be sensitized unless by previous blood transfusion. Has she lost previous babies? If so special caution is indicated. If she is Rh negative her blood must then be tested for antibodies. If there are none, there is little to worry about although this should be checked periodically during the pregnancy to see if she has become sensitized. If antibodies are present you know you are in for potential trouble. The *amount* of antibody present is apparently not very important. Severe cases occur in women with low titers and mild ones in those with high titers. Even a rising titer as pregnancy progresses does not seem to

indicate the severity of the disease that may be expected in the baby. The significant thing is whether antibodies are or are not present in any degree.

If such a situation exists we must be prepared in advance of delivery to care for the baby. If the mother lives in an area where adequate hospital facilities are not available, she should be sent to some center for delivery that is equipped to handle the case.

Immediately upon birth the baby should be carefully examined. The important things on physical examination are jaundice (often indicated by yellow vernix), anemia, or enlargement of the liver and spleen. However, the baby is often born in good physical condition and shows no gross abnormal symptoms. This can be very deceiving for in the course of only a few hours he may develop serious and quickly fatal symptoms. Anemia or jaundice developing in the first twenty-four or even forty-eight hours is highly significant.

The baby's blood must be examined at once to determine his Rh, hemoglobin, red blood count and the number of nucleated red blood cells. If he is Rh negative your worries are over except in the most unusual cases. The Combs Test for antibodies in the baby's blood is merely confirmatory since it will be positive if the mother has antibodies in her blood. If he is Rh positive but has no anemia or jaundice and there are fewer than ten nucleated red blood cells per 100 leukocytes it is usually safe to wait and see what happens, but if there is any anemia or jaundice or an increase of more than ten nucleated erythrocytes for each 100 white blood cells he should be transfused at once no matter how good his clinical condition appears. Do not wait for him to go bad. It may be too late, then. One of the most tragic complications which happens in babies who are severely jaundiced but do not die is the deposition of blood pigments in the vital nuclei of the brain, resulting in varying degrees of irreparable damage.

Transfusion is our only weapon against this disease. It serves two purposes; it replaces destroyed blood and neutralizes the antagonistic antibodies. There has been a great deal of discussion as to the best method of transfusion and about what kind of blood to use. There is probably little doubt that the exchange transfusion where from 500 to 1000 cc. of the baby's blood is replaced is the method of choice, certainly in severe cases. It is technically more difficult but can be done through the umbilical vein if done soon and if proper equipment is available. However many people think they get just about as good results with straight transfusion, particularly if packed red cells are used. The blood used should be Type O, Rh negative blood. For a time it was thought that female blood was preferable but this is by no means certain.

Sometimes a single transfusion is sufficient, but more often repeated ones are necessary. This is of course determined by frequent clinical and blood examinations. Some of the hemolytic cases may require as many as ten or twelve transfusions over a two or three week period.

Terminating the pregnancy before term does not lessen the incidence or severity of hemolytic disease and merely adds to the child's difficulties if he is very much premature. Delivery by cesarean section likewise does not influence hemolytic disease.

There is another condition which must always be considered when a baby presents the symptoms of hemorrhage, jaundice, and anemia. This is infection. Perhaps this is the commonest cause of changes in the blood.

While it does not happen often, it is now recognized that transplacental infection can occur and babies are occasionally born with pneumonia, meningitis, endocarditis, or general septicemia. More often these infections take place during or shortly after delivery. Congenital syphilis is not often seen in communities where good prenatal care is carried out but must be kept in mind for it can closely simulate erythroblastosis in all its details. Infections are much more frequent than commonly realized, and very often are not recognized. They can be very obscure and may not follow at all the symptom patterns that they do in older children.

Practically all of these babies will show jaundice, many of them progressive anemia, and some spontaneous hemorrhage. Accordingly until a clear cut diagnosis is made it is usually wise to assume the possibility of infection, and treat the baby accordingly. Here again, blood transfusion is one of our most potent weapons but it is our practice when we suspect an infection to employ everything at our command. This means the usual antibiotics and perhaps gamma globulin. It is seldom safe to wait for laboratory confirmation of the diagnosis because the bacteria work much faster than

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The Impact of Psychoanalytic Knowledge on the Medical and Surgical Care of Children

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PSYCHOANALYSIS is a method and technique of therapy for mental and emotional disorders and, as is generally known, was originated by Sigmund Freud. In the course of this therapy, many important observations were made concerning the importance of the early years in the personality development of the human being.

It is not our purpose to discuss the various schools of psychoanalysis or to enter into a discussion as to whether certain specific activities of our infants and children are instinctive or cultural, or whether the impression they make on the individual is due to instinctive drives or to conflicts with parents or parent substitutes. Let us rather direct our attention to certain specific phases in the life of every child, the importance of which was first demonstrated through psychoanalytic study, and attempt to show how our knowledge and gradual acceptance of this importance has influenced our attitude in the practice of pediatrics.

One of the first observations which can be made on almost all newborn infants is their ability to suck. This ability is so well developed that even as a baby is being delivered it will often suck on a finger that chances to find its mouth. Of course this sucking instinct is necessary for the survival of the helpless infant. But, if during the early months of life one studies the sucking habits of infants, he will come to a rather interesting conclusion—that the sucking does not seem to be entirely related to the taking of food. In fact, many infants will suck their fingers, tongues, bed covers or other close objects even after they have been completely satisfied with the feeding. The amount of this sucking activity seems to vary considerably with different infants.

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This finger sucking tendency is not new or related to our culture. Paintings from The Renaissance Period show infants sucking on their fingers.[4] Among primitive tribes finger sucking is likewise seen although less frequently.[6,27]

This tendency was viewed as unexplainable by most child psychologists,[3] and as a noxious habit by most pediatricians as recent as fifteen or twenty years ago.[27,36] A good deal was written on finger sucking as the cause of malformations of the jaw or even adenoid facies,[1,5] and all pediatricians resorted to the various means advised for the prevention of this habit. Finger splints, aluminum hand covers, celluloid wrist cuffs, elbow cuffs or cloth bound around the elbows to permit only slight flexion, as well as bitter substances to be painted on the fingers and finger nails were all advised.

However, in the meantime Sigmund Freud had contended as a result of his psychoanalytic investigations that during the development of the child, three areas of the body—the mouth, the anus and the genitals were at various times all absorbing organs of erotic pleasure and satisfaction. During the first year or two, he concluded, the zone of erotic pleasure was located in the lips and mouth.[8]

Following Freud's presentation of his observations, pediatricians and child psychologists began to study child activities in the light of this new concept. They noted that infants who finished their formulas quickly had a greater tendency to finger sucking than those who sucked more leisurely or who were given slower flowing nipples.[22,23,30,31] They noted that infants deprived of an adequate amount of sucking satisfaction were usually very unhappy and cried a great deal. It was also noted that many so-called colic babies quieted immediately when given a pacifier.[20] All of this was impressive evidence and gradually the attitude of the pediatric profession toward finger sucking changed to one of much greater leniency. With the knowledge that restriction of the intense desire for sucking satisfaction would bring great frustration, the artificial means of restricting finger sucking have been almost completely discontinued. Most modern pediatricians are not disturbed by the sucking activities, and many even offer pacifiers to the infants to satisfy this need. It is of interest to note, in passing, that studies have demonstrated that infants placed early on pacifiers do not resort to finger sucking later[16] and that

the so-called pacifier infants discard this sucking apparatus much sooner than finger sucking infants discontinue the use of their fingers in satisfying the same need.[16,20]

The knowledge of the instinctive need for oral stimulation has also led pediatricians to be more moderate in regard to weaning. Whereas, in the past, the weaning process from bottle to cup was attempted earlier and performed abruptly, today it is generally approached more in relation to the needs of the individual child and is usually discontinued more gradually.[26,34]

Psychoanalytic studies have demonstrated that the next area of the body on which great attention is focused is the anal area. Freud held that toward the end of the oral period the erotic zone shifted to the anus.[8] Other schools of analysis admit the focus of attention on the anal area but feel that the importance is the result of the conflict of the child with his parents or parent substitutes.[37]

And so, in response to this knowledge, our pediatric attitudes have also changed in relation to the toilet training of children, and are beginning to change considerably in our approach to constipation. All physicians who deal with growing children in their practices have repeatedly observed evidences of the child's interest in his bowel movements and his resistance to toilet training toward the end of his second year. Many small children during this stage play with their feces, if given the opportunity, smearing them over the play-pen or wall and at times even placing it in their mouths. During attempts at toilet training some will resist violently, screaming and stiffening when placed on the potty or toilet, while others will sit on the seat without resistance but without performance and then as soon as they are taken off have a movement on the floor or in their pants. Still others will go to the corner of a room or in a closet and defecate, feeling that they are unobserved. And there are those who resist toilet training to such a degree that severe and chronic constipation results, at times even producing a megacolon.[13,33] Freud pointed out that this marked resistance to toilet training is to be expected for, according to his findings, the child during this anal period is also going through a period when he is instinctively aggressive and resistant to force or pressure. This is the period when small children bite, kick and push.

As time goes on more and more physicians are accepting the opinion that over-emphasis of anal function and anal manipulation are detrimental. The old practice of advising a "habit time" is being discarded for it usually increases resistance. The suggestion of using each day a thermometer, enema tip or a suppository to stimulate an evacuation is also being discontinued. These might not only increase resistance or accustom a child to an unusual activity and possible dependency, but, in certain cases, such abnormal anal stimulation becomes extremely pleasurable, and the child later will place objects in his anus to gain similar satisfaction.

Today most pediatricians advise against any pressure in toilet training and suggest considerable flexibility in adapting the time of training to the individual child.[25] The approach to the subject of childhood constipation, in the light of psychoanalytic knowledge, is only beginning to obtain acceptance by the medical profession. Unfortunately the present-day mother has been so molded by her own upbringing and the force of advertising that she develops considerable anxiety if she feels her child to be constipated, and she usually consults her physician regarding this condition.

Mothers are now being advised by many physicians to guard against placing too much emphasis on the regularity of the movements, and especially to refrain from any show of anxiety in the presence of the child. Mothers are also being assured that daily bowel movements are not a necessity and that a child might have a normal two-day cycle. Furthermore, if he is in no distress and has no difficulty passing his movements, there is no danger if occasionally a child misses an evacuation even more than two days.

There is little doubt but that the greatest cause of chronic constipation in children, as evidenced by case studies as well as psychoanalytic investigation, is still the mother who forces the child in toilet training. Of special detriment is the mother who uses terms such as "filthy," "dirty," "nasty" when by chance a diaper is soiled. These latter mothers are usually meticulous and their children, becoming constipated, also, as a rule, become meticulous for not only are they resisting parental pressure by developing constipation, but attempting likewise not to do anything considered "filthy," "dirty," or "nasty."

The treatment of such cases is emotional as well as physical and, in a great many cases, can be successfully handled by the physician without resort-

ing to outside aid. It involves reassuring the mother and relieving her concern over so-called "intestinal poisons" or the possibility of impaction; giving plenty of laxative foods, or even, if necessary, mild disguised laxatives to keep the stools soft; directing the mother to show no apparent interest in the time, number or consistency of the movements; and advising that both mother and child play with and wallow in finger paints, plasticine, and even mud without any concern over the consequences of "getting dirty."

One cannot leave the subject of constipation without noting the decline in the use of objects advertised to the physician for dilating the anus of the constipated child. As has been stated previously such objects are of considerably more harm than benefit.

By the age of three years most children have already passed the period when oral stimulation is of such extreme importance. Most children by the age of three have also passed through the so-called anal aggressive stage; although there still may remain problems relative to it such as constipation or occasionally even soiling.

Psychoanalytic studies of Freud had also brought forth evidence that at some time between the ages of three and five years the primary interest shifts to the genitals, and it is during this period that all children learn that a great deal of sensual pleasure may be gained by handling the genitals. This is borne out by pediatric observations and evidence would seem to show that all children masturbate at some time during this period.

It is extremely interesting to note how greatly the attitude of physicians toward masturbation has changed since the psychoanalytic concepts were first promulgated.

In the 1925 edition of Holt's *Diseases of Infancy and Childhood* the tying of the hands and legs to the corners of the crib was advised and among other treatments suggested were circumcision, separation of the head of the prepuce from the clitoris, and dorsal slitting of the prepuce of the penis. In obstinate cases cauterization of the clitoris, "and even blistering the inside of the thighs, the vulva or the prepuce is sometimes useful." "In serious cases," suggests the same book, "send the child away from home and keep him from other children."[11]

The 1933 edition of the same book gives the same advice about mechanical restraints but eliminates the suggestion concerning the blistering of the thighs, vulva, or prepuce. Also it further states that "masturbation should not be painted as a shameful thing but a physiological process to be brought under control like excreta are brought under control."[10]

In the 1940 edition of Holt's *Diseases of Infancy and Childhood* there is a decided change in attitude toward masturbation. Instead of the repressive tactics advised it is stated, "It is of the greatest importance to prevent destructive handling of the situation. Mechanical restraints are poorly borne and may cause resentment and negativism. Much worry and anxiety about the act may be produced in the child by threats and punishments. Phimosis and preputial adhesions are not to be regarded as causes *per se,* and circumcision should not be performed except for the usual indications. As a psychotherapeutic procedure it is contraindicated. There is no evidence that any physical harm comes from masturbation, no matter how frequently practiced."[12]

Today all up-to-date textbooks on pediatrics consider masturbation as a normal activity of children, and of no unusual significance unless it is practiced excessively to the exclusion of many other activities. However, although most physicians agree today that there is no harm in masturbation, a good many still concur with the anxieties of parents and advise various means of attempting to prevent it.

The dangers which result from repressive tactics, including threats and punishments, are extreme for they may force a child to repress the instinctual sexual feeling and the anxiety may become a barrier to normal sexual development. The impression that there is something bad about touching or using the sexual organs may tend in later life to frigidity and even impotency.

One other finding of psychoanalytic study relative to the period which has only begun to be accepted by physicians is a child's fear of castration. This may seem far-fetched to many physicians but the results of numerous analytic studies on children and also adults give credence and backing to this finding.

It follows that it is important for the physician to avoid any unnecessary traumatic manipulation or operative procedure on the genitals of a child during this period, such as circumcisions, catheterizations and cystoscopic examinations, all of which are performed far too frequently. Most children

of this age level who have undergone these procedures look upon them as castration activities and feel that they have not only been punished but damaged as well.[18,19,35]

All of us realize the complete dependency of an infant on its mother or mother substitute during the first two years of life, and the almost complete dependency up to the approximate age of six years. Psychoanalytic studies have demonstrated that during these years, total separation from the mother or even a threat of separation or lack of maternal affection produces great anxiety in the child which may be expressed in many ways.[7,29]

Within recent years a great deal of material bearing on this subject has appeared in psychoanalytic literature concerning the disastrous effects of separating young children from their parents.[2,9,21,24] The response of children to lack of mothering, to institutional care, to hospitalization have all been well documented.[15,28,32] These findings have already made a considerable impression on pediatricians, nurses and hospital administrators throughout the country.[14] As a matter of fact many pediatricians when presented with a child who has developed enuresis, sleep problems, stammering, stuttering or habit spasms will ask, in the course of history taking, if there has been any separation from the parent. This concept has already taken root to such a degree that many physicians will attempt in every way to prevent the hospitalization of a small child realizing that the close attachment to the mother is a child's "life-line," and that separation might cause severe emotional upset. If hospitalization is a necessity, every effort is made to have the parent remain with the child at least during the early days in the hospital. This is of particular importance if the child must undergo an operation, for it means everything to that child to awaken from an operation and find his mother at the bedside. It is worth noting that a number of children's hospitals have already arranged to have parents remain in the hospital with small children. It is also interesting to note that an effort is being made by certain surgeons today, in co-operation with the pediatricians, to discharge children from the hospital at the earliest possible moment.

Children who undergo herniotomies are discharged from the hospital on the first postoperative day and uncomplicated appendectomies on the second postoperative day. In such cases, they are brought to the physician's office for the removal of stitches. Such postoperative care has been found uniformly successful.

With this new approach, hospitalization for children in the future will probably be advised only under extreme circumstances, such as the need for intricate treatments, surgical procedures, or for studies which cannot be performed by the physician or a local clinical laboratory.

Unfortunately at the present time, a great many children are hospitalized for the convenience of the physician with little regard for the emotional effect upon the child. Probably over 50 per cent of hospitalized children could have been studied and treated at home. It should also be added that under the impulse of the numerous studies relative to separation and the need for mothering, most of the child adoption agencies make every attempt to bring an infant quickly to its adoptive home. Also, the former method of institutionalizing small children of working widows or deserted mothers is being gradually discarded in favor of child care centers where children are cared for during the day, and returned to their homes in the evening so that they might have the care and affection of their own mothers.

Another subject of great interest to those who observe children is the tendency to regress when emotionally upset. A child will start finger sucking years after the habit was discarded; after years of being dry, will become enuretic; he may even start soiling again. As an example, a child age five years already completely toilet trained and clean, may start soiling again when faced with the presence of a new baby in the home, a situation frought with anxiety lest he lose part of the affection of his parents.

Frequently children regress following traumatic experiences, a fact to which many physicians can attest. A child of three and one-half years was run down by a truck and was hospitalized with a fractured skull, collapsed lung and internal injuries. During the early days in the hospital, he was extremely restless in spite of sedation until, on the pediatrician's suggestion, a pacifier was offered, an object which the child had given up at eighteen months of age. The child relaxed immediately and continued this sucking activity throughout most of his convalescence.

The understanding of regressions is another of the valuable contributions made by psychoanalytic study. These indicate that when a child or adult

experiences frustration due to deprivation, anxiety, danger or trauma, he reverts to infantile or childhood patterns in an attempt to obtain gratification in ways found satisfying when he was younger. As an example, the lips gave him great comfort and satisfaction as an infant and by his reversion, he gains some sense of this same gratification.

Today the relation of regressions to the emotional status of the child is accepted by almost all pediatricians. When an older child is excessively finger sucking, nail biting, masturbating, or even bed wetting, the pediatrician will usually attempt to ferret out some underlying anxiety instead of looking on these activities as bad habits which must be overcome by force or punishment. In other words, it is now recognized that regressions, whenever observed, are evidences of frustration or anxiety and the problem is one of relieving the anxiety rather than preventing the regressive habit.

This has been but a brief summary of some of the influences of psychoanalysis on the modern practice of pediatrics. Through the years this science has contributed a tremendous amount of information concerning human personality and the factors which influence it.

This information has focussed attention on the importance of certain periods in the course of child development. The application of this knowledge has resulted in notable changes in the science of pediatrics—changes, which it is hoped will aid considerably in the emotional well being of our children.

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Circumcision in Gentiles

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THOUGH it is common knowledge that almost all Jews lose their prepuces on the eighth day, and most Mohammedans near puberty, there are few statistics available regarding circumcision rates in gentiles and Negroes. Wilson,[5] in a study of 1,000 whites at a Canadian Army induction center found 48 per cent circumcised. Of 2,001 new-born males at the Vancouver General Hospital in 1945 he found 50 per cent circumcised.

Auto-Circumcision

Of the 1,900 men of this series who were examined and questioned regarding circumcision, 1,796 were white gentiles. Physical examination revealed that apparently 41.2 per cent were circumcised and 58.8 per cent uncircumcised. All of the circumcised were examined and questioned as to whether a surgical circumcision had been done, and if so, as to when and why. Of those that were apparently circumcised 28 per cent had never had any surgical procedure done. They had trained their foreskin to remain back over the carona, producing a self or auto-circumcision.

Though the most common reason for auto-circumcision was for obvious esthetic reasons, a few had done this often at the request of their physician due to venereal disease, recurrent balanitis, venereal warts, and recurrent herpes progenitalis. In my original studies[2,3] auto-circumcision was considered a rare event and was unfortunately ignored.

Auto-circumcision is seen more often as men enter their active sex period. This increased from 31.6 per cent of those apparently circumcised being auto-circumcised in their twenties to 82.6 per cent of those apparently circumcised being auto-circumcised in their fifties.

Circumcision

Prior to the turn of the century circumcision was a rare operation in white gentiles in this area, occurring in 6.8 per cent. It was even rarer in those born on the farm.

The few urban males that were circumcised were definitely from better class families.

From 1900 to 1910, circumcision increased due, perhaps, to the broad improvements in medical sciences in this country, until 18.6 per cent of white gentiles were circumcised. It still was confined chiefly to urban males from the upper classes. This trend continued until 1930 except that a few more rural and lower class urban males were hospital born and subsequently circumcised. Twenty per cent of the white gentiles were circumcised during this period.

From 1930 to 1940 due to a number of factors —improvement in hospital facilities, general economic improvement, and the start of hospital and surgical insurance coverage—more and more babies were hospital born. The circumcision rate increased until 45.6 per cent of the white gentile males were circumcised. Those from families in better circumstances were still more likely to be circumcised. The rural rate increased but still lagged behind the urban rate.

These trends have continued in all classes from 1940 to the present time, chiefly due to the rapid increase in hospital and surgical insurance coverage and continued improvement in hospital facilities. Of the white gentiles in this area born in this period 77.9 per cent were circumcised. As practically all white urban babies are hospital born in this area the circumcision rate in urban white males is nearing 90 per cent. The rural rate still lags behind the urban rate as many rural babies are still born out of hospital.

Though a few circumcisions were done in doctors' surgeries the great majority were done at birth in hospitals, either as a routine measure or at the request of the parents. This is particularly true during the last twenty years. A few were done later, usually before puberty when a younger brother was circumcised, or at the time of some other operation such as tonsillectomy or appendectomy. A few more were done in military life. Some were done due to venereal disease, recurrent balanitis, venereal warts, phimosis, and recurrent herpes progenitalis. Cure in herpes progenitalis usually did not occur after circumcision. Surgical circumcision was rarely performed after twenty-five years of age. The oldest in this series was done at age thirty-eight due to recurrent venereal infection.

The remaining men consisted of twenty-two Jews, fifty-six Negroes and twenty-six Mexicans. It would be hazardous to draw any inferences from the few Mexicans, Jews or Negroes in this

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series. The twenty-two Jews were all circumcised.

The twenty-six Mexicans were chiefly itinerant farm help and foundry workers. None of these were circumcised although three were auto-circumcised. The history of venereal disease was high in those that had reached the age of sexual experience.

The fifty-six Negroes examined were almost all foundry workers. Twelve or 23.2 per cent were apparently circumcised and forty-three or 76.8 per cent were uncircumcised. Four of those apparently circumcised were auto-circumcised. Four of the surgically circumcised were done at birth, and four in late life due to venereal disease. As expected, a history of venereal disease was extremely high in this group.

TABLE I. CIRCUMCISION RATES IN WHITE GENTILES

Age	Number	Surgical Circumcision	Auto-Circumcision	Apparently Circumcised	Uncircumcised	Short Foreskin	Long Foreskin
0–10	272	78.0%		78.0%	22.0%	10.3%	11.7%
11–20	236	44.0%	0.9%	44.9%	54.9%	18.4%	36.5%
21–30	384	20.3%	9.3%	29.6%	70.4%	37.8%	32.5%
31–40	380	20.0%	13.2%	33.2%	66.8%	36.8%	30.0%
41–50	246	18.6%	15.4%	34.0%	66.0%	34.2%	31.8%
51–60	126	6.3%	30.1%	36.4%	63.6%	30.1%	33.5%
61–70	108	5.0%	31.4%	36.4%	63.6%	41.8%	21.8%
70–	44	9.0%	22.5%	31.5%	68.5%	23.5%	45.0%
Total	1796	29.7%	11.5%	41.2%	58.8%	29.9%	28.9%

Summary and Discussion

There is little doubt that the circumcision rate in white gentiles is increasing and may eventually approach the rate seen in Jews. It is of interest to conjecture as to what has been and what may be the result of this trend. The venereal disease rates in all parts of this country, especially for syphilis, have fallen rapidly from the postwar time highs. Though the use of penicillin and other antibiotics have undoubtedly been a big factor, there are some, including Shaffer,[4] who believe other factors, especially the increase in circumcision rates, may also be important.

The age when the youth makes his first fumbling approach to sexual relationships until the period when most men take up a monagamous relationship with or without benefit of clergy could be called the period of active sexual promiscuity. This is roughly eighteen to twenty-five years of age, and is the period when most men acquire venereal disease if they are that unfortunate.

Prior to the middle of the 1940's, 30 per cent of the white gentile men who were in their period of sexual promiscuity, were circumcised (surgical plus auto-circumcision). At that time more and more men in the period of sexual promiscuity began to be circumcised due to the increase in surgical circumcision which began in 1930. This may be a partial cause of the drop in venereal rates. As this increase in surgical circumcision has continued until almost 80 per cent of the white gentiles are being circumcised at this time, venereal disease rates in white gentiles should continue to decerease.

A gradual decrease in Vincents' and non-specific balanitis, penile condylomata acuminata and certainly phimosis and paraphimosis can be expected in white gentiles.

If Bessesen's[1] theory (confirmed by Plaut and Kohn-Speyer) is correct that smegma contains a carcinogenic agent that may be a cause of penile cancer and also cervical cancer in the sex partners of the uncircumcised, we can expect a gradual decrease in cancer of the cervix in white gentiles until the rate approaches the low rate seen in Jewish women. Cancer of the penis should also become less common as it is almost never seen in the circumcised.

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Postgraduate Continuation Courses

Wayne University College of Medicine

December 8, 1952-March 14, 1953

These courses are open to all qualified persons. Veterans receiving benefits under the G.I. Bill should contact Dr. Arthur Johnson, Veterans Administrator at Wayne University, 5524 Cass Avenue, Detroit, Michigan.

Registration for these courses should be made in the office of Postgraduate Medical Education at the College of Medicine, 1512 St. Antoine, *before December 6.*

MICROBIOLOGY			
Seminar in Microbiology	College of Medicine	Tuesday 3:30-5:00	$15.00
PHYSIOLOGICAL CHEMISTRY			
P. Chemistry Seminar	College of Medicine	Thursday 3:30-4:30	$15.00
Intermediary Metabolism	College of Medicine	Friday 1:00-2:00	$15.00
PATHOLOGY			
Gynecologic Pathology	College of Medicine	Wednesday 1:00-5:00	$50.00
Neuropathology	College of Medicine	Friday 1:00-5:00	$50.00
Advanced Hematology (Limited to 5)	College of Medicine	Monday 1:00-5:00	$50.00
Dermatology (Beginning Dec. 17)	College of Medicine	Wednesday 1:00-5:00	$50.00
DERMATOLOGY			
Seminar in Dermatology	Receiving Hospital	Wednesday 10:00-11:30	$15.00
Conference on Venereal Diseases	Social Hygiene Clinic	Thursday 12:30-2:00	$15.00
INTERNAL MEDICINE			
Medical Conference	Receiving Hospital	Saturday 11:00-12:30	$15.00
Gastroenterology	Receiving Hospital	Saturday 8:00-9:00	$15.00
Medical X-Ray Conference	Receiving Hospital	Tuesday 11:00-12:00	$15.00
Allergy Clinic and Conference	Receiving Hospital (Minimum of 4)	Tuesday 8:00-11:00	$25.00
SURGERY			
Surgery Seminar	College of Medicine	Monday 4:00-5:00	$15.00
COMPREHENSIVE UNIT COURSE OPHTHALMOLOGY			
Basic Ophthalmology (Limited)	Kresge Eye Institute and hospitals	Full Time (9 months)	$900.00

This class in Ophthalmology will begin in September, 1953, and applications must be in immediately. Applications can be secured from the Postgraduate Department at the College of Medicine, 1512 St. Antoine, Detroit 26, Michigan.

Hospital Standards Upheld by Michigan Voters

The national elections are now relegated to the past and all can be proud of the fact that such a large number of voters exercised their franchise to express their choice in a truly democratic fashion.

There was an important issue voted upon in one of the cities of our state, namely whether practitioners other than doctors of medicine would be allowed to admit patients to a municipal hospital. The result of this election demonstrated that the public desires hospital standards of high quality. The people of that community voted overwhelmingly to uphold such standard of hospital and medical care. If the hospital trustees, together with their medical advisory boards, assume this responsibility, I am convinced the public will feel they are receiving the best care available, regardless of the label applied, and such an issue as recounted above would in all likelihood never arise.

We should be grateful to the American College of Surgeons for instituting its hospital accreditation program many years ago. It was an early step in the right direction but it became a financial burden. Realizing the benefits accruing to patients from such a program, a new plan was instituted this year sponsored and supported proportionately by the American College of Surgeons, American College of Physicians, American Hospital Association, American Medical Association and the Canadian Medical Association, to incorporate the basic principles of high quality medical care and to insure their continuance in our hospitals. There will be uniform procedures in inspections of hospitals, each institution to be surveyed every two years.

If medicine stands for the search of truth in medical practice arrived at by sincere research and clinical experience, we have no cause to fear the application of such standards to the practitioner of any healing art.

R. J. Hubbell

President, Michigan
State Medical Society

President's



Message

Editorial

1953 MICHIGAN CLINICAL INSTITUTE

THE SEVENTH annual Michigan Clinical Institute will be held at the Sheraton-Cadillac Hotel, Detroit, on Wednesday-Thursday-Friday, March 11-12-13, 1953 (following the Michigan Industrial Health Day scheduled for Tuesday, March 10).

Sponsors of the 1953 MCI include: Michigan State Medical Society, Wayne County Medical Society, University of Michigan School of Medicine, Wayne University College of Medicine, the University of Michigan Department of Postgraduate Medicine, the Michigan Department of Health, the Michigan Foundation for Medical and Health Education, Inc., the Michigan Heart Association, Michigan Regional Committee on Trauma of the American College of Surgeons, and the Michigan Division of the American Cancer Society.

The popular "block system," which achieved great success at last year's Institute, will be repeated at the 1953 Institute. For complete Program, see page 1576.

CONSTANT WATCHFULNESS THE PRICE OF FREE MEDICINE

THE ELECTION has been held, the new president elected, and from the standpoint of political party in control presumably the independent and private practice of our profession, and the other professions also, is assured. We hope and we believe this to be true. The new party control will surely remove from the political scene such thorns in our sides as Truman and Oscar Ewing who have been the spearhead of the socializing program for the nation, with especial attention to the practice of medicine. Truman we know is out—Oscar Ewing is out too, unless through some last minute manipulation he is placed on Civil Service.

The drive toward socializing the profession and the people started long before either Truman or Ewing came on the horizon. For many years a small group has been entrenched in the bureaucracies of Washington, in safe protection of Civil Service. They have helped the formation of the International Labor Organization, to which the U. S. has subscribed. They went to England and helped write the socialized medicine program there. Because of Civil Service these career bureaucrats are secure in their jobs, and President Eisenhower will find difficulty in displacing them in the Social Security Administration. They have worked with socializers, like Mike Davis, Dr. Frothingham, Dr. Boas, the social-minded labor leaders, and will not give up easily.

The President's Commission on the Health Needs of the Nation—The Magnussen Committee—held a recent meeting in Washington where many proposals were made and a report promised the President in the near future. One of the suggestions made by several, including Oscar Ewing, was that the solution of the medical problem be built upon the vast success and resources of the voluntary medical and hospital plans, the Blue Cross and Blue Shield: that through work with the doctors and hospitals the voluntary plans be extended, through federal government supervision, or aid, to cover all the persons who really need the prepayment services. Some commentators and a considerable number of persons thought this a masterful suggestion.

It was suggested that provision could be made so that our voluntary plans could be used in the care of the indigent and other wards of the state. Insurance could be provided, a subsidy given, or a system of repayment be adopted similar to the Veterans plans now in force. Fortunately, when the profession and the hospital groups were building our plans they took a decided stand against any subsidizing or entanglements by or with the government. After our work had been well started and had demonstrated its possibilities, the Supreme Court of the United States made a decision that the Federal Government may dominate anything which it subsidizes. We must have had warnings of evil, for that subsidy is the one thing we never fell for.

How about our veteran's plan? We foresaw the possibilities of a worthy and needed program to give the veteran home town, and private physician attention, bridging a failure in the

government set-up. In making arrangements with the Veterans Administration we provided strictly and specifically that our plans should never make a dollar profit from that service. Michigan Medical Service pays our doctors for their care of the veteran, then charges the total cost to the government, with the addition of the absolute cost of operation. These books are audited for that purpose. It was felt that if the Michigan Medical Service made absolutely no profit, simply was reimbursed for our expenditures, there never could be a claim of subsidy.

If the voluntary prepayment plans in operation can be kept independent, we do not fear their use in socializing. We believe we are much safer now after the people have expressed their choice against the socializing influences. The country has chosen an Administration which believes in private enterprise.

Another caution must be sounded—and this one is a real threat. According to provisions of the Constitution a treaty, or an international agreement of treaty status supersedes any federal or state law. The United States has several such entanglements. For many years the International Labor Organization has had U. S. approval and support. Its action of last July in Geneva set up a proposed standard of health care for the world, with intention to have such plans adopted generally by all the subscribing nations. That plan we mentioned editorially this summer. That program is completely socialized medicine. We also are a part of the United Nations, and subject to the same control. The United Nations has advocated and set up many plans which call for the socializing of medicine. The ILO is actually endorsed by that body.

Proposals have been made in the Congress to amend the Constitution removing the provision that treaties supersede our own laws. Until this is done we are not secure in our independence. The socializers are always at work, and protected in their Civil Service jobs of so great importance and opportunity. Their program has been to bite a little here, and there—to gain one small item in the whole general program, then another, neither of which seems to be of vital or special interest, but all together will amount to complete socialization.

We now are confident there will be no more socialization advocated and forced upon us from the heads of the new government, and we are apt to let down our guard because of a feeling of security. But never was there more need of constant watchfulness. The socializers are still in the government and will try to carry out their nefarious ambitions. Eternal vigilance is necessary to give us the same protection in the future as we have achieved in the past. That is the price of continuing our way of life.

OFFICERS' RECOMPENSE

DURING the Annual Session of the Michigan State Medical Society held in Detroit, September 24-26, 1952, several times the Editor and other officers were asked "What do the officers get out of the Michigan State Medical Society? How much are they paid? What do the members get in return for their dues?"

The implication was the officers and members of The Council get salaries and material benefits and that the dues-paying members get little in return. This question from just a few is perennial. It has been asked often enough for us to believe a reply should be given.

There are two officers of the Michigan State Medical Society who draw *part-time* salaries from the Michigan State Medical Society. The Medical Secretary, L. Fernald Foster, M.D., of Bay City, is paid for his service as Secretary, and the Editor, Wilfrid Haughey, M.D., of Battle Creek, draws a salary for his editorial work.

Dr. Foster last year was away from his home town part of 156 days on duties connected with the Michigan State Medical Society. At home he is a pediatrician with an exacting practice.

The Editor was out of town last year on matters connected with service to the Medical Profession, ninety-three days. At home his practice is Eye, Ear, Nose and Throat, with very little chance to do editorial work during office hours. Most of his editorial work is done at home after 7:00 p.m.

All the 25 members of The Council attend three full meetings of the Council: One in January, taking four days, one in July, four days, and one in September at the Annual Session of the Michigan State Medical Society—frequent meetings—with many duties from Sunday noon until Friday afternoon. These Council meetings usually begin the first day at noon and continue till about 12 or 1:00 a.m. The second and third days they may start with breakfast or they may start at 9 a.m. and they continue till late at night. Every function of the State Medical Society, the reports of all of the over fifty active committees, and re-

ports of executive personnel must be studied in detail and approved before they are effective.

The Executive Committee of the Council meets each month in which a general Council meeting does not occur. These meetings start about 10:30 a.m. and continue until 10:00 p.m. or midnight after which the Doctors must go back home or stay overnight and go back home the next day. Their function is the same as The Council.

The Executive Committee consists of the Chairman, the Vice Chairman, the Chairman of the Publications Committee, the Chairman of the Finance Committee, the Chairman of the County Societies Committee, the Speaker of the House of Delegates, the Vice Speaker of the House of Delegates, the President, the President-elect, the Secretary and the Treasurer. Also invited are the immediate Past President and the Editor. All are expected to attend these meetings and the attendance percentage is extremely high.

The Councilors representing the eighteen MSMS districts are expected also to attend the meetings of the County Societies in their districts. They are frequently called upon to go to various places in the state, and elsewhere, representing the State Society. For several years a delegation has gone to the Upper Peninsula to bring the story of the Michigan State Medical Society and its activities to the members in that far distant region, many of them farther from Detroit than New York City.

The proper execution of these duties, and they *are* so executed, takes tireless hours and much travel. The only recompense is traveling expense —except that many of these men refuse or forget to send in their expense accounts.

The President of the Society, the President-elect and the Past President are called upon many times to fill in on emergencies, to take messages to local societies, to preside at meetings of other groups. The privilege of being President, or any other officer of our medical society is a costly one. We have known many men who accepted the honor and the responsibility and found that the personal cost ran into the thousands of dollars, but they were willing to serve and did serve US.

Multitudinous Duties

Other groups serving the medical profession in Michigan without recompense are worthy of our greatest respect. No medical member on the Board of Directors of Michigan Medical Service is paid one cent in salaries or benefits. That Board meets eight or nine times a year involving a trip to Detroit and frequently an overnight one. This group started with nothing but a loan of $17,000 from the Michigan State Medical Society and has built a business paying physicians almost $20,000,000 this current year. It is one of the biggest public service corporations in the Nation. One Doctor of Medicine receives part-time pay as medical director appraising claims. The medical members of the Board and others appointed, constitute the Medical Advisory Committee to which is referred every question in dispute on the matter of services and recompense for services rendered to our people. The doctor who cares for the patient is supposed to send in a report, detailing the type of case, and the services rendered. All items which require individual consideration go to the Medical Advisory Committee which studies each case in detail, asking for and securing any additional information if necessary to a decision. Many times the discussion of one case will take several hours and a close vote. The committee meets at least once a month and frequently all day Sunday.

Political Doctors

Another and a heartless comment has been made too frequently. The member who has been selected and is serving as an officer of the Society is referred to as a "political doctor." One of our very promising Councilors was so mentioned not too long ago, and he promptly refused to hold office any longer. Many of our well intentioned officers have met this criticism. Some years ago the Editor was confronted with the charge of being a political doctor while the speaker boasted of being a scientific doctor. He was promptly challenged to match published scientific papers or original research, and was forced to admit he had neither. That our officers are men of scientific attainment is proven by the fact that during the past year several papers have been published in our JOURNAL and other good medical publications of the nation by Presidents or Councilors.

Benefits to Members

What does the dues paying doctor get for his money? We think that has been answered above: In addition to the careful services of the various officers and committees working on his problems he also gets an opportunity to attend two of the most outstanding graduate sessions with the best teachers possible coming to our state and giving us instruction. He gets the benefits and satisfaction that his patient may if he wishes pay for his hos-

pital, medical and surgical attention through a prepayment program devised and established by his colleagues. He gets many postgraduate study opportunities. He gets a monthly JOURNAL through which he may keep himself well informed of his professional and economic interests. He gets the services of over five hundred of his fellow members working on committees doing research and investigation.

But he only gets all these benefits if he himself puts in a little effort.

THE YEAR'S END

WITH THIS issue of the JOURNAL the Michigan State Medical Society completes the fifty-first year of publication. As in the past years the editorial effort has been to give the members and readers the best possible scientific articles, a review of the sociologic and economic interests of the society and its members, and to present the considered and consistent leadership which has made the Michigan State Medical Society one of the forefront in the progress of good medicine, good government and good relationship with our clientele.

The year 1952 has been one of decision, one of challenging problems and one of real accomplishment. We have directed through the Legislature the modernizing and partial rewriting of the Medical Practice Act, which was entirely outdated. We have studied and rewritten the Basic Science Law and corrected the mistakes or items which made it unsatisfactory. It now has a chance to prove its adequacy and workability.

During the year we have conducted two sessions, the annual Michigan Clinical Institute in March and the MSMS Annual Session in September, attracting ever greater numbers in attendance, and bringing to our State over fifty of the nation's great names in professional practice and leadership.

We bow to the passing year with satisfaction in its opportunities and achievements, and we look forward to the new year with hope and anticipation.

Hail and Farewell!

Postgraduate Course in Early Detection of Cancer

Wayne University College of Medicine

Three facilities of the Wayne University College of Medicine are to be used throughout the year in the presentation of the course: The Yates Memorial Clinic at 4811 John R, Detroit; the Detroit Receiving Hospital; and the Veterans Administration Hospital, Dearborn. The course is scheduled so that it may be taken for the entire year of three quarters, or so that any one quarter may be elected. It is designed so that doctors of medicine may become acquainted with the means of diagnosis and with the tools of diagnosis which are readily available to them.

Second Quarter—December 8, 1952-March 14, 1953

Monday—Cancer Control Clinic (women)	
Yates Memorial Clinic	3:00- 5:00 p.m.
Wednesday—Review of Biopsy Slides and Papanicolaou Smears	
Yates Memorial Clinic	10:30-11:30 a.m.
Friday—Consultation Clinic	
Yates Memorial Clinic	10:00-12:00 a.m.
Friday—Tumor Board	
Veterans Administration Hospital, Dearborn	3:00- 5:00 p.m.

Third Quarter—March 16-June 13, 1953

Wednesday—Review of Biopsies and Papanicolaou Smears	
Yates Memorial Clinic	10:30-11:30 a.m.
Wednesday—Tumor Clinic	
Detroit Receiving Hospital	12:30-2:00 p.m.
Thursday—Cancer Clinic (women)	
Yates Memorial Clinic	3:00- 5:00 p.m.
Friday—Consultation Clinic	
Yates Memorial Clinic	10:00-12:00 a.m.

Registration for this course can be made in the office of Postgraduate Medical Education at the College of Medicine, 1512 St. Antoine, Detroit 26. Those wishing to be enrolled for the second quarter must register *before December 6.* Tuition is $50.00 per quarter, and the class is limited to fifteen.

Seventh Annual Michigan Clinical Institute

SHERATON-CADILLAC HOTEL, DETROIT

Wednesday-Thursday-Friday, March 11, 12, 13, 1953

J. Milton Robb, M.D., Detroit, General Chairman

Information

- **HEADQUARTERS**—Sheraton-Cadillac Hotel; Assemblies, Exhibits and Press Room on Fourth Floor.

- **REGISTER**—Pan American Room, Fifth Floor, Sheraton-Cadillac Hotel—as soon as you arrive.
 Hours: **Tuesday, March 10—1:00 p.m. to 5:00 p.m.**
 Wednesday, March 11—7:30 a.m. to 5:00 p.m.
 Thursday, March 12—8:30 a.m. to 5:00 p.m.
 Friday, March 13—8:30 a.m. to 3:30 p.m.

- **NO REGISTRATION FEE for Members of MSMS and other State Medical Associations, AMA, and Canadian Medical Association.**

- **ADMISSION BY BADGE ONLY** to all Assemblies, Discussion Conferences and the Exhibition. Please present your MSMS or other State Medical Association, AMA, or CMA Membership Card to expedite registration.

- **GUESTS**—Members of any state medical association, AMA, or CMA members from any province of Canada and physicians of the Army, Navy, and U. S. Public Health Service are invited to attend, as guests. No registration fee. Please present credentials at the Registration Desk.

 Bona fide doctors of medicine serving as residents, interns, or who are associate or probationary members of Michigan county medical societies, if vouched for by the president or secretary of the county medical society in whose jurisdiction they practice, will be registered as guests. Please present credentials at the Registration Desk.

- **MICHIGAN DOCTORS OF MEDICINE**, in practice but who are not members of MSMS, if listed in the American Medical Directory, may register as guests upon payment of $25.00. This amount will be credited to them toward dues in the Michigan State Medical Society FOR 1953 ONLY, provided they subsequently are accepted as members by the County Medical Society in whose jurisdiction they practice.

- **DOCTOR**, register Tuesday, to save your time! Registration of physicians will be held Tuesday afternoon from 1:00 to 5:00 p.m.—as well as on Wednesday, Thursday, Friday, during the 1953 Michigan Clinical Institute. The Tuesday afternoon registration hours are arranged so that physicians may avoid waiting in line Wednesday morning before the opening Assembly.

 We recommend to Detroit physicians—and those who arrive in Detroit on Tuesday—that they register Tuesday, March 10, from 1:00 to 5:00 p.m., Pan American Room, Fifth Floor, Sheraton-Cadillac Hotel.

- **TELEPHONE SERVICE**—Local and long distance telephone service will be available in the Sheraton-Cadillac Hotel, fourth floor. In case of emergency, physicians will be paged from the meetings by announcement on the screen. Call the Sheraton-Cadillac Hotel, Detroit, Woodward 1-8000, and ask for the Michigan Clinical Institute extensions on the fourth floor.

- **CHECKROOM** is available in the Sheraton-Cadillac Hotel, fourth floor.

- **GUEST ESSAYISTS** are very respectfully requested not to change time of their lecture with another speaker without the approval of the Committee on Arrangements. This request is made in order to avoid confusion and disappointment on the part of members of the audience.

- **PAPERS WILL BEGIN AND END ON TIME**—Nothing makes a scientific meeting more attractive than by-the-clock promptness and regularity; therefore, all meetings, luncheons, and panels will open on time, all speakers will be required to begin their talks exactly on time and to close exactly on time, in accordance with the schedule in the Program. All who attend the Institute are respectfully requested to assist in attaining this end by noting the schedule, carefully and being in attendance accordingly, in order not to miss that portion of the program of greatest interest.

- **TECHNICAL EXHIBITS**—Seventy-four interesting and instructive displays—will open daily at 8:30 a.m. and close at 5:30 p.m., except on Friday when the exhibit breaks up at 3:15 p.m. Frequent intermissions to view the exhibits have been arranged daily before, during and after the assemblies.

- **REGISTER AT EVERY BOOTH**—There is something of interest or education in the large exhibit of technical displays.
 SAVE AN ORDER FOR THE EXHIBITOR AT THE MICHIGAN CLINICAL INSTITUTE.

- **POSTGRADUATE CREDITS** are given to every MSMS member who attends the Michigan Clinical Institute. Notify H. H. Cummings, M.D., Chairman, MSMS Committee on Postgraduate Medical Education, 1313 E. Ann St., Ann Arbor, Michigan.

THREE DISCUSSION CONFERENCES

These quiz periods will be held Wednesday-Thursday-Friday, March 11-12-13, Grand Ballroom, Sheraton-Cadillac Hotel, 12:00 to 1:00 p.m. with all the guest speakers of the day invited to appear on the platform.

An opportunity to ask questions concerning the presentations of the guest essayists, or to discuss one of your interesting cases with them, is thus provided.

- **PARKING**—Do not park on Detroit's streets. Inside parking, at a convenient distance from the Sheraton-Cadillac Hotel, is available at the Book Tower Garage, 333 State, the DAC Garage, 1754 Randolph, and the Grand Circus Garage, 1776 Randolph.

- **INFORMATION OF PRACTICAL VALUE IN DAILY PRACTICE** will be found at the Michigan Clinical Institute. All subjects on the Institute Program are applicable to clinical medicine. They stress diagnosis and treatment, usable in every-day practice.

- **"UBIQUITOUS HOSTS"**—The following doctors of medicine have placed themselves at the disposal of the thirteen visiting guest essayists who grace the program of the seventh annual Michigan Clinical Institute in Detroit; they will demonstrate the meaning of Michigan hospitality to the eminent speakers from other parts of the United States:

 P. S. Barker, M.D., Detroit; G. S. Bates, M.D., Detroit; J. G. Bielawski, M.D., Detroit; W. S. Carpenter, M.D., Detroit; R. C. Connelly, M.D., Detroit; Leon DeVel, M.D., Grand Rapids; A. E. Heustis, M.D., Lansing; H. Y. Kasabach, M.D., Detroit; E. E. Martmer, M.D., Detroit; H. M. Nelson, M.D., Detroit; G. C. Penberthy, M.D., Detroit; A. H. Price, M.D., Detroit; and A. B. Stearns, M.D., Detroit.

- **J. M. ROBB, M.D.,** is General Chairman of Arrangements for the 1953 Michigan Clinical Institute.

- **PRESS RELATIONS COMMITTEE** for the 1953 Michigan Clinical Institute:

 C. L. Weston, M.D., *Chairman*, Owosso; A. B. Gwinn, M.D., Hastings; H. F. Dibble, M.D., Detroit; Ralph Johnson, M.D., Detroit.

- **PUBLIC MEETING**—on Medical Civil Defense will to be held on Wednesday, March 11, in the Grand Ballroom of the Sheraton-Cadillac Hotel at 8:30 p.m. Invite your patients and other lay friends to this meeting. Program on page 1580.

- **SCROLL TO S. L. LOUPEE, M.D.,** Dowagiac, Chosen by the Michigan State Medical Society House of Delegates in September as "Michigan's Foremost Family Physician of 1952." Dr. Loupee will be honored on Wednesday, March 11, when the scroll emblematic of his new title will be presented to him just before adjournment of the morning assembly of the M.C.I.

- **SCROLLS OF APPRECIATION** will be presented on March 11, during the Michigan Clinical Institute, to E. A. Irvin, M.D., Detroit, President of the national Industrial Medical Association; and to H. M. Nelson, M.D., Detroit, President of the American Cancer Society.

 Testimonial dinners, sponsored by members of their respective specialty groups, have been arranged as follows:

 1. Honoring Dr. Irvin on Tuesday, March 10, 6:30 p.m. following the Industrial Health Day, in the Grand Ballroom of the Sheraton-Cadillac Hotel, Detroit;

 2. Honoring Dr. Nelson on Thursday, March 12, 6:30 p.m. in the Grand Ballroom of the Sheraton-Cadillac Hotel, Detroit.

- **ACKNOWLEDGMENTS:** The Michigan Clinical Institute gratefully acknowledges the co-operation of:

 1. **R. S. Sykes, D.D.S.,** Muir, Michigan, sponsor of the Sykes Lecture presented by Harold W. Dargeon, M.D. of New York City.

 2. **The Michigan Department of Health,** the Michigan Division and the Southeastern Michigan Division of the American Cancer Society, Sponsors of Raymond W. Houde, M.D. of New York; Matthew H. Griswold, M.D., Hartford, Conn., and James R. Driver, M.D., Cleveland, Ohio, respectively.

 3. **The Michigan Regional Committee on Trauma,** American College of Surgeons, sponsor of the Surgery of Trauma program (seven speakers) on Thursday afternoon, March 12, 1953.

 4. **The Michigan Heart Association,** sponsor of the Heart and Rheumatic Fever Program on Friday morning, March 13.

 5. **Michigan Medical Service** which contributed 2,000 notebooks for use of M.C.I. registrants.

- **MEETING FOR RESIDENTS, INTERNS**

Residents, interns and senior medical students will be honor guests at a special meeting arranged during the 1953 Michigan Clinical Institute.

J. Milton Robb, M.D., Detroit, General Chairman of Arrangements for the MCI, announces that on Wednesday, March 11, a special meeting has been arranged to which all residents, interns and senior medical students of Michigan are to be invited. This meeting at the Sheraton-Cadillac Hotel, Detroit, will include the following program:

4:00 p.m.—Special inspection of the MCI exhibits.

5:00 p.m.—*"Modern Medical Practice"* by Ralph A. Johnson, M.D., Detroit.

5:30 p.m.—Question Period.

The formal program will be followed by a reception honoring the residents, interns and senior medical students.

This meeting, an innovation at the Michigan Clinical Institute, has been arranged to introduce the M.D.'s of tomorrow to the work in medical organization being done by their precursors of today.

• MEETINGS OF SPECIAL SOCIETIES, ALUMNI AND AUXILIARY GROUPS

Tuesday, March 10, 1953:

1. Michigan Industrial Health Day (fourth annual) will be held Tuesday, March 10, 1953 from 10:00 a.m. to 5:00 p.m., English Room, Sheraton-Cadillac Hotel, Detroit. For program write: T. I. Boileau, M.D., 7700 Russell St., Detroit 11. All MSMS members, other state medical society members, and Canadian Medical Association members are cordially invited to attend.

 Testimonial Banquet in honor of E. A. Irvin, M.D., Detroit, President of Industrial Medical Association, Grand Ballroom, Sheraton-Cadillac Hotel, Detroit, 6:30 p.m.

Wednesday, March 11, 1953:

2. Michigan Health Council. The Executive Committee of the Michigan Health Council will hold a luncheon-meeting beginning at 12:00 noon in Parlor J, Sheraton-Cadillac Hotel, March 11.
3. Woman's Auxiliary to the Michigan State Medical Society. The Board of the Woman's Auxiliary will meet at 10:00 a.m. in the Founders' Room and for luncheon at 12:00 noon in Parlors G-H-I, Sheraton-Cadillac Hotel, March 11.
4. Reception and brief meeting for interns, residents and senior medical students beginning at 5:00 p.m. in Parlors G-H-I, Sheraton-Cadillac Hotel, Detroit.
5. Public Meeting on Atomic Energy-Civil Defense, Grand Ballroom, 8:30 p.m., Sheraton-Cadillac Hotel, Detroit.
6. Detroit Academy of Orthopedic Surgery, dinner-meeting, 6:30 p.m. in the Pan American Room, Sheraton-Cadillac Hotel, Detroit.
7. Dinner-meeting of Michigan Health Officers Association, 6:30 p.m. in the Founders' Room, Sheraton-Cadillac Hotel, Detroit.

Thursday, March 12, 1953:

8. Michigan Regional Committee on Trauma. Meeting and luncheon beginning at 12:00 noon in Parlors G-H-I, Sheraton-Cadillac Hotel, March 12.
9. Michigan Academy of General Practice. Board of Directors meeting and dinner beginning at 6:00 p.m. in Parlor K, Sheraton-Cadillac Hotel, March 12.
10. Michigan Branch of the Academy of Pediatrics. Dinner beginning at 6:00 p.m. in the Founders' Room, Sheraton-Cadillac Hotel, March 12.
11. The Michigan Proctologic Society will meet March 12, in Suite 500, Sheraton-Cadillac Hotel and at Harper Hospital, Detroit. 2:00 p.m.—Operative Clinic, Harper Hospital. By the Department of Proctology. 6:00 p.m.—Cocktails and dinner (with Detroit Proctologic Society), Suite 500, Sheraton-Cadillac Hotel. 7:00 p.m.—"The Normal Role of Sodium and Potassium from the Biochemist's Point of View," Robert Fenichel, M.S., Biochemist, Chrysler Medical Department, Detroit.
12. Testimonial Banquet in honor of Harry M. Nelson, M.D., Detroit, President of American Cancer Society, Grand Ballroom, Sheraton-Cadillac Hotel, Detroit, at 6:30 p.m.

Friday, March 13, 1953:

13. Michigan Heart Association. Annual Meeting of members beginning at 5:00 p.m. in Parlors G-H-I, Sheraton-Cadillac Hotel, followed by dinner meeting of the Board, in the Founders' Room, 6:30 p.m., Friday, March 13.

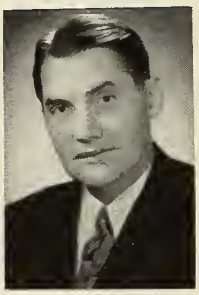


E. A. Irvin, M.D.

IRVIN BANQUET

Earle A. Irvin, M.D., Detroit, President of the National Industrial Medical Association, will be honored by his confreres in the field of industrial medicine and surgery on Tuesday, March 10, 1953, following the Industrial Health Day program. A testimonial banquet will be held in the Grand Ballroom of the Sheraton-Cadillac Hotel All doctors of medicine and others interested in industrial health and medicine in Michigan, Ontario, Ohio, Indiana and Wisconsin are cordially invited to the Irvin dinner.

The Committee on Banquet, appointed by the Michigan Industrial Medical Association is composed of: L. R. Martin, M.D., Detroit, *Chairman,* and W. A. Dawson, M.D., Inkster.



H. M. Nelson, M.D.

NELSON BANQUET

A testimonial banquet in honor of Harry M. Nelson, M.D., Detroit, President of the American Cancer Society, is planned by his confreres in cancer education for Thursday, September 12, 1953, in the English Room of the Sheraton-Cadillac Hotel, Detroit A reception in the Pan American Room will precede the dinner, to which all registrants at the Michigan Clinical Institute and all M.D.'s and other cancer workers in Michigan, Ontario, Ohio, Indiana and Wisconsin are cordially invited to attend.

The Committee on Arrangements for the Nelson Dinner includes: E. I. Carr, M.D., Chairman; F. W. Bald, M.D., William Bromme, M.D., Glenn Brooks, D.D.S., M. R. Burnell, M.D., Mrs. H. H. Cornelius, M. A. Darling, M.D., Mr. C. H. Dreger, A. C. Furstenberg, M.D., F. W. Hartman, M.D., A. E. Heustis, M.D., Mrs. Harold Heyser, R. J. Hubbell, M.D., W. A. Hyland, M.D., Mr. D. E. Johnson, C. H. Keene, M.D., A. B. McGraw, M.D., Dr. Harvey M. Merker, N. F. Miller, M.D., J. A. Molner, M.D., H. W. Porter, M.D., F. L. Rector, M.D., Dr. G. H. Scott, W. L. Simpson, M.D., O. D. Stryker, M.D., Mr. J. V. Stuart, Dr. Henry F. Vaughan, and Mrs. E. C. Witwer.

14. **The Wayne University Alumni Association will have a headquarters suite in the Sheraton-Cadillac Hotel, Detroit, during the 1953 Michigan Clinical Institute on Wednesday-Thursday-Friday, March 11-12-13.**

Michigan Clinical Institute

Program

WEDNESDAY, MARCH 11, 1953

SHERATON-CADILLAC HOTEL

A.M.
7:30 REGISTRATION—Pan American Room, Fifth Floor

8:30 EXHIBITS OPEN—Fourth Floor

FIRST ASSEMBLY

Grand Ballroom, Sheraton-Cadillac Hotel
R. A. Frary, M.D., Monroe, *Chairman*

8:50 WELCOME
Reader J. Hubbell, M.D., Kalamazoo
President, Michigan State Medical Society
E. D. Spalding, M.D., Detroit
President, Wayne County Medical Society

Four Surgical Subjects

9:00 "Ulcerative Colitis (Medical Treatment)"
E. N. Collins, M.D., Cleveland, Ohio
Head of Medical Section on Gastroenterology, Cleveland Clinic and Cleveland Clinic Hospital



E. N. Collins, M.D.

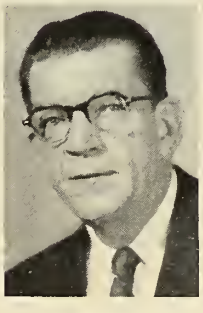
9:30 "Ulcerative Colitis (Surgical Treatment)"
Lester R. Dragstedt, M.D., Chicago, Illinois
Thomas D. Jones Distinguished Service Professor of Surgery and Chairman of the Department of Surgery, the University of Chicago



L. R. Dragstedt, M.D.

10:00 INTERMISSION TO VIEW EXHIBITS

11:00 "Abuse of Blood Transfusion"
Gaylord S. Bates, M.D., Detroit
Assistant Clinical Professor of Surgery, Wayne University College of Medicine; Associate Surgeon, Receiving and Harper Hospitals; Chief of Surgery, Oakwood Hospital, Dearborn.



G. S. Bates, M.D.

11:20 "Constant Problems of Biliary Surgery"
Robert S. Dinsmore, M.D., Cleveland, Ohio
Chief of Surgery, Cleveland Clinic Foundation

11:50 End of First Assembly

M
12:00 Discussion Conference
Grand Ballroom, Sheraton-Cadillac Hotel
Leader: W. H. Huron, M.D., Iron Mountain
Participants: Donald J. Barnes, M.D.; Gaylord S. Bates, M.D.; Lester E. Bauer, M.D. E. N. Collins, M.D.; Robert S. Dinsmore, M.D.; Lester R. Dragstedt, M.D.; Joseph C. Gemeroy, M.D.; John S. Lundy, M.D.; John M. Nokes, M.D., and Cleary N. Swanson, M.D.

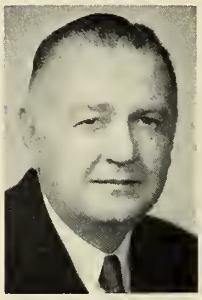


R. S. Dinsmore, M.D.

P.M.
1:00 End of Discussion Conference



L. E. Bauer, M.D.



J. M. Nokes, M.D.



D. J. Barnes, M.D.



C. N. Swanson, M.D.



J. S. Lundy, M.D.



P. Aebersold, Ph.D.

SECOND ASSEMBLY

Grand Ballroom, Sheraton-Cadillac Hotel
A. B. Gwinn, M.D., Hastings, *Chairman*

Six Obstetric, Gynecology and Pediatric Subjects

2:00 "The Hypertensive in Pregnancy"
Lester E. Bauer, M.D., Detroit
Attending Gynecologist and Obstetrician, Grace Hospital

2:20 "Pitfalls in Pelvic Surgery"
John M. Nokes, M.D., Charlottesville, Virginia
Professor of Obstetrics and Gynecology, University of Virginia Medical School; Obstetrician and Gynecologist, University of Virginia Hospital

2:50 "Pitfalls and Styles in Infant Feeding"
Donald J. Barnes, M.D., Detroit
Senior Physician, Harper Hospital

3:10 INTERMISSION TO VIEW EXHIBITS

4:10 "Crossed Eyes"
Joseph C. Gemeroy, M.D., Detroit

4:30 "Pain Control in Labor"
Cleary N. Swanson, M.D., Detroit
Assistant Clinical Professor of Obstetrics and Gynecology, Wayne University; Head of Department of Obstetrics and Gynecology, Mt. Carmel Mercy Hospital.

4:50 "Accidents in Anesthesia"
John S. Lundy, M.D., Rochester, Minnesota
Senior Consultant in Section on Anesthesia, Mayo Clinic; Professor of Anesthesia, Mayo Foundation for Medical Education and Research, Graduate School, University of Minnesota

5:20 End of Second Assembly

WEDNESDAY EVENING, MARCH 11, 1953

Grand Ballroom, Sheraton-Cadillac Hotel

P.M.
8:30 MEDICAL CIVIL DEFENSE MEETING
The evening meeting of Wednesday, March 11, will be devoted to the medical phases of civil defense.

Max L. Lichter, M.D., Detroit, *Chairman*

"Recent Advances in the Medical Application of Radioactive Isotopes"
Paul Aebersold, Ph.D.
Director, Isotope Division, Atomic Energy Commission, Oak Ridge, Tennessee

All MCI registrants, their wives and guests are cordially invited

THURSDAY, MARCH 12, 1953

Sheraton-Cadillac Hotel



M. H. Griswold, M.D.

A.M.
8:30 **REGISTRATION—Pan American Room, Fifth Floor**
EXHIBITS OPEN—Fourth Floor

THIRD ASSEMBLY—CANCER MORNING

Grand Ballroom, Sheraton-Cadillac Hotel
C. H. Keene, M.D., Willow Run, *Chairman*

Four Cancer Control Subjects

The presentation of Raymond W. Houde, M.D., is sponsored by the Southeastern Michigan Division of the American Cancer Society; the presentation of Matthew H. Griswold, M.D., is sponsored by the Michigan Department of Health; and the presentation of James R. Driver, M.D., is sponsored by the Michigan Division of the American Cancer Society.



H. W. Dargeon, M.D.

9:00 **"Diagnostic Problems in Cancer"**
Raymond W. Houde, M.D., New York, New York
In Charge Examining Office, Memorial Hospital

9:30 **"Use of Morbidity Records in Cancer Control Programs"**
Matthew H. Griswold, M.D., Hartford, Connecticut
Chief, Division of Cancer and Other Chronic Diseases, Connecticut State Department of Health; Lecturer in Public Health, Yale School of Public Health.

10:00 **INTERMISSION TO VIEW EXHIBITS**



J. R. Driver, M.D.

11:00 **THE R. S. SYKES LECTURE**
"Cancer in Childhood"
Harold W. Dargeon, M.D., New York, New York
Attending Pediatrician, Memorial Hospital and St. Luke's Hospital; Consulting Pediatrician Monmouth Memorial Hospital, Long Branch, New Jersey; Chairman Committee on Tumor Registry (American Academy of Pediatrics); Chairman, Sub-Committee for Study of Radiation Effects in Childhood (American Academy of Pediatrics)

11:30 **"Diagnostic Problems in Skin Cancer"**
James R. Driver, M.D., Cleveland, Ohio
Associate Clinical Professor of Dermatology, School of Medicine, Western Reserve University

M
12:00 **End of Third Assembly**

12:00 **Discussion Conference**
Grand Ballroom, Sheraton-Cadillac Hotel
Leader: F. A. Coller, M.D., Ann Arbor
Participants: George T. Aitken, M.D.; Harold W. Dargeon, M.D.; A. Jackson Day, M.D.; James R. Driver, M.D.; Matthew H. Griswold, M.D.; Raymond W. Houde, M.D.; Elmer R. Jennings, M.D.; Prescott Jordan, Jr., M.D.; Joseph L. Posch, M.D.; Albert D. Ruedemann, M.D., and Homer M. Smathers, M.D.



R. S. Sykes, D.D.S.
Muir, Michigan
Sponsor of the Annual Sykes Lecture

P.M.
1:00 **End of Discussion Conference**



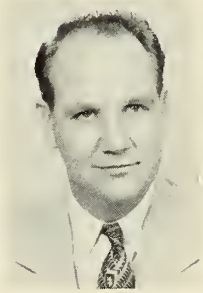
A. J. Day, M.D.



A. D. Ruedmann, M.D.



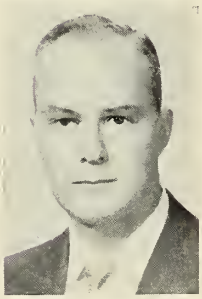
E. R. Jennings, M.D.



H. M. Smathers, M.D.



G. T. Aitken, M.D.



H. B. Houser, M.D.

FOURTH ASSEMBLY—TRAUMA AFTERNOON

Grand Ballroom, Sheraton-Cadillac Hotel

D. A. Cameron, M.D., Detroit, *Chairman*

Seven Surgery of Trauma Subjects

The Michigan Regional Committee on Trauma, American College of Surgeons is sponsor of the Surgery of Trauma talks.

2:00 **"The Use of Intramedullary Nail"**
A. Jackson Day, M.D., Detroit
Assistant Clinical Professor of Orthopedics, Wayne University

2:20 **"Trauma to the Eye"**
Albert D. Ruedemann, M.D., Detroit
Professor of Ophthalmology, Wayne University

2:30 **"The Care of Fractures of the Hand"**
Joseph L. Posch, M.D., Detroit
Clinical Instructor in Surgery, Wayne University

2:40 **"The Use of Plasma Expanders"**
Elmer R. Jennings, M.D., Detroit
Associate Professor of Pathology, Wayne University

2:50 **Discussion Conference**

3:00 **INTERMISSION TO VIEW EXHIBITS**

4:00 **"Review of Basic Principles of Vascular Surgery and their Application in Trauma"**
Prescott Jordan, Jr., M.D., Detroit
Assistant Clinical Professor of Surgery, Wayne University

4:15 **"The Treatment of Tetanus"**
Homer M. Smathers, M.D., Detroit
Instructor in Clinical Surgery, Wayne University

4:30 **"Fractures of the Upper Third of the Humerus"**
George T. Aitken, M.D., Grand Rapids
Consultant in Orthopedic Surgery, St. Mary's Hospital, Grand Rapids

4:45 **Discussion Conference**

5:00 **End of Fourth Assembly**

FRIDAY, MARCH 13, 1953

Sheraton-Cadillac Hotel

A.M.
8:30 **REGISTRATION—Pan American Room, Fifth Floor**

EXHIBITS OPEN—Fourth Floor

FIFTH ASSEMBLY

FOURTH ANNUAL MICHIGAN HEART DAY

Grand Ballroom, Sheraton-Cadillac Hotel

H. L. Smith, M.D., Detroit, *Chairman*
President-Elect, Michigan Heart Association

Six Heart and Rheumatic Fever Subjects

The *Michigan Heart Association* is sponsor of the heart and rheumatic fever talks.

9:00 **"Prophylaxis of Rheumatic Fever by Prevention of or Treatment of Streptococcal Infections"**
Harold B. Houser, M.D., Syracuse, New York
Assistant Research Director, Weiting-Johnson Hospital; Instructor in Medicine, State University of New York, College of Medicine, Syracuse, N. Y.

9:20 **"Clinical and Physiological Evaluation of the Results of Mitral Valve Surgery"**
HARPER K. HELLEMS, M.D., Detroit
Assistant Professor of Medicine, Wayne University College of Medicine

9:40 **"Some Aspects of the Mechanical Heart"**
FOREST D. DODRILL, M.D., Detroit
Thoracic Surgeon, Research Division, Harper Hospital



F. D. DODRILL, M.D.

10:00 **INTERMISSION TO VIEW EXHIBITS**

11:00 **"The Role of the Physician in the Employment of the Cardiac Wofker"**
EDWARD M. KLINE, M.D., Cleveland
Clinical Instructor in Internal Medicine, Western Reserve University; Medical Consultant, Lamp Division, General Electric Co.



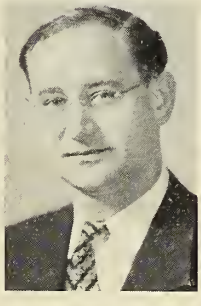
H. K. HELLEMS, M.D.

11:20 **"Cortisone in Acute Myocardial Infarction"**
ROBERT A. GERISCH, M.D., Detroit
Voluntary Assistant in Medicine, Harper, Florence Crittenden and Receiving Hospitals, Detroit



E. M. KLINE, M.D.

11:40 **"Heart Diseases of Mid-Life"**
WILLIAM B. KOUNTZ, M.D., St. Louis, Missouri
Assistant Professor of Clinical Medicine; Director of Clinical Services, Division of Gerontology, Washington University School of Medicine.



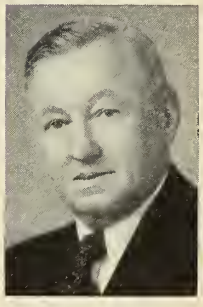
R. A. GERISCH, M.D.

M
12:00 **End of Fifth Assembly**

12:00 **Discussion Conference**

Grand Ballroom, Sheraton-Cadillac Hotel

Leader: E. D. SPALDING, M.D., Detroit
Participants: CARL B. BEEMAN, M.D., ABRAHAM I. BRAUDE, M.D., MICHAEL M. DAGSO, M.D., WINTHROP N. DAVEY, M.D., FOREST D. DODRILL, M.D., ROBERT A. GERISCH, M.D., HARPER K. HELLEMS, M.D., HAROLD B. HOUSER, M.D., EDWARD M. KLINE, M.D., WILLIAM B. KOUNTZ, M.D., HENRY A. LUCE, M.D., and WILLIAM S. REVENO, M.D.



W. B. KOUNTZ, M.D.

SIXTH ASSEMBLY

Grand Ballroom, Sheraton-Cadillac Hotel

J. D. LITTIG, M.D., Kalamazoo, *Chairman*

Six Internal Medicine Subjects



W. S. REVENO, M.D.

P.M.
2:00 **"The Periodic Health Appraisal"**
WILLIAM S. REVENO, M.D., Detroit
Assistant Professor of Clinical Medicine, Wayne University College of Medicine.

2:20 **"Isonicotinic Acid Derivatives in Treatment of Tuberculosis"**
WINTHROP N. DAVEY, M.D., Ann Arbor
Assistant Professor Internal Medicine, University of Michigan; Director, Medical Tuberculosis Unit, University Hospital.



W. N. DAVEY, M.D.

2:40 **FINAL INTERMISSION TO VIEW EXHIBITS (35 minutes only)**



A. I. Braude, M.D.

3:15 "Present Status of Antibiotic Therapy"
Abraham I. Braude, M.D., Ann Arbor
Assistant Professor of Internal Medicine

3:35 "Pneumonia—Is It or Isn't It?"
Carl B. Beeman, M.D., Grand Rapids
Consultant in Medicine, Blodgett Memorial Hospital.

3:55 "Psychiatry in General Practice"
Henry A. Luce, M.D., Detroit
Assistant Professor of Clinical Psychiatry, Wayne University College of Medicine; Consultant in Psychiatry, Harper Hospital; Consultant in Neuropsychiatry, Jennings Memorial, Evangelical Deaconess and Receiving Hospitals.

4:15 "Management of the Chronic Disabling Diseases in the Aged"
Michael M. Dacso, M.D., New York, New York

4:45 End of Sixth Assembly and of the Institute



C. B. Beeman, M.D.



H. A. Luce, M.D.

Michigan Industrial Health Day

English Room—Sheraton-Cadillac Hotel
Detroit, Michigan

Tuesday, March 10, 1953

Henry S. Brown, M.D., Detroit, *Chairman*

Morning Session

9:30 Registration
10:00 Welcome to Detroit
10:10 How Industrial Hygiene Can Assist the Industrial Physician
10:40 Burn Shock. Its Pathologic Physiology and Treatment
11:10 The Cardiac Patient in Industry
12:00 Luncheon

Afternoon Session

1:30 Applied Physical Medicine
2:15 Recent Advances in Surgery of Trauma
3:15 Hernia Repair
4:00 Cerebro-Vascular Accidents in Industry
5:00 Annual Business Meeting

Evening Activities

Grand Ballroom, Sheraton-Cadillac Hotel
6:00 Cocktail Hour
7:00 Testimonial Dinner in honor of E. A. Irvin, M.D., Detroit, President, Industrial Medical Association.

(Speakers for program printed on page 1588)



M. M. Dacso, M.D.

1953 MICHIGAN CLINICAL INSTITUTE

COMMITTEE ON ARRANGEMENTS AND PROGRAM

J. M. Robb, M.D., Detroit, *Chairman*
W. D. Barrett, M.D., Detroit, *Vice Chairman*
R. J. Hubbell, M.D., Kalamazoo, *President, Michigan State Medical Society*
Otto O. Beck, M.D., Birmingham, *Immediate Past President, Michigan State Medical Society*
L. Fernald Foster, M.D., Bay City, *Secretary*
E. F. Sladek, M.D., Traverse City, *Advisor*
G. C. Penberthy, M.D., Detroit, *Advisor*
Representing Michigan State Medical Society

* * *

C. E. Badgley, M.D., Ann Arbor
H. H. Cummings, M.D., Ann Arbor
A. C. Furstenberg, M.D., Ann Arbor
O. T. Mallery, M.D., Ann Arbor
J. M. Sheldon, M.D., Ann Arbor
Representing University of Michigan School of Medicine and University of Michigan Department of Postgraduate Medicine

* * *

Harold Henderson, M.D., Detroit
H. A. Howes, M.D., Detroit
W. S. Reveno, M.D., Detroit
J. H. Schlemer, M.D., Detroit
Representing Wayne University College of Medicine and Wayne County Medical Society

* * *

M. G. Becker, M.D., Edmore
W. C. Beets, M.D., Grand Rapids
R. A. Frary, M.D., Monroe
A. B. Gwinn, M.D., Hastings
W. H. Huron, M.D., Iron Mountain
F. E. Luger, M.D., Saginaw
Representing out-state practitioners of medicine, members of the Michigan State Medical Society

* * *

A. E. Heustis, M.D., Lansing
O. D. Stryker, M.D., Mt. Clemens
Representing Michigan Department of Health and Michigan Health Officers Association

* * *

E. I. Carr, M.D., Lansing
Representing the Michigan Foundation for Medical and Health Education, Inc.

* * *

MUCH THAT IS NEW AND INTERESTING WILL BE FOUND IN THE MCI EXHIBIT

THE "BLOCK SYSTEM" at the 1953 MICHIGAN CLINICAL INSTITUTE

Surgery—Wednesday *morning*, March 11
Obstetrics, Gynecology, Pediatrics — Wednesday *afternoon* March 11
Cancer Control—Thursday *morning*, March 12
Trauma—Thursday *afternoon*, March 12
Heart and Rheumatic Fever—Friday *morning*, March 13
Internal Medicine—Friday *afternoon*, March 13

The Michigan Clinical Institute presents practical concentrated medical education.

MEDICAL DEFENSE MEETING

The Medical Civil Defense meeting of Wednesday, March 11, 1953, will be held in the Grand Ballroom of the Sheraton-Cadillac Hotel at 8:30 p.m.

This public meeting will present Paul Aebersold, Ph.D., of Oak Ridge, Tennessee, who will speak on "Recent Advances in the Medical Application of Radioactive Isotopes."

Sponsors of the Medical Civil Defense Meeting of March 11 are the Wayne County Medical Society, the Michigan Clinical Institute, and the Michigan State Medical Society.

All Michigan Clinical Institute registrants and all members of the Michigan State Medical Society, their wives and guests are cordially invited to attend the interesting presentation on medical civil defense of March 11.

HOTEL RESERVATIONS MICHIGAN CLINICAL INSTITUTE

Detroit, March 11-12-13, 1953

The reservation blank below is for your convenience in making your hotel reservations in Detroit. Please send your application to Robert M. Buckley, Sheraton-Cadillac Hotel, Detroit, Michigan. Mailing your application now wll be of material assistance in securing hotel accommodations

As very few singles are available, registrants are requested to co-operate with the Committee on Hotels by sharing a room with another registrant, when convenient.
Committee on Hotels,

Michigan Clinical Institute,
c/o Sheraton-Cadillac Hotel,
Detroit, Michigan

Attention: Robert M. Buckley

Please make hotel reservation (s) as indicated below:

.....Single Room(s)
.....Double Room(s) for.....persons
.....Twin-Bedded Room(s) for.....persons
Arriving March.....hour.....A.M.....P.M.
Leaving March.....hour.....A.M.....P.M.
Hotel of First Choce:.....
Second Choice:.....

Names and addresses of all applicants including person making reservation:

Name	Address	City	State
.....			
.....			
.....			
.....			
.....			

Date Signature
Address City.....

Michigan State Medical Society

Eighty-Seventh Annual Session

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IX.	Resolutions and Motions:		
	(a) Resolution re Fees for Surgical Assistants in Hospitals (Berrien)	1597	1607
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	(h) Resolution re Fees for Surgical Assistants in Blue Shield (Wayne)	1598	1607
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	(n) By-Laws, Chapter 10, Section 1—Abolish Committee on Distribution of Medical Care	1599	1608
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	(p) Motion: Legislation re recalcitrant tuberculous patients	1608	X
	(q) Resolution re Endorsing work of World Medical Association	1608	1609
	(r) Motion: Committee to Report on Press Releases re AMA Public Relations	1609	1612
	(including Resolution adopted by MSMS House of Delegates)	1612	
	(s) Motion: Committee to Study Requirements for Special Memberships	1611	X
X.	Reports of Standing Committees		1601
	(a) Postgraduate Medical Education	1600	1601
	(b) Preventive Medicine and its Sub-Committees	1600	1601; ?

	(c) Distribution of Medical Care	1600	X
	(d) Public Relations and its Sub-Committees	1600	1602
	(e) Ethics	1600	X
	(f) Legislative	1600	1602
	(g) Mediation	1600	1602
XI.	Reports of Special Committees:		1602
	(a) Beaumont Memorial	1600	1602
	(b) Scientific Radio	1600	1602
	(c) Advisory Committee to Woman's Auxiliary	1600	1602
	(d) Advisory Committee to Michigan State Medical Assistants Society	1600	1602
	(e) Advisory Committee to National Foundation for Infantile Paralysis	1600	1602
XII.	Reports of Committees of The Council	1600	1601
XIII.	Reference Committee Reports:		
	(a) On Officers Reports. (1) Speaker's Address (1600); (2) President's Address (1601); (3) President-Elect's Address (1601); (4) Delegates to AMA (1601); (5) Woman's Auxiliary to MSMS (1601); (6) AMA Welfare Fund for Needy M.D.'s (1601).		1600
	(b) On Reports of The Council (including Annual Reports of Committees of The Council)		1601
	(c) On Standing Committees. (1) Postgraduate Medical Education (1601); (2) Preventive Medicine (1601 and 1608); (3) Public Relations (1602); (4) Legislative (1602); (5) Mediation (1602).		1601
	(d) On Special Committees. (1) Beaumont Memorial (1602); (2) Scientific Radio (1602); (3) Advisory to Woman's Auxiliary (1602); (4) Advisory to Michigan State Medical Assistants Society (1602); (5) Advisory to National Foundation for Infantile Paralysis (1602).		1602
	(e) On Constitution and By-Laws. (1) Constitutional amendment to Article X, Section 2 re Treasurer being Member of Executive Committee	from 1951	1602
	(2) Constitutional amendment to Article X, new Section 3, re Vice Speaker's membership on Council and its Executive Committee	from 1951	1603
	(3) By-Laws amendment, Chapter 8, Section 4 re Special Sessions of House of Delegates (1605, 1609); (4) By-Laws amendment, Chapter 10, Section 1 re abolishing Committee on Distribution of Medical Care (1608); (5) By-Laws Amendment re "sessions" and "meeting" (1608).		
	(f) On Legislation and Public Relations. (1) Expert Testimony (1605); (2) Endorsing work of World Medical Association (1609); (3) Support of Keogh-Reed bills in Congress (1609); (4) Repeal of Citizenship in Medical Practice Act (1610).		1605
	(g) On Hygiene and Public Health. (1) Migratory laborers (1603).		1603
	(h) On Resolutions. (1) Leniency in Administration of Act 59 of P.A. 1937 (Berrien) (1604); (2) Re Act 59 of P.A. 1937 (1604); (3) By-Laws amendment re Special Sessions of House of Delegates (1605, 1609).		1604
	(i) On Medical Service and Prepayment Insurance. (1) Simplified Insurance Reporting Form (1607); (2) Fees for surgical assistants—three resolutions (1607).		1607
	(j) On Special Memberships		1610
XIV.	Presentation of Dean Cornwell's painting "Beaumont and St. Martin" to MSMS by Wyeth, Inc., Philadelphia		1614
XV.	Presentation of Honorary Membership Scroll to Paul de Kruif, Ph.D., Holland		1614

XVI. Elections 1615

(a) Councilor, Seventh District (1615); (b) Councilor, Eighth District (1615); (c) Councilor, Ninth District (1615); (d) Councilor, Tenth District (1615); (e) Delegates to AMA (1615); (f) Alternate Delegates to AMA (1616); (g) President-Elect (1616); (h) Speaker (1617); (i) Vice-Speaker (1617); (j) Councilor, First District (1617).

XVII. Adjournment 1618

Michigan Industrial Health Day

March 10, 1953

English Room, Sheraton-Cadillac Hotel, Detroit

HENRY S. BROWN, M.D., Detroit, *Chairman*

—PROGRAM—

9:30 Registration

10:00 Welcome to Detroit

10:10 "How Industrial Hygiene Can Assist the Industrial Physician"
W. G. FREDRICKS, Sc.D., Duluth, Minn.

10:40 "Burn Shock. Its Pathologic Physiology and Treatment"
COL. WM. H. AMSPACHER, M.C., Houston, Tex.

11:20 "The Cardiac Patient in Industry"
J. G. BIELAWSKI, M.D., Detroit

12:00 LUNCHEON
Speaker: E. C. HOLMBLAD, M.D., Chicago, Ill.

1:30 "Applied Physical Medicine"
C. R. DEAN, M.D., Detroit

2:15 "Recent Advances in Surgery of Trauma"
J. M. DZIOB, M.D., Buffalo, N. Y.

3:15 "Hernia Repair"
L. T. PALUMBO, M.D., Veterans Administration

4:00 "Cerebral Vascular Accidents in Industry"
ROBT. BASSETT, M.D., Ann Arbor

5:00 Annual Business Meeting

Evening Program in Grand Ballroom

6:00 Cocktail Hour

7:00 Testimonial Dinner in honor of E. A. IRVIN, M.D., President, Detroit Industrial Medical Association
Speaker of National Prominence
(to be announced)

Michigan State Medical Society

Eighty-seventh Annual Session

DIGEST OF PROCEEDINGS OF THE HOUSE OF DELEGATES

MONDAY MORNING SESSION

September 22, 1952

The Annual Session of the House of Delegates of the Michigan State Medical Society convened at ten-ten o'clock in the English Room, Sheraton-Cadillac Hotel, Detroit, Michigan, with the Speaker, R. H. Baker, M.D., presiding.

I. RECORD OF ATTENDANCE

Office	*Officer*	*Meetings*				
		1st	*2nd*	*3rd*	*4th*	*5th*
Speaker	R. H. Baker, M.D.	x	x	x	x	x
Vice Speaker	J. E. Livesay, M.D.	x	x	x	x	x
Secretary	L. Fernald Foster, M.D.	x	x	x	x	x
County	*Delegate*					
1. Allegan	L. F. Brown, M.D.	x	x	x	x	x
2. Alpena-Alcona-Presque Isle	E. S. Parmenter, M.D.	x	x	x	x	x
3. Barry	A. B. Gwinn, M.D.	x	x	x	x	x
4. Bay-Arenac-Iosco	O. J. Johnson, M.D.	x	x	x	x	x
	Walter S. Stinson, M.D.	x	x	x	x	x
5. Berrien	D. W. Thorup, M.D.	x	x	x	x	x
6. Branch	H. J. Meier, M.D.	x	x	x	x	x
7. Calhoun	S. T. Lowe, M.D.	x	x	x	x	x
	H. C. Hansen, M.D.	x	x	x	x	x
8. Cass	S. L. Loupee, M.D.	x	x	x	x	–
9. Chippewa-Mackinac	B. T. Montgomery, M.D.	x	x	x	x	x
10. Clinton	F. W. Smith, M.D.	x	x	x	x	x
11. Delta-Schoolcraft	W. A. Lemire, M.D.	x	–	x	x	x
12. Dickinson-Iron	L. E. Irvine, M.D.	x	x	–	x	x
13. Eaton	P. H. Engle, M.D.	x	x	x	x	x
14. Genesee	F. A. Barbour, M.D.	x	x	x	x	–
	F. W. Baske, M.D.	x	x	x	x	x
	L. M. Bogart, M.D.	x	x	x	x	x
	C. W. Colwell, M.D.	x	x	x	x	x
	F. D. Johnson, M.D.	x	x	x	x	x
15. Gogebic	W. A. Gingrich	x	x	x	x	x
16. Grand Traverse-Leelanau-Benzie	D. G. Pike, M.D.	x	x	x	x	x
17. Gratiot-Isabella-Clare	M. G. Becker, M.D.	x	x	x	x	x
18. Hillsdale	A. W. Strom, M.D.	x	x	x	x	x
19. Houghton-Baraga-Keweenaw	John T. P. Wickliffe, MD.	x	x	x	x	x
20. Huron	C. W. Oakes, Jr., M.D.	x	x	x	x	x
21. Ingham	Kenneth Johnson, M.D.	x	x	x	x	x
	O. B. McGillicuddy, MD.	x	x	x	x	x
	F. L. Troost, M.D.	x	x	x	x	x
	H. W. Wiley, M.D.	x	x	x	x	x
22. Ionia-Montcalm	W. L. Bird, M.D.	x	x	x	x	–
23. Jackson	G. L. Otis, M.D.	–	–	x	x	x
	J. W. Rice, M.D.	x	x	x	x	x
24. Kalamazoo	I. W. Brown, M.D.	x	x	x	x	x
	F. C. Ryan, M.D.	x	x	x	x	x
	W. A. Scott, M.D.	x	x	x	x	x
25. Kent	L. C. Carpenter, Jr., MD.	x	x	x	x	x
	G. W. DeBoer, M.D.	x	x	x	x	x
	W. B. Mitchell, M.D.	x	x	x	x	x
	S. L. Moleski, M.D.	x	x	x	x	x
	A. A. Van Solkema, M.D.	x	x	x	x	x
	A. V. Wenger, M.D.	x	x	x	x	x
26. Lapeer	D. J. O'Brien, M.D.	x	x	x	x	x
27. Lenawee	J. D. Hamilton, M.D.	x	–	–	–	–
28. Livingston	H. C. Hill, M.D.	x	x	x	x	x
29. Luce	E. H. Campbell, M.D.	Not Represented				
30. Macomb	Sidney Scher, M.D.	x	x	x	x	x
31. Manistee	E. A. Oakes, M.D.	x	x	x	x	x
32. Marquette-Alger	A. S. Narotzky, M.D.	x	x	x	x	x
33. Mason	E. B. Boldyreff, M.D.	x	x	x	x	x
34. Mecosta-Osceola-Lake	Paul Ivkovich, M.D.	x	x	x	x	–
35. Menominee	J. R. Heidenreich, M.D.	x	x	x	x	x
36. Midland	H. L. Gordon, M.D.	–	x	x	x	x
37. Monroe	T. A. McDonald, M.D.	x	x	x	x	–
38. Muskegon	R. D. Risk, M.D.	x	x	x	x	x
	N. W. Scholle, M.D.	x	x	x	x	x
39. Newaygo	J. P. Klein, M.D.	x	x	x	x	x
40. North Central	S. A. Stealy, M.D.	x	x	x	x	x
41. Northern Michigan	J. R. Rodger, M.D.	–	–	x	x	x
42. Oakland	W. B. Cudney, M.D.	–	x	–	–	–
	H. A. Furlong, M.D.	x	x	x	x	x
	O. R. MacKenzie, M.D.	–	–	x	x	–
	Edson Rupp, M.D.	x	x	x	x	x
43. Oceana	W. G. Robinson, M.D.	Not Represented				
44. Ontonagon	W. F. Strong, M.D.	x	x	x	x	x
45. Ottawa	D. C. Bloemendaal, M.D.	x	x	x	x	x
46. Saginaw	M. F. Bruton, M.D.	x	–	x	x	–
	D. P. Gage, M.D.	x	–	x	x	–
	J. P. Markey, M.D.	x	x	x	–	x
47. Sanilac	R. K. Hart, M.D.	Not Represented				
48. Shiawassee	C. L. Weston, M.D.	x	x	x	x	x
49. St. Clair	J. F. Beer, M.D.	x	x	x	x	x
50. St. Joseph	R. A. Springer, M.D.	x	x	x	x	x
51. Tuscola	L. L. Savage, M.D.	x	x	x	x	x
52. Van Buren	W. R. Young, M.D.	x	x	x	x	x
53. Washtenaw	P. S. Barker, M.D.	x	x	x	x	x
	J. S. DeTar, M.D.	x	x	x	x	x
	O. K. Engelke, M.D.	x	x	x	x	x
	R. W. Teed, M.D.	x	x	x	x	x
54. Wayne	Sidney Adler, M.D.	x	–	x	x	x
	Raphael Altman, M.D.	x	x	x	x	–
	W. W. Babcock, M.D.	x	x	x	x	x
	L. J. Bailey, M.D.	x	x	x	–	–
	E. A. Bicknell, M.D.	x	x	–	x	–
	W. L. Brosius, M.D.	x	x	x	x	x
	C. L. Candler, M.D.	x	x	x	x	x
	W. S. Carpenter, M.D.	x	–	–	–	x
	E. G. Cochrane, M.D.	x	x	x	x	–
	J. E. Croushore, M.D.	x	x	–	x	x
	M. A. Darling, M.D.	x	x	x	x	x
	H. F. Dibble, M.D.	x	x	x	x	x
	E. H. Fenton, M.D.	x	x	x	x	x
	R. F. Fenton, M.D.	x	x	x	x	x
	W. L. Foster, M.D.	x	x	x	x	x
	J. D. Fryfogle, M.D.	x	x	–	x	–
	P. C. Gittins, M.D.	x	x	x	x	x
	C. K. Hasley, M.D.	x	x	x	x	x
	L. T. Henderson, M.D.	x	x	x	x	x
	Louis Jaffe, M D.	x	x	x	x	x
	R. A. Johnson, M.D.	x	x	x	x	x
	D. H. Kaump, M.D.	x	x	x	x	x
	E. D. King, M.D.	x	x	x	x	x
	E. G. Krieg, M.D.	x	x	–	x	x
	H. J. Kullman, M.D.	x	x	x	x	x
	Edward Lauppe, M.D.	x	x	x	x	x
	M. L. Lichter, M.D.	x	x	x	x	x
	J. J. Lightbody, M.D.	x	x	x	x	x
	E. C. Long, M.D.	x	x	–	x	x
	G. T. McKean, M.D.	x	x	x	x	x
	J. G. Molner, M.D.	x	x	x	x	x
	R. L. Novy, M.D.	x	x	x	x	–
	E. A. Osius, M.D.	x	x	x	x	x
	C. I. Owen, M.D.	x	x	x	x	x
	A. E. Price, M.D.	x	x	x	x	x
	A. H. Price, M.D.	x	x	x	–	x
	W. S. Reveno, M.D.	x	x	x	x	–
	J. H. Schlemer, M.D.	x	x	x	x	x
	E. D. Spalding, M.D.	x	x	x	x	x
	D. I. Sugar, M.D.	x	x	x	–	x
	E. C. Texter, M.D.	x	x	x	x	x
	R. V. Walker, M.D.	x	x	x	x	x
	Arch Walls, M.D.	x	x	x	x	–
	F. A. Weiser, M.D.	x	x	x	x	x
	D. A. Young, M.D.	x	x	x	x	–
55. Wexford-Missaukee	R. V. Daugharty, M.D.	x	x	x	x	x

IN MEMORIAM

The Speaker: One item which we usually introduce at this time is recognition of deaths in our membership in the past year. I regret to report to you the death of G. C. Stucky, M.D., of Charlotte, and the death of another valiant member of our Society who has served in many capacities, Andrew S. Brunk, M.D., Detroit.

It is appropriate at this time that we read a few of the things for which Dr. Brunk made himself so distinguished and so beloved; I am reading from a resolution which reads as follows:

"Whereas, Doctor Brunk gave generously of his valuable talents and boundless energy in founding and maintaining several organizations of lasting value to the medical profession, including the Michigan Health Council (founding President, 1943 to 1950, and charter member Board of Trustees, 1943 to 1952); Michigan Medical Service (charter member, Board of Directors, 1940 to 1952); the Conference of Presidents and Other Officers of State Medical Associations (founding President, 1945, and charter member of Executive Committee, 1945 to 1952); the Michigan Foundation for Medical and Health Education, Inc. (charter member, 1945 to 1952)." He served as our President very efficiently and as Treasurer of the Society for some years.

I would like to ask the gentlemen of this House to stand for a moment in silent recognition of the services of these two men.

[*The assembly arose in a moment of silent tribute.*]

II. SPEAKER'S ADDRESS

By R. H. Baker, M.D., Pontiac

Several thoughts have gone through my mind as to what we are here for. Some of the items, which I will not list in any particular order or in order of importance, have occurred to me of what we have accomplished and what we will try to accomplish.

I hope that all of the delegates take the trouble to go through the Handbook and read it—at least scan it pretty carefully for the reports of The Council and reports of committees.

It is very important, too, that you familiarize yourselves repeatedly with the Constitution and By-laws because there are certain changes that continue to come up and that will answer your questions.

I consider that we are here as a representative body, that the delegates have been chosen by their county societies because they are considered leaders in their groups. As such, we have a great responsibility in representing the affairs of the Society.

There is an additional responsibility on the part of your officers, actually. The House of Delegates elects your officers. We elect our President. We elect our Councilors, and they serve for the Society and the House in between sessions of the House.

You have selected them as key men to carry on the progress of the Society and to use sober judgment in their deliberations on all questions.

Sometimes I wonder if we properly evaluate the quality of the men that we so elect. There are eighteen Councilors, and six more officers who sit with The Council, part of whom serve on the Executive Committee between meetings of The Council.

That is all repetitious to you, but sometimes I think we forget it. I am sure that some of the doctors back home wonder what the House of Delegates is, who The Council is, and what they do.

The average young doctor starting out in practice knows too little about the organization of his medical societies. He is presumed to have certain ideals of service on a personal basis, and after he becomes organized in his local community, he finds that he becomes a part of a general organized society.

If he takes any interest—and I hope he does—he takes a part in his local society action and very quickly finds that the medical society and the medical profession are being assigned more and more public responsibility as a matter of advice in all sorts of affairs, and some of these things come to my mind that we are doing which we need to continue to do. I am going to name them rather briefly, not in any order of their importance. They just come to me.

We are very much concerned, and the Society expects us to advise them, regarding the question of private enterprise versus socialization of medicine. I am not going to orate on that.

One thing which we have undertaken recently in this Society, and it is becoming a greater and greater problem, is the care of the aged. We have a committee that has worked valiantly on that. You will find a report in the Handbook.

Care of the aged is constructive work, and as some of us get older and grayer and our mothers and fathers and our aunts and our uncles come into this aged group, we survey the economic standards of society, the small homes instead of the big homes where the old folks used to be cared for, and we realize there are a great number of facets in the care of the aged.

It isn't just a medical problem. We are bound to handle that, and society expects it, but we have to help individuals also in housing and the economic conditions, the coverage of medical care for the aged, whether it be done through county service or through insurance plans or whatnot.

I consider care of the aged a very important part of our society activity, and I know it will continue.

We have recently been thrown more and more into the psychiatric field as it relates to medical practice and the public responsibility. We have been asked to advise in the development of methods to handle the mentally ill, and I hope the House may have a chance to hear about this work. If they do not, they must read the publicity of our committee which studied the medical care and needs in our state prisons. It is a very enlightening report, very important, and society looks to us for just such advice.

We have not failed them. We are continuing our activities for which we can be proud, I believe, in the development and extension of group and individual medical schools. There is more to be done in that.

Another thing in which we have taken an important part, and must continue to do so, is using our influence and our guidance in the provision of more and extended nursing service.

Sort of indirectly this year, we have assisted in the development of a new bill passed by the Legislature to provide licensing and registration of practical nurses. I think the doctors in practice in Michigan realize that the graduate nursing profession has not been able to handle the problem. Sometimes they have handled understandable reactions of jealousy, we might say, in allowing the less trained person to come into the hospital field and take over some of their duties. That becomes a public and economic problem. There just aren't enough graduate nurses. Their period of training has been increased so greatly that hospitals can't get them and can't afford to pay enough to get them.

Society has demanded that we furnish a new type of nurse who can do the routine things. I hope that that action of our Society and our interest will not lag.

We are constantly interested in the providing of training and improvement of standards of doctors. Already, since the action of last year's House of Delegates, we have effected certain changes in the Basic Science Law which was hampering the registration of doctors in Michigan and possibly cutting down the potential number of practitioners.

We have effected certain amendments to the Medical

Practice Act at the request of the House of Delegates last year. Those are clearly stated in the Handbook on pages 59 and 65. It is well to read them over if you are not clear as to just what was accomplished.

We have undertaken in the last year, through the energy and enthusiasm of our president, a new activity—the Beaumont Memorial, for which Dr. Beck should be given most of the credit. That is a very important tribute to a pioneer in medical research and should be a monument for the public education of medical progress and prowess. It deserves our continued support until the project is completed.

I have another idea which may not come up for any resolution from this House, but which I suggest that the delegates take home to their county societies.

I receive the *Wayne County Medical Bulletin*, as many of you do. They have had a committee working for a long time on amplification and clarification of medical ethics as it deals with a number of things that are not included in the usual handbook on medical ethics by the AMA.

I feel that this committee—I read their proposals and studied them carefully—has done a monumental piece of work. I am sure it was done with very careful deliberation. Of course, it applies particularly to Wayne County's problems, but I am sure that the answers in their selection of ethical questions and how they have solved them, are answers for any society in any part of the state—the matter of how a doctor shall announce himself, how he shall be listed in the telephone book, and so on. There are a number of details which county societies could very well consider and make a part of their medical ethics and their Ethics Committee could be so guided.

Another thing which I understand is coming up before this meeting is a resolution concerning a change to permit the court to select medical witnesses in cases of controversy and misunderstanding.

That is just another evidence of the public's demand for technical help from the profession.

I again call your attention to the outstanding committee work. I don't wish to single out any one committee. The reports are in your Handbook. Some of them you will favor more than another, but there has been some excellent work done, and every member of the Society serving on those committees deserves a lot of credit.

I mention these things so that you gentlemen can take them home and answer the questions of your members when they say: "What do you fellows do down there, and what is the Society accomplishing?"

I refer you particularly to pages 65, 66, and 67 in your Handbook, matters referred to The Council by the delegates. That is in The Council report.

That again reports the things which you referred last year to The Council for action, and the report is there.

* * *

The Speaker's Address was referred to the Reference Committee on Officers' Reports.

III. PRESIDENT'S ADDRESS

By Otto O. Beck, Birmingham

I shall not attempt to present to you the many problems which were considered by MSMS during the past year. The annual report of The Council and the many committee reports will give you a good understanding of the numerous perplexing situations that arose and what disposition was made of them.

I appear before you mainly to talk about the Beaumont Memorial, probably the finest Public Relations activity ever attempted by this Society. That which makes it doubly valuable is that this project is financed by the voluntary contributions of the individual doctors of this State. Thus it provides a personal interest to every contributor. Had MSMS undertaken this project and financed it from its public relations funds, much of its value would have been lost.

Many messages have been received from our members which gave praise and encouragement. Had all our members been able to read these letters, as I have, the project would certainly be farther advanced today. One letter in particular was very touching to me. It came from an old member of this Society who had practiced medicine for many years, but who was then in an almost helpless debilitated state because of old age and the ravages of cancer.

He wrote in warm and glowing terms of praise of our undertaking and concluded his letter with sincere regrets that he was unable to send a contribution. He is now dead. His letter gave to me a courage and determination that I had not possessed before.

Letters have come from organizations and individuals outside of our profession. They were all in terms of praise and best wishes for success.

The Public Relations Program of the MSMS has had far reaching results toward a better understanding of the ideals and problems of medicine. Our efforts, of necessity, have been to some extent defensive in nature. The restoration of the American Fur Company Store on Mackinac Island is an effort which gives us a positive approach to a better understanding of the ideals and value of Medicine.

Things of most historical value and of greatest interest are buildings. People enjoy visiting a building in which something of importance has happened. The value of display is increased if the building is old and of a different era. The restoring of the old American Fur Company Store, where Dr. Beaumont first saw his famous patient, Alexis St. Martin, will provide us with an opportunity to convey a better understanding of true medical values to many thousands of people for hundreds of years to come.

The location is excellent, for Mackinac Island is a beautiful State Park, and furthermore it was the center of activity for the great North-west Territory of our early history.

One year ago you were given an estimated figure of $40,000 required to demolish the present super-structure and to restore the building to its 1822 appearance. At the present time $21,000 has been received for this project. That sum of money includes donations made by 1386 doctors, by Parke, Davis & Company, by special groups, and by various Chapters of the Woman's Auxiliary. A number of years ago, Parke, Davis & Company gave $10,000 to purchase the present property. Since the Early House was purchased for less than that sum the balance of $4,000 is included in the present Beaumont Memorial Fund.

Professor Emil Lorch of the University of Michigan—an outstanding architect—has been employed to complete the restoration. After a number of years of careful research he has completed preliminary plans and designs. Soon the demolition of the present building will begin.

We are deeply grateful for the assistance we have received from Mr. Wm. F. Doyle, Chairman of the Mackinac Island State Park Commission; D. Hale Brake, State Treasurer; A. N. Languis, State Building Director; H. J. Loynd, President, Parke, Davis & Company; Prentice M. Brown, former U. S. Senator, and Professor Emil Lorch.

ANNOUNCEMENTS

Tomorrow night at the last session of this House of Delegates the Dean Cornwell painting, "Beaumont and St. Martin," will be presented to the MSMS by Wyeth, Inc. Three representatives of Wyeth's are coming to Detroit from Philadelphia to make the presentation.

Thursday morning at 7:30 a.m. we are having a Beaumont Breakfast. To this breakfast have been invited a representative from each County Medical Society and the members of the MSMS Beaumont Restoration Committee.

The Council has requested me to issue an invitation to the members of this House of Delegates to attend the Breakfast which will be held in the English Room of this Hotel. So please come to our Breakfast of Beaumont workers, Thursday, September 25 at 7:30 a.m.

Thursday evening at 8:30 p.m. over radio station WWJ a half-hour dramatic presentation of the life of William Beaumont will be broadcast. You are invited to attend —or to listen in.

A Beaumont Memorial Restoration Booth will be placed in the Exhibit on the fourth floor of this Hotel. Every member of The Council and the members of the Beaumont Memorial Restoration Committee have been assigned certain hours to man this Booth. The purpose is to give every Michigan doctor of medicine the opportunity of an interview and to assist in the MSMS project on Mackinac Island.

Every member of this House should consider himeslf as a builder and organizer of this project. Carry the message of the Beaumont Memorial back to the members of your County Society. A few County Societies have done a splendid job, but in others very little effort has been given to this cause.

Remember, it's a worthy project that public-relations-wise is TOPS. It will redound to your credit and will build up the reputation of Michigan Medical men in the minds of our people. Every visitor to the Beaumont Memorial on Mackinac Island—and there will be hundreds of thousands—will read a plaque that will give them this lasting impression: The Doctors of Medicine of Michigan are doing a grand job. We're proud of them.

THE SPEAKER: Thank you, Dr. Beck. This will be referred to the Reference Committee on Reports of Officers.

IV. PRESIDENT-ELECT'S ADDRESS

By R. J. Hubbell, M.D., Kalamazoo

I might start out by saying that I do not have an address because I believe that the President-Elect is the totem pole and should not take up your valuable time.

I simply want to say a few words in appreciation of the work of the members and the officers of the Society over the past years, and I want to bespeak the continued interest and work of you members and all the people that help us.

It is certainly in order that I express my appreciation for the work of Past President Beck and the officers of The Council and of our executive office. I also am aware of the very fine interest and work of the members of the Society. Of course, if it weren't for them and the work that they do, the Society could not get along.

We must realize that our interest as an organization not only is for the benefit of ourselves, but for the elevation and the sustaining of the health of the people of Michigan. We should realize that fact very strongly.

I would like also to emphasize another point of which we should be cognizant, and that is our younger members in the Society. We should make every effort to recognize their ideas and their thoughts, and perhaps their willingness to furnish us with new ideas and new thoughts of what is valuable for our organization. I hope to be able to put some of these men on committees so that they may have an opportunity to give us their ideas.

Of course, the work of the Society is scientific and organizational, and both phases are important. I do not need to tell you what is important in the way of scientific work for the Society. There are several factors that might perhaps be of interest.

One of our aims and our purposes of work has been along the line of good citizenship. You know the CAP program that we had, and I think that certainly should be continued, not as an organization alone, but as individuals. That is, we should attempt to interest ourselves in local good citizenship.

The problem of cultists should occupy the thoughts of each of you because we are going to have to recognize that, and certainly the only way we can get any united opinion as an organization is for each of you to try to settle in your own mind what you think is right.

Of course, socialism is not dead, but we are still interested in that as a doctor of medicine, and a fourth item that I would like to mention specifically is liaison with other groups in the state, not only those particularly designated in the line of health work, but other lay organizations appreciate the opinion of medicine, and they seek our help many times, so that we do not have to force ourselves on to them, but we should be ready to help the lay organizations in any way they wish.

Just one more thing, in closing. Many times the members of the Society do not realize what goes on in the state organizational work; that is, what goes on in The Council meetings, what goes on in the Executive Committee meetings.

It is obviously necessary that the Executive Committee meet once a month as we know, and it is necessary that it be a smaller body than the full Council because there is a lot of work to do. There are many small items that are routine, of course, but nevertheless, they have to be taken up.

It has been my idea, however—and I take full responsibility for this—that I think any of you should feel free at least on request to attend as guests either our Council meetings or the Executive Committee meetings.

I know many of you will not be interested in it at all, but I thing that invitation should be given to you, and I hope that occasionally some of you will be interested in accepting it.

THE SPEAKER: Thank you, Dr. Hubbell.

This address will be referred to the Reference Committee on Officers' Reports.

The Speaker this year tried to secure in advance of the meeting copies or summaries of proposed resolutions that would be considered before this House. Of course, some of them are bound to develop on the floor. I believe that in future meetings you will save yourselves time and will assist the chairman in study and delegation of those reports to the proper committee if we can have more clearly enforced the request, which many societies have, that these resolutions coming from various county societies be sent to the state office in ample time. Thirty days ahead of time is suggested.

I don't know that that requires a special resolution or a change in the by-laws, but I wish you would give it thought.

V. REPORT OF THE COUNCIL

The supplemental report of The Council was presented by Dr. William Bromme.

SUPPLEMENTAL REPORT OF THE COUNCIL

The Annual Report of The Council is printed in the Handbook for Delegates on page 49.

We wish to present the following Supplemental Report of The Council as of September 21, 1952:

1. *Membership*—As of September 1, 1952, the membership of the Michigan State Medical Society totaled 5,212, including 518 Special Members who are relieved from paying dues and assessments.

2. *Finances*—The Constitution of the Michigan State Medical Society places responsibility on The Council for administration of the funds of the Society, and charges the Treasurer with safekeeping of the Society's invested funds.

Following the provision of the MSMS Constitution, The Council has caused an "annual audit to be made of the funds of the Society by a certified public accountant." The complete report of Madan and Bailey for the year 1951 was published in the March, 1952, issue of

THE JOURNAL of the Michigan State Medical Society, beginning at page 366. On pages 369-370 of the same number of THE JOURNAL are printed the MSMS budgets for the year 1952. As in the past, the audit of the accounts is and always has been available for inspection by any member of the Michigan State Medical Society who may call at the Executive Offices, 606 Townsend Street, Lansing 15.

The report of our staff accountant for the first eight months of this year (from January 1, to September 1, 1952) of income and expenses is as follows:

INCOME AND EXPENSES

Account	On Hand 1/1/52	Income to 9/1/52	Expenses to 9/1/52	Balance on Hand 9/1/52
General Fund	$ 70,923.65	$ 94,395.00	$ 71,382.56	$ 93,936.09
Annual Session	—	20,400.00	4,397.70	16,002.30
P. G. Institute	—	11,590.00	10,260.49	1,329.51
THE JOURNAL	—	43,044.93	40,302.50	2,742.43
Public Education	32,055.98	94,452.15	65,207.12	61,301.01
Public Education Reserve	30,000.00	—	—	30,000.00
Rheumatic Fever Control	26,431.80	12,000.00	18,093.08	20,338.72
Surplus from dues	7,117.81	7,061.67	—	14,179.48
Building Fund	9,490.42	9,415.50	7,654.39	11,251.53
TOTALS	$176,019.66	$292,359.25	$217,297.84	$251,081.07

This also includes report from the Treasurer presented to The Council in July, 1952.

More detailed financial reports, including the public relations accounts from January 1, 1952, to September 1, 1952, have been presented today (in mimeographed form) to all members of the House of Delegates.

3. *Michigan Medical Service.*—An up-to-date report on this Corporation, including its finances, will be presented to you at the meeting of Michigan Medical Service membership tomorrow, September 23, at 2 p.m., in the Grand Ballroom, Sheraton-Cadillac Hotel, Detroit. All MSMS delegates are members of the Michigan Medical Service Corporation and are expected to attend this important annual meeting.

4. *Beaumont Memorial.*—Progress has been made on plans for the Beamont Memorial Restoration since The Council's Annual Report was drafted in July: a Working Committee under the Chairmanship of W. S. Jones, M.D., was appointed and met on July 30; a contract has been entered into with University of Michigan Emeritus Professor Emil Lorch who will act as architect of the Beaumont project; the dismantling of the nonhistorical portion of the old American Fur Company store soon will be under way and the old lumber and stones having historical importance will be stored, ready for the construction job to begin next spring on Mackinac Island. However, Architect Lorch feels that the building cannot be ready for dedication much before the summer of 1954.

A Consultative Committee, under the Chairmanship of President Otto O. Beck, M.D., was appointed to guide the Beaumont Memorial Restoration Committee and the Working Committee in their efforts; this Committee is representative of the general public as well as of medical men.

The Council authorized a loan, not to exceed $20,000 —if necessary—to assure that sufficient monies are on hand to complete the Beaumont Memorial; if the generous contributions of MSMS members continue, this offer of a loan from the MSMS General Fund will not be required.

President Beck has recommended a Beaumont Memorial Organizational Breakfast for Thursday morning, September 25, 7:30 a.m., in the English Room of this hotel, to which the Chairmen of all County Medical Society Beaumont Memorial Committees have been invited. All members of the House of Delegates are cordially invited to attend this Organizational Breakfast.

The Council and President Beck are pleased to announce that the pharmaceutical house of Wyeth, Incorporated, of Philadelphia will present to the Michigan State Medical Society, tomorrow evening (Tuesday, September 23) at the last meeting of the House of Delegates, its famous painting "Beaumont and St. Martin," the masterful work of Dean Cornwell. This portrait will be the possession of the Michigan State Medical Society for housing in the Beaumont Shrine at Mackinac Island. We are deeply indebted to Wyeth Incorporated for this generous gesture; we sincerely trust that it will stimulate the contribution of much other Beaumont memorabilia and many historical documents.

May The Council again invite to the serious consideration of each and every Delegate and member our Recommendation No. 4 on the Beaumont Memorial Restoration Fund; this is found on page 68 of the Handbook for Delegates.

5. *Michigan's Foremost Family Physician for 1952.*—Selection of one of our Michigan general practitioners as nominee for the AMA Gold Medal Award is now the privilege of the House of Delegates. According to the procedure worked out last year by The Council, the field of nominees has been narrowed to three from which the House of Delegates will elect one. The three names, alphabetically arranged, are: (a) Sherman L. Loupee, M.D., of Dowagiac; (b) Duncan J. McColl, M.D., of Pt. Huron; and (c) Edwin L. Thirlby, M.D., of Traverse City.

6. *List of non-members.*—Pursuant to the House of Delegates' instruction of 1948, The Council (through the Secretary) today submits a list of former members whose 1952 MSMS dues were not paid as of September 1, 1952. To insure accuracy, this list recently was submitted to and certified as correct by county and district medical society secretaries.

7. *Cancer Control Committee.*—It is good to announce that a cancer manual entitled "The Story of Cancer for High Schools" recently has been printed and is now being distributed to every high school and college in the State of Michigan. This manual was developed by the MSMS Cancer Control Committee and published at a cost of $1,635, through the coöperation and generosity of the Michigan Department of Health and Commissioner A. E. Heustis, M.D. We are grateful to Dr. Heustis and to the Michigan Department of Health for their fine and tangible help. A fitting expression of appreciation to the State Department of Health is indicated in "The Story of Cancer for High Schools."

8. *Michigan State Board of Registration in Medicine.*—At the request of the Michigan State Board of Registration in Medicine, an MSMS Liaison Committee recently was appointed, composed of W. B. Harm, M.D., Detroit; L. Fernald Foster, M.D., Bay City; and W. S. Jones, M.D., Menominee. The State Board of Registration in Medicine has appointed as its representatives to this joint Liaison Committee E. W. Schnoor, M.D., Grand Rapids; E. C. Swanson, M.D., Vassar; and O. D. Stryker, M.D., Mt. Clemens.

The State Board of Registration in Medicine has adopted new Rules and Regulations applicable to the 1952 amendments to the Medical Practice Act. For a copy, write Secretary J. Earl McIntyre, M.D., 202 Hollister Building, Lansing.

The Council feels that the 1953 Legislature should be requested to allocate additional funds to the Michigan State Board of Registration in Medicine to cover the increased costs of greater services resulting from the new provisions made in the Medical Practice Act by the 1952 Legislature.

9. *Medical Advisory Committee to Michigan Hospital Service.*—At the request of Michigan Hospital Service, the Michigan State Medical Society in July, 1952, created

a Medical Advisory Committee to Michigan Hospital Service. This Committee will undertake a delineation of the scope of coöperative activities between the Michigan State Medical Society and Michigan Hospital Service; it has been requested by MHS to set up the duties and to be advisory to Harry F. Becker, M.D., of Battle Creek, Director of the newly created Physicians Relationship Division of Michigan Hospital Service. The personnel of the new MSMS Committee is: W. S. Reveno, M.D., Chairman, Detroit; E. C. Baumgarten, M.D., Detroit; Otto O. Beck, M.D., Birmingham; William Bromme, M.D., Detroit; W. M. LeFevre, M.D., Muskegon; J. E. Livesay, M.D., Flint; J. D. Miller, M.D., Grand Rapids; R. L. Novy, M.D., Detroit; Ralph W. Shook, M.D., Kalamazoo; D. R. Smith, M.D., Iron Mountain, and L. Fernald Foster, M.D., Secretary, Bay City.

10. *Health and Accident Insurance Plan for Michigan M.D.'s.*—The MSMS Study Committee headed by W. S. Jones, M.D., Menominee, presented its report in detail to The Council at its meeting yesterday (September 21). After a careful analysis of a contract proposed by Marsh and McLennan, insurance brokers of Chicago, the committee was of the opinion that the contract submitted would not meet the expectations of the needs of the MSMS. The Committee therefore cannot recommend the proposed policy. However, after hearing the objections and suggestions of the Committee, the brokers have agreed to submit a more adequate contract for further consideration by the Committee. The Council therefore recommends that its committee be authorized to continue its study of suitable health and accident group policies to the end that a reasonably priced contract with adequate coverage may be developed for recommendation to the Michigan State Medical Society.

11. *President's Commission on Health Needs of the Nation.*—This Commission, which created a furore at the June, 1952, AMA House of Delegates Session, is holding public hearings throughout the country. One of these hearings is scheduled for Detroit tomorrow, September 23, under the co-chairmanship of Walter Reuther, a member of the President's Commission, and K. B. Babcock, M.D., Detroit, President of Michigan Hospital Service. The oral presentations of the medical and health organizations of Michigan have been coördinated by The Council, through the able help of Immediate Past President C. E. Umphrey, M.D., Detroit, who served as Chairman of the Coördinating Committee meetings. At tomorrow's hearing, every effort will be made to present practical statements pointing out: (a) the great advancement of medical science in recent years; (b) the high quality of health and medical care resulting from voluntary methods and freedom from compulsion; (c) modern methods to overcome economic barriers to secure health service; (d) the local needs and how they are being met; (e) that medical and health problems can be solved locally, and (f) that much of the present difficulty now is due to the draining off of local money into federal taxes.

12. *Prison Survey.*—In 1947, a Joint Committee of the MSMS and of the Michigan Hospital Association surveyed the medical and hospital facilities of the State Prison of Southern Michigan, at the invitation of the Michigan Corrections Commission.

A resurvey of the facilities at Jackson was made, again upon official request, in 1952 by a committee composed of Otto O. Beck, M.D., and Phillip Riley, M.D. for the Michigan State Medical Society and K. B. Babcock, M.D., and Glen Fausey for the Michigan Hospital Association. This group reports a remarkable improvement accomplished in five years. Despite excessive overcrowding, the health facilities of the Prison are now clean and sanitary, records are accurate and complete, patients' diets are posted on each cell door, x-ray and laboratory facilities are excellent, the dental program is adequate, the eye clinic well run, and the pharmacy is well managed. Acute hospital care of inmates is greatly improved over 1947. However, The MSMS Committee feels there is much room for greater improvement and lists 6 areas: (1) overcrowding; (2) psychiatric facilities and personnel; (3) active tuberculosis; (4) nursing care; (5) geriatrics; and (6) new prison facilities. The Council urges all members of the House of Delegates to peruse this thorough-going report when it appears in JMSMS (November number). Finally, The Council thanks the present Committee for its survey and reiterates the Committee's congratulations to R. L. Finch, M.D., head physician of the State Prison of Southern Michigan and his associates, three full-time doctors of medicine, for an inspiring example of constructive work. Sincere commendation goes to these four M.D.'s and to the large number of Michigan medical practitioners whose consultative services are being utilized at the State Prison of Southern Michigan. These doctors of medicine have been responsible for an amazing betterment in the mental and physical health of the population of 6,500 at Jackson prison.

13. *Public Relations.*—Since the July Report, The Council is pleased to advise that the management of Radio Station WWJ has offered to MSMS a series of weekly round-table discussion programs; in addition, WWJ will present a half-hour dramatic show entitled "Dr. Beaumont has a Patient," during the MSMS Annual Session—Thursday evening, September 25.

14. *Organization.*—Your Chairman wishes to pay tribute to the many men of medicine who make up your committees. It is their activity at your mandate which has made this Michigan State Medical Society the important agency it is in the improvement of the health of the people of this Commonwealth. The devotion to this call goes somewhat beyond the routine of the practice of medicine, and the time taken from the office or from the quieter moments with the family amounts to a very great number of hours. Your chairman thinks we must all recognize that our delegates, our committee members, and our councillors are contributing a great share of themselves in working in our behalf, so your Council Chairman takes this occasion to express his personal thanks to them for what they are doing for all of us. The laymen who make up the personnel of our headquarters at Lansing have become something more than people working at a job; they likewise feel the import of the medically sponsored projects of the Michigan State Medical Society, and we are indeed fortunate to have them in our organization as part of us.

Recommendations

We respectfully invite to your attention the five recommendations in the original report of The Council, printed in the Handbook on page 68. They read as follows:

1. That MSMS representatives be instructed to continue their yearly visit to Washington, D. C., on the occasion of Michigan Day sponsored by the U.S. Chamber of Commerce.

2. That the MSMS Committee on Distribution of Medical Care, which for several years has been inactive, be abolished. (This will require amendments to the By-Laws, Chapter 10, Section 1-c with the renumbering of 1-d-e-f; Section 4; also Sections 5, 6, and 7 will have to be renumbered Sections 4, 5 and 6).

3. That continued active tangible coöperation with the American Medical Association be maintained by every MSMS member who is urged to continue and strengthen his support of the AMA. Strength comes from unity and work. Joined hand in hand, it flows from the roots to the trunk.

4. That contributions to the Beaumont Memorial Restoration Fund, by every individual member of the MSMS, are urged; and that the members of the MSMS House of Delegates in their individual districts be delegated as committees to spearhead this drive so that the fund of $40,000 may be obtained before the end of 1952. A memorial to Dr. Beaumont on Mackinac Island

will be a lasting shrine to the science of medicine and to the generosity of Michigan practitioners of medicine.

5. That members continue to remember in their generosity the American Medical Education Foundation—a strong bulwark against socialized medical education—and that annual and more frequent contributions be urged upon every member of the MSMS and their friends who are interested in a maintenance of the present high unfettered standards in medical education.

Respectfully submitted,
WILLIAM BROMME, M.D., *Chairman*
L. W. HULL, M.D., *Vice Chairman*
R. S. BREAKEY, M.D.
G. W. SLAGLE, M.D.
RALPH W. SHOOK, M.D.
J. D. MILLER, M.D.
H. H. HISCOCK, M.D.
H. B. ZEMMER, M.D.
L. C. HARVIE, M.D.
G. B. SALTONSTALL, M.D.
F. H. DRUMMOND, M.D.
C. A. PAUKSTIS, M.D.
A. H. MILLER, M.D.
W. S. JONES, M.D.
B. M. HARRIS, M.D.
D. B. WILEY, M.D.
W. D. BARRETT, M.D.
W. B. HARM, M.D.
R. H. BAKER, M.D.
OTTO O. BECK, M.D.
R. J. HUBBELL, M.D.
L. FERNALD FOSTER, M.D.
W. A. HYLAND, M.D.
C. E. UMPHREY, M.D.

THE SPEAKER: Thank you, Dr. Bromme.

The bulk of this report of The Council and supplemental report will be referred to the Reference Committee on Reports of The Council.

The item pertaining to Michigan's foremost family physician, is being referred to the Reference Committee on Miscellaneous Business, and the item of The Council's recommendation for removal of the Committee on the Distribution of Medical Care is referred to the Reference Committee on Constitution and By-Laws.

VI. REPORT OF DELEGATES TO AMA

At the recent American Medical Association Meeting in Chicago in June your delegates as also the alternates met each morning for breakfast followed by a discussion of the day's program. The many resolutions presented were discussed and classified as of general importance or local significance.

Dr. Wyman Barrett discussed the more important resolutions and assigned the delegates and alternates to the various committee hearings of their choice with the thought in mind of obtaining full coverage. Each delegate reported back the next morning the result of the committee hearings. In this manner the group was cognizant of all that transpired.

Among the more important discussions was the resolution concerning preparedness of the American Medical Association for discussing the subject of relations with the osteopathic group. Another was the resolution concerning the President's Commission on Health Needs. Still another one, non-medical, limited the taxing power of the government and provided that no treaty or executive agreement shall conflict with any provisions of the constitution or regulate purely domestic affairs.

Concerning the first resolution, pertaining to the relations with osteopathic groups, it was felt that the Judicial Council and the Board of Trustees should study this question with the thought in mind that should we be asked to aid in the advance of medical service to the public we should help in every manner to elevate the health of the country. The public expects us to take the lead as they endorse our standards and ethics and have supported us very well in the recent years.

The Furey Resolution, which was quite forceful in condemning the President's Health Commission and some of its members, was freely discussed by the committee to which it was assigned. This group held many long and fruitful sessions, including one in which many members of the Association were heard. This resulted in substituting a resolution by Dr. Best's committee which concluded that no judgment of the commission should be expressed until its report is submitted late this year or early in 1953. The substitution suggested the House, at this time, re-affirm its confidence in the Board of Trustees for their diligence in carrying out the policy of the House of Delegates which is the governing body of the American Medical Association; their resolution was passed unanimously. The third resolution, concerning the limitation of taxation and restricting the executive powers to make agreements conflicting with the constitution, was also passed.

The resolution presented by Dr. Kenny of New York condemning the efforts of the International Labor Organization to socialize medicine was passed.

The Public Relations advisors, Whitaker and Baxter, requested that they be relieved of the greater portion of their responsibilities at this time due to the fact that most of their work was completed. This was passed with the advice to the members of the House to diligently watch our opponents in order for us not to be caught unprepared again.

The Michigan Delegation was active in the election of Dr. Edward McCormick of Toledo to the office of President-Elect. Dr. McCormick, a personal friend of the present and past Michigan delegates, was very appreciative of the Michigan Delegation's friendship and so expressed himself in a collective and also individual notes to all of us.

Dr. Edward Reuling of Long Island was elected Speaker of the House. Dr. Reuling who had an emergency operation just previous to leaving for Chicago expressed his gratefulness to the Michigan Delegation for their friendship and support and also their wire of good cheer, in a recent communication to us.

Dr. John Cline was most effusive in his declaration of friendship to Michigan as he spoke from the floor of the House after the unanimous passage of the Michigan resolution, which was approval and recognition by the House of Delegates (to be spread on the minutes) of his contribution to American medicine. Later on, he personally sent individual notes to the Michigan delegation to more intimately convey to us what our friendship and loyalty meant to him.

The Interim Meeting will be held in Denver in December with the annual session in New York next June.

Your committee appreciates the confidence you have expressed in us by sending us as your representatives and asks for a continuance of your wholehearted support.

Respectfully submitted,
WYMAN D. BARRETT, M.D.
JOHN S. DETAR, M.D.
WILLIAM H. HURON, M.D.
W. A. HYLAND, M.D.
R. A. JOHNSON, M.D.
R. L. NOVY, M.D.

THE SPEAKER: Thank you, Dr. Hyland. The Report of the Delegates to the American Medical Association will be referred to the Reference Committee on Officers' Reports.

VII. REPORT OF WOMAN'S AUXILIARY TO MSMS

The Guest of Honor at a recent Auxiliary luncheon in Chicago began his remarks with this statement, "Reading a speech is like delivering a kiss over the telephone—by all means the safest way, but not at all exciting."

I am deeply appreciative of the opportunity to bring

to the House of Delegates of the Michigan State Medical Society a résumé of the activities and accomplishments of the Woman's Auxiliary during the past year. Since our mimeographed reports cover twenty-four legal size sheets I'm sure you will be glad to have me present it in capsule form.

Many of you are already aware of the fine work in your own counties, but some of you, I regret to say, still represent areas where your wives as a group are not sharing the responsibilities and obligations which fall upon us as doctors' wives, and so are not experiencing the mutual satisfaction and joy of working together and completing any of our worthwhile objectives.

With the generous assistance of our husbands and the Public Relations personnel of MSMS, the Formula for Freedom has been translated into action by the women as well as the men.

Throughout the state we find a great variance in the projects being sponsored by Auxiliaries. This is naturally to be expected when we realize that county memberships vary in size from eight to 419 and our dues from $2.00 to $8.00 with $1.00 forwarded to both the State and National treasurers. Let me say here that we are grateful to you for the financial assistance you give toward defraying Convention expenses and others throughout the year.

Activity in nurse recruitment far outranks all others. Thirty-one of the forty-three county organizations report that they do some work for recruitment. We know of eighteen scholarships given with a total value of $2,830. In addition there are thirteen loan funds worth $3,500 and a reserve fund of $600 available. Many counties report an educational recruitment program being carried on in their schools, and great strides are being made in the organization of Future Nurse Clubs.

Five counties deserve commendation for outstanding work with the State Mobile Blood Plasma Bank. In all these counties auxiliary members have recruited donors, and served as receptionists, registrars and nurse aides. In many other counties the Auxiliary has given partial assistance, either by recruiting donors or by acting as staff assistants.

The TB Speaking Project which we co-sponsor, is still one of our best Health education endeavors. An estimated 2,300 students from seventy-nine schools spoke about tuberculosis to audiences totaling approximately 14,000 persons last winter.

Ingham and Washtenaw have had special PR meetings this year; the former entertained the wives of state officials and legislators, and the latter invited wives of senior medical students to a combined business and social evening, giving the girls a preview of Auxiliary work and urging them to join in the future, when the opportunity presents.

The Adult Education Program of MSMS has been well received and publicized in several counties, and others have arranged for the showing of the new film "To Save Your Life."

Most of the other projects may be definitely classed under Voluntary Medical Services. Ingham and Kent counties are to be complimented on having collected over two and a half tons for Medical and Surgical Relief for overseas and fourteen other groups collected lesser amounts. Perhaps the following statement from the National Committee will make members of more medical societies willing to save their sample pharmaceuticals and old instruments for collection once a year. I quote, "The distress calls continue to come to this office from all parts of the world, and the need today is greater than ever before for all possible medications and surgical instruments, so that whatever supplies you are able to procure will be most welcome and can be put to immediate use. It most certainly is worth a great deal of effort to continue this wonderful work and we hope you will do all you possibly can to stimulate activity on our behalf. With renewed thanks and appreciation for the splendid work you have done in the past and the hope we may continue to count on your efforts to help carry on this humanitarian work."

Many Auxiliaries give aid to local hospitals, to the Red Cross, the Cancer Society, the Infantile Paralysis Foundation, Crippled Children, the Cardiac Housewife, and other health programs. Civil Defense plans are gradually taking shape, and whenever requested, women help with Blue Cross-Blue Shield community enrollment, exhibits at State and County fairs, and other things too numerous to mention, all with the approval of their Medical Advisory Committees. We appreciate the guidance of the men in each county and especially the State Committee of which Dr. Josef Rozan was chairman.

And more than all else, let me pay tribute to my husband, whose home has been turned into an office, whose telephone bills have been astronomical, and whose partner has often been off traveling when he'd have preferred having her "safe now in her trundle bed." With his patience and his wisdom he has sustained me in moments of trial as well as triumph, knowing well that I have gained in friendships and satisfactions fully as much as I have given in service these past two years.

On two occasions this summer I have sent out personal communications to all Auxiliary members, at the specific request of the men. One was the letter mailed from Mackinac Island inviting our support of the Beaumont Memorial project. There was brief mention of the fascinating and interesting experience of going through the old Early House with the committee, guided by Professor Lorch (who has spent ten years in research which Dr. Beck has already told you about, determining how the building was constructed at the time of Alexis St. Martin's memorable accident). We, too, want to share in the restoration of this shrine of honor to a great physician, and I'm proud to say Wayne Auxiliary has already given $500 and some smaller auxiliaries proportionate amounts.

Perhaps in this world of surprises and mixed-up values we should always "expect the unexpected"—but I still look back with amazement upon my introduction to the problem of Reapportionment. Returning home from a few weeks of enforced vacation, I had planned to visit several counties, write my report to National, and catch up on a few neglected duties, when I was confronted with the necessity of helping obtain 250,000 signatures on petitions for a Balanced Legislature. Once more 2,300 letters were prepared and sent with explanatory literature, two copies of the petition, and a request for immediate action on the part of all doctors' wives and widows. This was followed up by two further notices to all County Presidents, by individual notices in my own county, and by telephone calls to eight of the largest Auxiliaries, as the deadline approached. In addition to the above I had an opportunity to speak to five professional and several lay groups and I do sincerely believe that the time and energy exerted by the women was a deciding factor in securing the 290,400 signatures which were filed on July 3. We must remember though, that the battle is only half won and we must continue to inform the public on the issues involved, and do all in our power to see that Proposal No. 2, sponsored by the CIO, is defeated, and Proposal No. 3 is carried on the November ballot. This, of course, is only a part of our Good Citizenship Campaign. We propose to distribute 10,000 copies of a little pamphlet entitled "What Can I Do?" to our friends and acquaintances who may take the responsibility of citizenship too lightly, or to members of other organizations to which we belong. Let us remember that "Bad politicians are elected by good people who do not VOTE" and that "To do nothing is to give comfort to the enemy."

I think the work on Reapportionment is a splendid example of what can be done through organization and how difficult it is to reach doctors' wives in the counties where we have no existing channels of communication. Mrs. George Cook of Ionia, our Members-at-Large chairman, sent four packets of Auxiliary material to the twenty-six women who had paid dues in 1951-52 and wrote personal letters to 236 other physicians' wives in thirteen unorganized counties, inviting them to join our ranks—without success, I regret to say. Someone has said,

"Prejudice is a great timesaver. It enables one to form opinions without bothering to get the facts." Do these women hesitate to become affiliated because you, their husbands, do not recognize the value of such contacts? Do you fail to realize the truth of Dr. Louis Bauer's statement, "The Woman's Auxiliary is the greatest undeveloped resource of the AMA" or the tribute to us which was included in the annual report of the Council and reprinted in the last *Auxiliary News* from which I quote briefly: "In the activity of the 2,200 members they have doubled the personal strength of all individual members of the medical society—The MSMS is deeply indebted to them for their splendid assistance, and confidently looks forward to their continued future help." Such appreciation makes all our efforts seem worthwhile, and I do hope the next few years will see the gap between potential and actual membership become practically non-existent. Thank you, too, for publishing the *Auxiliary News* (formerly the *News Bulletin*), the technical details of which are competently handled by Jack Kantner of the Public Relations office of MSMS. Working with him and the other members of the staff at 606 Townsend Street is always a pleasure, and I am sure I speak for all of us when I say that we appreciate the coöperation so readily extended to us year after year.

Two of us from Michigan have been on National Committees this year. Mrs. Robert Hart of Sanilac County is North Central Regional Chairman of Bulletin circulation, and I am Regional Chairman of the recently created American Medical Education Foundation Committee. You know, of course, that the medical profession has accepted the challenge to raise more than two million dollars this year through voluntary contributions, to save our financially distressed medical schools, and has requested the Auxiliary to lend its efforts in making the present campaign a success. We propose to do this by encouraging contributions from members, by voting money from our treasuries, or initiating special projects to raise funds for the Foundation, and I should certainly be proud to have my state lead all others.

Apparent lack of interest in "Today's Health" is a puzzle to many of us who are familiar with the magazine in its present form. Is that prejudice, too, because an occasional uninformed husband facetiously says he doesn't want his wife to be a magazine saleswoman? The four-year professional subscription for $4.00 should be an inducement to have a copy in every physician's office and home, and if you prefer to subscribe directly from AMA please ask that your Auxiliary be given the credit for this subscription.

I think you gentlemen would be surprised at the material which comes to us from the AMA with the request that we call it to your attention. The most recent arrivals are the attractive pamphlet "Winning Ways With Patients" for the guidance of office personnel, and one entitled "Your Money's Worth In Health." I sincerely believe that if the factual information in this excellent brochure was familiar to everyone connected with the practice of medicine, and a few copies of it were placed in every office and hospital waiting room, many of the misunderstandings and complaints of patients regarding the cost of medical care would be greatly minimized.

Thank you again for your faith and trust in us. May our ideals remain constant, and may we continue to serve together with enthusiasm and vigilance, so that the cause of American medicine may prosper in the land.

Respectfully submitted,

Mrs. Robert S. Breakey, *President*

The Speaker: Thank you, Mrs. Breakey.

This report will be referred to the Reference Committee on Officers' Reports.

VIII. SELECTION OF MICHIGAN'S FOREMOST FAMILY PHYSICIAN

The Speaker: The Council has nominated three candidates. We shall have the reading of the biographies of these three men so that you may ballot at this time.

Secretary L. F. Foster, M.D., read the biographical material on the nominees.

O. K. Engelke (Washtenaw): The vote shows Dr. Loupee in first position.

The Speaker: Gentlemen, I present Dr. Loupee, our foremost family physician of the year. Applause; response by Dr. Loupee.

IX. RESOLUTIONS AND MOTIONS

IX—a. FEES FOR SURGICAL ASSISTANTS IN HOSPITALS

D. W. Thorup, M.D. (Berrien):

"WHEREAS, there is no provision in the present Blue Cross, and other comparable insurance policies for the payment of surgical assistant's fees, and

"WHEREAS, in smaller community hospitals where there is no intern or resident surgical assistant, therefore the assistant's fee must be paid by the surgeon, and

"WHEREAS, surgical fees have not been raised by the Michigan Medical Service in proportion to hospital costs, be it now therefore

"RESOLVED: That the Michigan State Medical Society, through its House of Delegates, convened September 22-23, 1952, at Detroit, Michigan, request the various insurance companies, and Blue Cross in particular, operating in the State of Michigan, that some provision be made to compensate surgical assistants in hospitals where there is no intern or resident."

The Speaker: This resolution will be referred to the Reference Committee on Medical Service and Prepayment Insurance.

IX—b. LENIENCY IN ADMINISTRATION OF ACT 59 OF P.A. 1937

"WHEREAS, it is the opinion of the Berrien County Medical Society that the multiplicity of examinations and increased restriction to the migration of physicians into the State of Michigan and to other states is an unhealthy trend; and

"WHEREAS, maintenance of certain minimal standards is desirable but that the imposition of excessive and unnecessary requirements leads to parochialism and invites tyranny; therefore, be it

"RESOLVED: That the Michigan State Medical Society recommend that properly qualified physicians be given reciprocity on a much more lenient basis, particularly as concerns the basic science laws or that the latter be repealed."

This resolution will be referred to the Reference Committee on Resolutions.

IX—c. SIMPLIFIED INSURANCE REPORTING FORMS

D. W. Thorup, M.D.:

"WHEREAS, the House of Delegates of Michigan State Medical Society in 1950 passed a resolution urging the development of a Simplified Insurance Reporting Form, and

"WHEREAS, the long, cumbersome, involved repetitious and confusing forms previously used are still being presented by insurance companies for completion to doctors in Michigan, and

"WHEREAS, personnel directors of manufacturing companies in at least one county of the State of Michigan have expressed themselves as favoring the use of a Simplified Insurance Reporting Form; therefore, be it

"Resolved: That the House of Delegates proceed in whatever fashion necessary to implement its action of 1950, and arrange for preparation and distribution to the members of MSMS of a Simplified Insurance Reporting Form which satisfies the intent of the resolution enacted in 1950."

The Speaker: This resolution will be referred also to the Reference Committee on Medical Service and Prepayment Insurance.

IX—d. SUPPORT OF KEOGH-REED BILLS IN CONGRESS

D. W. Thorup, M.D.:

"Whereas, it has come to the attention of the members of this Society that legislation has been proposed to refund part of the income tax of doctors to provide a retirement fun; therefore, be it

"Resolved: That the House of Delegates of the Michigan State Medical Society go on record as supporting such legislation; namely, such as is embodied in the Keogh Bill, by whatever means it has at its disposal."

The Speaker: This resolution will be referred to the Reference Committee on Legislation and Public Relations.

(See revised wording of Resolution on Page 1609)

IX—e. MOTION: PRESIDENT-FOR-A-DAY, R. L. NOVY, M.D., DETROIT

W. D. Barrett, M.D.:

I move that Robert L. Novy, M.D., Detroit, be made President-for-a-Day of the Michigan State Medical Society.

I also move that the rules and regulations be set aside and this be decided without reference at this time.

E. C. Texter, M.D. (Wayne): I support the motion.

The Speaker: Supported by Dr. Texter and several others.

You have heard the motion, gentlemen. It has been seconded.

A. B. Gwinn, M.D.: I would like to second the motion, too.

The Speaker: Are you ready for the question? It takes a two-thirds vote.

J. S. DeTar, M.D. (Washtenaw): I consider this a very highly appropriate gesture. On only one other occasion, I believe, has this society elected a president for the day. That was Dr. Wilfrid Haughey, and he is now listed as a past President of this Society. I certainly am strongly in favor of this motion.

(*The question was called for.*)

The Speaker: All in favor of the motion say "aye"; opposed, "No." The motion is carried unanimously.

Robert L. Novy, M.D., has been made President-for-a-Day.

IX—f. AMA WELFARE FUND FOR NEEDY M.D.'s

F. C. Ryan, M.D. (Kalamazoo):

"Whereas, fellow members of our Society are sometimes stricken with a totally disabling illness, leaving them and their families without visible means of support; and

"Whereas, it is the wish of their fellow physicians to aid them through the official channels of the State Society; be it therefore

"RESOLVED: That the Michigan State Medical Society instruct its delegates to the convention of the American Medical Association to initiate legislation in that governing body for the purpose of studying the feasibility and ways and means of establishing a general welfare fund from a portion of the $25 dues presently charged to each member of the American Medical Association."

The Speaker: The Chair will refer that resolution to the Reference Committee on Officers' Reports.

IX—g. FEES FOR SURGICAL ASSISTANTS IN UNIFORM FEE SCHEDULE FOR GOVERNMENTAL AGENCIES

E. H. Fenton, M.D. (Wayne):

"WHEREAS, there is now no provision for payment of assistant's fees by the Michigan Blue Shield, and

"WHEREAS, there is a definite shortage of interns and residents in many hospitals, and

"WHEREAS, it is highly desirable that the patient's physician follow the case and give aid and advice based on his personal knowledge of the case, and

"WHEREAS, it is desirable to preserve the family physician-patient relationship, and

"WHEREAS, there is a definite need for establishing a fair compensation for an assistant's efforts and thus discourage fee-splitting, and

"WHEREAS, Blue Shield in a number of other states has recognized this situation and is paying assistant's fees,

"RESOLVED: That the uniform Fee Schedule for Governmental Agencies be amended to provide for an assistant's fee on major surgical procedures."

The Speaker: The resolution will be referred to the Reference Committee on Medical Service and Prepayment Insurance.

IX—h. FEES FOR SURGICAL ASSISTANTS IN BLUE SHIELD

E. H. Fenton, M.D.:

"WHEREAS, there is now no provision for payment of assistant's fees by the Michigan Blue Shield, and

"WHEREAS, there is a definite shortage of interns and residents in many hospitals, and

"WHEREAS, it is highly desirable that the patient's physician follow the case and give aid and advice based on his personal knowledge of the case, and

"WHEREAS, it is desirable to preserve the family physician-patient relationship, and

"WHEREAS, there is a definite need for establishing a fair compensation for an assistant's efforts and thus discourage fee-splitting, and

"WHEREAS, Blue Shield in a number of other states has recognized this situation and is paying assistant's fees,

"RESOLVED: That the Michigan Blue Shield be requested to revise their fee schedule to provide for assistant's fees on major surgical procedures."

The Speaker: This will be referred to the Reference Committee on Medical Service and Prepayment Insurance.

IX—i. EXPERT TESTIMONY

E. D. Spalding, M.D., Amend Section 617.69 C.L. 1948, being Section 27.918 M.S.A., by adding a new section as follows:

"Whenever, in a civil proceeding, a dispute arises between experts, the court on its own motion, or on the request of any party, may appoint one or more experts, not exceeding three on each issue, to investigate such issues and to testify at the trial. Such expert witness must be appointed from a panel designated by the society, association, board, or similar organization in his profession or field, and the compensation of such person or persons shall be fixed by the court at a reasonable amount, and paid as directed by the court. The fact that such witness or witnesses have been appointed by the court shall be made known to the jury. Any party to the proceeding may also call other expert witnesses.

"Experts called by the court or by the parties in the proceeding shall be permitted access to the persons, things, or places under investigation for the purpose of inspection and examination.

"An expert witness may be asked to state his inferences, and these may be stated as a fact, whether these

inferences are based on the witness' personal observation, or on evidence introduced at the trial and seen or heard by the witness, or on his technical knowledge of the subject, without first specifying hypothetically in the question the data on which these inferences are based. An expert witness may be required, on direct or cross-examination, to specify the data on which his inferences are based."

The Chairman referred this to the Reference Committee on Legislation and Public Relations.

IX—j. RESOLUTION RE ACT 59 OF P.A. 1937

F. L. Troost, M.D. (Ingham):

"WHEREAS, the basic science law was enacted by the legislature in 1937 as Public Act No. 59 with the hope that it would raise the standard of the healing arts in the State of Michigan; and

"WHEREAS, the experience of the past 15 years has demonstrated that the original concept has not been accomplished, but rather the reverse, and that in fact, the citizens of Michigan have been deprived of the services of many well qualified physicians; and further,

"WHEREAS, the amendments to this law, enacted in 1952, can do but little to increase the physician supply in Michigan; and further,

"Whereas, it was hoped these amendments would increase the reciprocity agreements in basic science with other states, but are having the opposite effect by decreasing Michigan's basic science reciprocity agreements; therefore, be it

"RESOLVED: That this House of Delegates go on record as favoring repeal of the Public Act No. 59 of the regular session of legislature of the State of Michigan, 1937; and be it

"RESOLVED FURTHER: That this House instruct the Council and the officers of the Michigan State Medical Society to sponsor through its legislative committee the necessary legislation to accomplish repeal of the above-named act, such proposed legislation to be introduced into the regular 1953 session of the legislature of the State of Michigan and to be vigorously sponsored and supported by the Michigan State Medical Society."

The Speaker: This resolution will be referred to the Reference Committee on Resolutions.

IX—k. REPEAL OF "CITIZENSHIP" IN MEDICAL PRACTICE ACT

E. G. Krieg, M.D. (Wayne):

"Whereas, Section 3 of Enrolled Senate Bill No. 301, Act No. 172, Public Acts of 1952 of the State of Michigan, provides that all men and women—who wish to begin the practice of medicine, surgery and midwifery in any of its branches in this state—shall furnish evidence of being either a citizen of the United States or of having valid second naturalization papers; and

"Whereas, the citizenship requirement is contrary to the legislative committee of the Michigan State Medical Society; and

"Whereas, there is a shortage of doctors in the State of Michigan; and

"Whereas, the citizenship requirement will keep doctors from Canada and other foreign countries, who have otherwise complied with the requirements of the law, from practicing in the State of Michigan; and

"Whereas, in excluding all aliens it undoubtedly would exclude from this state extremely brilliant men who could make worthwhile contributions to the welfare of medicine; now, therefore, be it

"Resolved: That the legislative committee of the Michigan State Medical Society recommend that the clause of Section 3, Act No. 172, Public Acts of 1952, State of Michigan, which deals with citizenship, be repealed."

The Speaker: The Chair referred this resolution to the Committee on Legislation and Public Relations.

IX—l. MIGRATORY LABORERS

D. C. Bloemendaal, M.D. (Ottawa):

"Whereas, a great many thousands of migratory laborers come to the State of Michigan every year, and

"Whereas, these people come mostly from the states of Texas, Alabama, Louisiana, Mississippi, Oklahoma, Kentucky, Tennessee and Arkansas, and

"Whereas, these migratory laborers include also Cubans, Puerto Ricans and Mexican nationalists, and

"Whereas, these migratory laborers come to the State of Michigan to help harvest the Michigan fruit and vegetable crops, and are also employed by the canning factories for seasonal employment only, thus causing a great influx of strangers within the State of Michigan, causing definite problems in health and sanitation, housing conditions, child labor and recreation, and

"Whereas, a great number of these people suffer from tuberculosis, infectious disease, and therefore constitute a health menace to the Michigan citizens, and

"Whereas, this has cost the State of Michigan considerable money for welfare relief, and

"Whereas, this load is entirely carried by the Michigan taxpayers; now, therefore, be it

"Resolved as follows: That

"1. Certain protective measures be instituted to protect the health of the people of Michigan, and that

"2. A reciprocal agreement between the State of Michigan and the various states from which these migratory laborers come be established whereby certain health requirements are necessary for employing these migratory laborers, and

"3. That a guarantee be obtained from these respective states that the expense of welfare be assumed by these states from where these migratory laborers come."

The Speaker: This resolution will be referred to the Reference Committee on Hygiene and Public Health.

IX—m. RE "SESSION" AND "MEETING"

S. A. Stealy, M.D. (Medical Society of North Central Counties): Resolution correcting Chapter 9 of the By-Laws.

"WHEREAS, in the general recodification of the Constitution and By-Laws of the Michigan State Medical Society some years ago the word "Session" was indicated with reference to the MSMS Annual Convention; and

"WHEREAS, the words 'Annual Meeting' still appear in the By-Laws in Chapter 9, Sections 1 and 7; therefore, be it

"RESOLVED: That the words 'Anual Meeting' be changed to 'Annual Session' in the By-Laws in Chapter 9, Sections 1 and 7."

The Speaker: This will be referred to the Reference Committee on Constitution and By-Laws.

IX—n. ABOLISH COMMITTEE ON DISTRIBUTION OF MEDICAL CARE

S. A. Stealy, M.D. (North Central Counties): Resolution to amend Chapter 10 of the By-Laws.

"WHEREAS, the work of the Committee on Distribution of Medical Care has been taken over by other committees of the Michigan State Medical Society and of The Council; and

"WHEREAS, the Committee on Distribution of Medical Care is now inactive; therefore, be it

"RESOLVED: That the Committee on Distribution of Medical Care be abolished and the necessary amendments by this action be made in the By-Laws by changing Chapter 10, Section 1, eliminating subsection (c) and renumbering subsections (d), (e) and (f) to (c), (d) and (e). Also, in Chapter 10, Section 4, deleting the

duties of the Committee on Distribution of Medical Care and renumbering Sections 5, 6 and 7 to 4, 5 and 6."

THE SPEAKER: This resolution will be referred to the Reference Committee on Constitution and By-Laws.

IX—o. SEMI-ANNUAL SESSIONS OF HOUSE OF DELEGATES

O. B. McGILLICUDDY, M.D. (Ingham):

"WHEREAS, the interests and activities of the MSMS are constantly increasing, and its obligations to its members and the public have become greatly expanded, and

"WHEREAS, the House of Delegates is the basic governing body of the MSMS and much business arises throughout the year which should receive consideration by the House, and

"WHEREAS, there are two state-wide scientific meetings of the MSMS annually; therefore, be it

"RESOLVED: That in the future the House convene for the consideration of such matters biennially and upon the occasion of the Scientific Meetings above mentioned."

E. A. OSIUS, M.D. (*Wayne*): I would like to raise a question. Biennial means once in two years, and semi-annual means twice in one. Which should it be?

O. B. MCGILLICUDDY, M.D.: It should be semi-annual.

THE SPEAKER: This resolution will be referred to the Reference Committee on Resolutions.

The meeting recessed at one o'clock.

MONDAY AFTERNOON SESSION

September 22, 1952

The meeting reconvened at two twenty-five o'clock with R. H. Baker, M.D., the Speaker, presiding.

X. REPORTS OF STANDING COMMITTEES

X—a. COMMITTEE ON POSTGRADUATE MEDICAL EDUCATION

This report will be referred to the Reference Committee on Standing Committees.

X—b. PREVENTIVE MEDICINE COMMITTEE AND ITS SUBCOMMITTEES

This report will be referred to the Reference Committee on Standing Committees.

X—c. COMMITTEE ON DISTRIBUTION OF MEDICAL CARE

This report will be referred to the Reference Committee on Standing Committees.

X—d. COMMITTEE ON PUBLIC RELATIONS AND ITS SUBCOMMITTEES

This report will be referred to the Reference Committee on Standing Committees.

X—e. COMMITTEE ON ETHICS

No report.

X—f. LEGISLATIVE COMMITTEE

VICE-SPEAKER: This is a very important committee. The members have done a lot of work and have been very successful in the things they have done. Since there were resolutions presented this morning concerning the basic science law, I would advise you to read the report of the Legislative Committee which will tell you what has been done in the past year in regard to the basic sciences and the Medical Practice Act.

This report was referred to the Reference Committee on Standing Committees.

XI. REPORTS OF SPECIAL COMMITTEES

XI—a. BEAUMONT MEMORIAL RESTORATION COMMITTEE

This report was referred to the Reference Committee on Special Committees.

XI—b. SCIENTIFIC RADIO COMMITTEE

This report was referred to the Reference Committee on Special Committees.

XI—c. ADVISORY COMMITTEE TO WOMAN'S AUXILIARY

This report was referred to the Reference Committee on Special Committees.

XI—d. ADVISORY COMMITTEE TO MICHIGAN STATE MEDICAL ASSISTANTS SOCIETY

This report was referred to the Reference Committee on Special Committees.

XI—e. ADVISORY COMMITTEE TO NATIONAL FOUNDATION FOR INFANTILE PARALYSIS

This report was referred to the Reference Committee on Special Committees.

XII. REPORTS OF COMMITTEES OF THE COUNCIL

The reports of the committees of The Council are included in the annual report of The Council as published and will be handled by the Reference Committee on Reports of The Council.

The meeting recessed at two-forty o'clock.

MONDAY EVENING SESSION

September 22, 1952

The meeting reconvened at eight-thirty o'clock, with R. H. Baker, M.D., the Speaker, presiding.

THE SPEAKER: We start the third meeting of this House of Delegates.

Is there a supplementary report of the Committee on Credentials? Dr. Gwinn.

A. B. GWINN, M.D.: Mr. Speaker, we have ninety-five delegates seated which constitutes a quorum, and 50 per cent of which are not from any one county.

THE SPEAKER: Thank you. That constitutes a roll call.

The next item of business is unfinished business. Is there any unfinished business or any new resolutions to be brought up at this time? That would come under new business. Is there any unfinished business?

If not, is there any new business? Are there any additional resolutions?

We are ready then for the reports of reference committees.

XIII. REPORTS OF REFERENCE COMMITTEES

XIII—a. OFFICERS' REPORTS

S. T. LOWE, M.D. [Calhoun]:

XIII—a (1). SPEAKER'S ADDRESS

The Speaker's Address gave an excellent summary of the accomplishments of the MSMS in the last year and the committee approves it thoroughly.

XIII—a (2). PRESIDENT'S ADDRESS

We as a committee, accept and approve the President's Address and particularly commend him on the excellent work he has done toward the Beaumont Memorial Project.

XIII—a (3). PRESIDENT-ELECT'S ADDRESS

Doctor Hubbell's address gave the committee a desire to fulfill the duties of our organization. We feel sure that the enthusiasm of the new president should be readily transferred to his new committees.

XIII—a (4). REPORT OF THE DELEGATES TO THE AMA

The report of the delegates was reviewed and the committee reaffirms the confidence we have placed in our elected delegates. Aside from the written report, we understand that the delegates were very active in all discussions and represented us well at the June, 1952, meeting in Chicago.

XIII—a (5). REPORT OF THE WOMAN'S AUXILIARY TO THE MSMS

The report of the Woman's Auxiliary to the MSMS shows the tremendous amount of work that has been done by them. Especially notable is their work on the reapportionment bill. Another notable field of endeavor has been their work in getting girls interested in the nursing profession and the securing of scholarships to further their education in that field. As a group, the MSMS salutes its Auxiliary.

XIII—a (6). AMA FUND FOR NEEDY M.D.'s

Resolution from the Kalamazoo County Society concerning a general welfare fund for indigent doctors and their families: It is the opinion of the reference committee that cases of indigent doctors and their families should be handled on the local or county level and in cases of sparsely settled areas at the district level. The committee recommends rejection of the resolution.

I move the acceptance of the report of the committee.

THE SPEAKER: You have heard the motion. Is there a second?

L. J. BAILEY, M.D. (Wayne): I support the motion.

THE SPEAKER: Is there any discussion?

All in favor of the motion say "aye"; opposed, "no." The motion is carried.

XIII—b. REFERENCE COMMITTEE ON REPORTS OF THE COUNCIL

B. T. MONTGOMERY, M.D. (Chippewa-Mackinac): Mr. Speaker, your committee takes cognizance of the tremendous amount of time which the Council spends in considering the business of the Society.

It is noticed by the committee that the membership of the State Society on September 1, 1952, is only two members short of the all-time high of 5,214 on December 31, 1951.

We take note of the sound financial position of the Society and commend the various committees for remaining within their budgets, and it is hereby urged that they continue their efforts in this direction.

The committee wishes to express regrets on the passing of Dr. Andrew S. Brunk and also to commend the Council on the selection of Dr. William A. Hyland as MSMS treasurer. The committee commends THE JOURNAL of the MSMS for its forward looking policy and recommends the adoption of the report of THE JOURNAL. In regard to the public relations activities, the committee wishes to commend the public relations department for its past efforts. It is suggested, however, that their program in the future be diverted to cover emergency situations of a more professional nature.

The Woman's Auxiliary is to be especially commended for its work during the past year. Special mention is here made for the time, effort and direction of their president, Mrs. Robert Breakey.

The State Health Department is to be commended for its assistance to and fine co-operation with the MSMS during the past year. The committee approves the Council's recommendations in respect to its contact and past relations with governmental agencies. Special mention is here made for the services rendered by Russell Finch, M.D., and his associates in regard to the remarkable improvement made during the past four years in the Jackson prison. It is hoped that the same trend can be continued.

The Council's report on voluntary agencies and organizations was reviewed and the adoption of The Council's report is moved.

The reference committee considered The Council's report as recorded in the Handbook under the section listed as "Committees" and suggests the Committee on Study of Health and Accident Insurance be continued.

The committee has carefully considered the matters referred to The Council by the 1951 House of Delegates and recommends the acceptance of the report of The Council as given in the Handbook.

The reference committee recommends the adoption of the five recommendations of The Council as listed in the Handbook.

Mr. Speaker, I move the adoption of the report of The Council as a whole.

THE SPEAKER: You have heard the motion.

L. C. CARPENTER, M.D.: I second the motion.

THE SPEAKER: Is there any discussion?

All in favor of the motion say "aye"; opposed, "no." The motion is carried.

XIII—c. REFERENCE COMMITTEE ON STANDING COMMITTEES

XIII—c (1) COMMITTEE ON POSTGRADUATE MEDICAL EDUCATION

The report of the Committee on Postgraduate Medical Education was approved with a commendation for the excellent work accomplished in the past year.

XIII—c (2) PREVENTIVE MEDICINE COMMITTEE

Annual report approved.

XIII—c (3). COMMITTEE ON RHEUMATIC FEVER CONTROL

Annual report approved.

XIII—c (4) CANCER CONTROL COMMITTEE

Annual report approved.

XIII—c (5) THE MATERNAL HEALTH COMMITTEE

Annual report approved.

XIII—c (6). COMMITTEE ON VENEREAL DISEASE CONTROL

Annual report approved.

XIII—c (7) COMMITTEE ON TUBERCULOSIS CONTROL

The annual report was fully discussed with particular emphasis to Section 1. The committee reports out this report with no recommendation.

XIII—c (8). COMMITTEE ON INDUSTRIAL HEALTH

Annual report approved.

XIII—c (9) MENTAL HYGIENE COMMITTEE

Annual report approved.

XIII—c (10). CHILD WELFARE COMMITTEE

Annual report approved.

XIII—c (11) COMMITTEE ON IODIZED SALT

The annual report was approved with commendation for the fine work that has been done by this committee through the past year and the many years preceding.

XIII—c (12). GERIATRICS COMMITTEE

Annual report approved.

XIII—c (13). COMMITTEE ON INFECTIOUS DIARRHEA

No comment since no meetings were held.

XIII—c (14). PUBLIC RELATIONS COMMITTEE

The annual report was approved with commendation for the fine work that this committee has continued to do in placing before the public the role that the practicing physician plays in the life of the American people.

XIII—c (15). LEGISLATIVE COMMITTEE

The annual report was approved with commendation for its alert action during the past year.

XIII—c (16). MEDIATION COMMITTEE

No comment since no meetings were held.

Respectfully submitted,
J. F. Beer, M.D., *Chairman*
L. M. Bogart, M.D.
L. F. Brown, M.D.
H. L. Gordon, M.D.
James Lightbody, M.D.
William F. Strong, M.D.

I move the adoption of this report.

The Speaker: You have heard the motion. Is there a second?

C. I. Owen, M.D. [Wayne]: I second the motion.

The Speaker: Is there any discussion?

All in favor signify by saying "aye"; opposed, "no." The motion is carried.

XIII—d. REFERENCE COMMITTEE ON SPECIAL COMMITTEES

XIII—d (1). BEAUMONT RESTORATION COMMITTEE

D. W. Thorup, M.D.: The report of this committee was presented in Dr. Beck's address this morning This committee is cognizant of the tremendous amount of work which this report embodies and wishes to applaud the efforts that have been made and the progress that this committee has achieved. I move the acceptance of Dr. Beck's report.

The Speaker: You have heard the motion. Is there a second?

R. A. Johnson, M.D. [Wayne]: I second the motion.

The Speaker: All in favor say "aye"; opposed, "no." The motion is carried.

XIII—d (2). SCIENTIFIC RADIO COMMITTEE

D. W. Thorup, M.D.: The report of this committee appears on page 115 of the Handbook. It is the opinion of the reference committee that the coverage obtained has appeared to be adequate and that the topics of the programs cover a wide field and are well diversified. We wish to emphasize the fourth paragraph of this report and urge the co-operation of county societies in order that the programs may be carried by a larger number of stations. We wish to commend this committee and wish them continued success, and I move the acceptance of this report as it appears in the Handbook.

The Speaker: You have heard the motion. Is there a second?

Roger V. Walker, M.D. [Wayne]: I second the motion.

The Speaker: All in favor say "aye"; opposed, "no." The motion is carried.

XIII—d (3). ADVISORY COMMITTEE TO WOMAN'S AUXILIARY

Donald W. Thorup, M.D.: The committee approves the committee report as printed in the Handbook and wishes to reaffirm the commendation of the efforts of the Auxiliary and to give special praise to that organization's competent President, Mrs. Robert Breakey.

We move the acceptance of this report.

The Speaker: You have heard the motion. Is there a second?

Eugene A. Osius, M.D. [Wayne]: I second the motion.

The Speaker: All in favor say "aye"; those opposed, "no." The motion is carried.

XIII—d (4). MICHIGAN STATE MEDICAL ASSISTANTS' ADVISORY COMMITTEE

Donald W. Thorup, M.D.: The report of this committee is accepted as printed in the Handbook, and the members of the committee are commended for their activity in this respect.

I move the acceptance of the report.

The Speaker: You have heard the motion. Is there a second?

Harold W. Wiley, M.D. [Ingham]: I second the motion.

The Speaker: All in favor of the motion say "aye"; opposed, "no." The motion is carried.

XIII—d (5). ADVISORY COMMITTEE TO NATIONAL FOUNDATION FOR INFANTILE PARALYSIS

Donald W. Thorup, M.D.: The Reference Committee recommends the acceptance of this committee report as printed in the Handbook. I so move.

The Speaker: You have heard the motion. Is there a second?

David I. Sugar, M.D. [Wayne]: I second the motion.

The Speaker: Is there any discussion? All in favor say "aye"; opposed, "no." The motion is carried.

Donald W. Thorup, M.D.: I move the acceptance of the report of the Reference Committee as a whole.

The Speaker: You have heard the motion. Is there a second?

Otto K. Engelke, M.D.: I second the motion.

The Speaker: All in favor of this motion say "aye"; opposed, "no." The motion is carried.

XII—e. REFERENCE COMMITTEE ON CONSTITUTION AND BY-LAWS

XIII—e (1) CONSTITUTIONAL AMENDMENT TO ART. X—Sec. 2, RE TREASURER'S BEING MEMBER, EXECUTIVE COMMITTEE OF THE COUNCIL

Myron G. Becker, M.D. [Gratiot-Isabella-Clare]:

Section 2.: "The Executive Committee of The Council shall consist of its Chairman; Vice Chairman; Chairman of the Finance Committee; Chairman of the County Societies Committee; Chairman of the Publica-

tion Committee; President; President-Elect; Secretary" —and there we should add the word "Treasurer and the Speaker of the House of Delegates," completing the sentence.

I move that the report of the committee be adopted.

RALPH A. JOHNSON, M.D. [Wayne]: I second the motion.

THE SPEAKER: You have heard the motion and the second.

All in favor signify by saying "aye"; opposed, "no." The motion is carried.

XIII—e (2). CONSTITUTIONAL AMENDMENT TO ART. X, SEC. 3 RE MAKING THE VICE SPEAKER OF THE HOUSE OF DELEGATES A MEMBER OF THE COUNCIL AND ITS EXECUTIVE COMMITTEE WITH POWER TO VOTE ONLY IN THE ABSENCE OF THE SPEAKER

All in favor say "aye"; opposed, "no." The motion is carried.

XIII—g. HYGIENE AND PUBLIC HEALTH

XIII—g (1). RESOLUTION RE MIGRATORY LABORERS

JOSEPH G. MOLNER, M.D. [Wayne]: In essence, this resolution takes cognizance of the fact that these people create a considerable public health and social problem. The resolution reads in termination as thus:

"RESOLVED: That

"1. Certain protective measures be instituted to protect the taxpayers and to protect the health of the people of Michigan, and that

"2. a reciprocal agreement between the State of Michigan and the various states from which these migratory laborers come be established whereby certain health requirements are necessary for employing these migratory laborers, and

"3. that a guarantee be obtained from these respective states that the expense of welfare be assumed by these states from where these migratory laborers come."

Mr. Chairman, the Reference Committee on Hygiene and Public Health in considering the resolution submitted by D. C. Bloemendaal, M.D., delegate of Ottawa County Medical Society, recognizes the tremendous medical, public health and social problem which is precipitated by some 50,000 to 90,000 migrant workers.

Your committee recognizes the fact that there is no specific state legislation which requires physical examinations or medical declarations of freedom from either the active stage or the carrier stage of certain communicable diseases.

Nationalists are properly screened by the United States Public Health Service, who are examined for tuberculosis and other communicable diseases as well as for the carrier state of these communicable diseases. The application of this type of screening has been ruled illegal and discriminatory for citizens by the Attorney General of the United States.

There has been an attempt made at a local level to have legislation passed which would require physical examinations and declarations of freedom from communicable disease of all migrant workers and further proposed that it be a misdemeanor by an employer to hire a person who has not had these examinations. This proposed legislation died in committee.

Your reference committee also realizes that these migrant workers pose a grave social and financial problem to the State of Michigan. Although there exist laws in the various states of this country which provide for the care of those citizens who have social welfare problems or who are indigent and in need of general or communicable disease medical care, the funds available to these state agencies in many instances are so limited that they refuse to accept the financial burdens of those patients which they are directly responsible for if such patients are in another state. Actually, this type of disagreement exists between counties within a state. There is also the problem that these migrant workers, although they were born in Arkansas, Louisiana or Texas, have been away from their parent state for so long that theoretically they have lost their citizenship in their parent state and have spent a greater length of time in the State of Michigan, but have not acquired citizenship in Michigan. Actually many of these people are without settlement rights in any state.

It is my understanding that the various branches of the state government, the State Health Department, the State Department of Social Welfare, the Michigan Crippled Children's Commission, etc., attempt to collect from the state the settlement for such migrant workers but without a great deal of success.

Your reference committee feels that not a great deal could be gained through attempted reciprocal agreements in view of the information we have herewith submitted to you, nor would there be a great deal accomplished by some type of alleged guarantee between states for payment for services rendered when actually legislation providing for the care of such people exists in the various states.

Your reference committee has learned that the Governor of the State of Michigan has named a committee to study all the facets of the various problems created by the migrant workers and that the chairman of said committee is Professor Edgar Johnson, Professor of Education, Wayne University, Detroit, Michigan. We, therefore, Mr. Chairman, recommend a change in the proposed resolution as follows:

"WHEREAS, the House of Delegates of the Michigan State Medical Society have knowledge of the fact that the Governor has appointed a committee to study the problems of migrant workers and that the chairman of said committee is Professor Edgar Johnson; now, therefore, be it

"RESOLVED: That the House of Delegates of the Michigan State Medical Society recognizing many of the problems of the migrant workers and the impact upon the citizens of the State of Michigan that these problems have, be they medical or social, wish to go on record as offering their assistance to said committee and urge that proper type of legislation be passed in the State of Michigan which would tend to alleviate this critical situation." *(See below.)*

Mr. Chairman, I move this change in the proposed resolution as submitted.

RUSSELL A. SPRINGER, M.D.: I second the motion.

OTTO K. ENGELKE, M.D.:

I think it would be entirely appropriate that the MSMS instruct the proper committee to work with the groups who employ these migrant laborers in an unofficial capacity, not through the passage of laws, and try to get them to agree to do a screening job at the place in which they are hired.

I move to amend this resolution to that effect.

THE SPEAKER: Is there a second to the amendment?

G. THOMAS MCKEAN, M.D. [Wayne]: I second the motion.

THE SPEAKER: All in favor of the amendment say "aye"; opposed, "no." The amendment is carried.

All in favor of the motion as amended say "aye"; opposed, "no." The motion is carried as amended.

PRESIDENT-FOR-A-DAY—R. L. NOVY, M.D.

Before we go to the next item of business we have on the agenda, we have something very important.

Is President Beck in the room? Is Dr. Novy in the room? President Novy and President Beck will please step up to the platform. This is another one of these

rare occasions when we have two presidents at the same time.

[The assembly arose and applauded as Dr. Beck and Dr. Novy approached the platform.]

PRESIDENT BECK: Dr. Novy, because of your long, faithful and uncompensated service to the medical profession and the people of Michigan, this House of Delegates this morning passed a motion declaring you President-for-a-Day.

It gives me a personal pleasure to present to you this symbol of the Presidency of the Michigan State Medical Society. This honor, you richly deserve.

[President Beck presented the symbol of office to President Novy.]

PRESIDENT NOVY: I fully appreciate what you fellows have done, and from the bottom of my heart, I thank you as I know it was meant in the best good will towards me and in appreciation of what I have tried to do for the Society. Thank you. [Applause].

INTRODUCTION OF MR. GEORGE COOLEY

THE SPEAKER: We have a visitor from Chicago in the audience: Mr. George Cooley of the AMA.

XIII—h. REFERENCE COMMITTEE ON RESOLUTIONS

XIII—h (1). LENIENCY IN ADMINISTRATION OF ACT 59 OF P.A. 1937

EUGENE A. OSIUS, M.D. [Wayne]:

"RESOLVED: That the Michigan State Medical Society recommend that properly qualified physicians be given reciprocity on a much more lenient basis, particularly as concerns the basic science laws; or that the latter be repealed."

The Committee on Resolutions recommends no action on this resolution.

Mr. Speaker, I move that the report on this resolution be accepted.

THE SPEAKER: You have heard the motion. Is there a second?

CLAUDE L. WESTON, M.D. [Shiawassee]: I second the motion.

All in favor say "aye"; opposed, "no." The motion is carried.

XIII—h (2). RE ACT 59 OF P.A. 1937

EUGENE A. OSIUS, M.D.: I might say we had a full attendance of the committee as well as a full room of visitors, all of whom entered into the spirit of the thing in a very fine fashion. At times you could hear a pin drop, and at other times it was difficult to hear the gavel, but all told, it was a profitable and very pleasant meeting.

After listening to a great deal of testimony pro and con, the committee does not favor the passage of this resolution, but offers in its stead the following suggestions:

"This Reference Committee recommends that action on this resolution be postponed until the 1953 session of the House of Delegates, and that the House instruct The Council to delegate to a Basic Science Study Committee the responsibility of studying the effects of the amendments of 1952 to the Basic Science Act. This committee shall have an equal number of proponents and opponents of repeal of the Basic Science Act, with consultation with the Deans of the two Michigan medical schools and others conversant with problems of licensure and distribution of doctors of medicine throughout the State of Michigan. Further, this committee recommends that the study committee be instructed to report its findings to the House of Delegates during the 1953 session, when this resolution will automatically be referred by the Speaker to the proper reference committee." (*See below.*)

Mr. Speaker, I move the adoption of this portion of the report.

R. WALLACE TEED, M.D. [Washtenaw]: I support the motion.

EDWARD D. SPALDING, M.D.: Before the delegates vote on this rather important matter, I would like them to be conversant with some specific information which appeared in THE JOURNAL, but which some of them may not recall, and I ask for a recess of five minutes that this may be put in their hands.

I so move a recess of five minutes.

JOHN H. SCHLEMER, M.D.: I second the motion.

THE SPEAKER: Is there any discussion? If not, all in favor of the motion say "aye"; opposed, "no."

All in favor of the motion say "aye," please; opposed, "no." The motion is carried.

We will go into recess for five minutes.

INTRODUCTIONS

THE SPEAKER: I shall take the opportunity during the recess to introduce our guests who are here from the State of Indiana. As I call their names, I ask them to rise.

J. William Wright, M.D., President of the Indiana State Medical Society. Dr. Wright. [*Applause*]

Donald Wood, M.D., Chairman of their Legislative Committee. [*Applause*]

R. M. Carter, M.D., Chairman of the Committee on Chronic Illness and the Chairman of the Governor's Committee on Chronic Illness. [*Applause*]

Jim Waggoner, Executive Secretary. [*Applause*]

F. L. Stone, M.D., Chairman of The Council of the Illinois State Medical Association. [*Applause*]

This paper that has been presented to you by distribution from Dr. Spalding you may recognize as his answer in the MICHIGAN STATE JOURNAL to an article written by Dr. Troost.

I hope that many of you have previously read these articles and have given them study. I believe Dr. Spalding felt in presenting this that Dr. Troost had a chance to do that and had distributed in addition to his article in THE JOURNAL, reprints to many of the delegates. Both sides are represented.

I now declare the recess ended.

We have a motion on the floor.

EDWARD D. SPALDING, M.D.: I rise to a point of information. How long after three years' consideration of this question does this House of Delegates propose to devote to the discussion of the question before you?

C. I. OWEN, M.D. [Wayne]: I move that we postpone consideration of this until tomorrow morning's session.

THE SPEAKER: Is there a second to that motion?

HAROLD W. WILEY, M.D. [Ingham]: I second the motion.

THE SPEAKER: That motion is debatable. Is there any discussion?

[*The question was called for.*]

THE SPEAKER: All in favor of postponing the discussion of this motion until tomorrow morning, the main motion, say "aye"; opposed, "no." The motion is lost.

JOHN H. SCHLEMER, M.D. (Wayne): I wish to call attention to one other amendment to the Basic Science Law that I think is very important that is not contained in this paper, and that is the fact that the examiners for the basic sciences cannot serve longer than two terms, consecutive terms, and then they must be retired for at least a period of ten years before they can be reappointed as examiners in the basic sciences. That, in my opinion, is a very important amendment.

It prevents usurpation of power that comes with year after year in office, be it examiner or any other office.

THE SPEAKER: Is there other discussion on the main motion, the motion of Dr. Osius' committee?

EDWARD D. SPALDING, M.D.: I rose to a point of information. May I have an answer to the point?

THE SPEAKER: What is your point, Doctor?

EDWARD D. SPALDING, M.D.: How long does this House of Delegates propose to discuss this question this evening?

THE SPEAKER: Dr. Troost has the floor. Dr. Troost. I can't answer Dr. Spalding's question. If the House can answer it, that is what we are here for.

FRANKLIN L. TROOST, M.D. [Ingham]: The resolution as adopted by the reference committee this afternoon is satisfactory to me, but I believe it should be amended a little, and I shall offer that amendment shortly.

The amendment should be, I believe, not only to study how the Basic Science Law has been working during this coming year, but to study the law as well. I make that distinction for this reason.

We have had presented to us tonight this paper which I hold and which I feel free to read from since it was passed out on the floor of the Society in which it says, "The article by Dr. Franklin L. Troost calling loudly for the repeal of the Basic Science Law." Below that it says that some of the arguments make sorry reading.

I have discussed this problem before. I have not engaged in personalities, and that I do not intend to do, but I do want to point out to you since this was a study committee, what kind of a study committee it was.

In 1950 I was not a member of the House of Delegates, but the delegates of Ingham County brought in a resolution to repeal the Basic Science Law, and at that time it was decided to refer it to a study committee.

In our constitution and by-laws it reads that all deliberations of this body are to be governed by Robert's Rules of Order unless otherwise specified, and what happened to our study committee?

A study committee of seven was appointed. There was no known opponent to basic science on that committee. That was strictly an illegal committee. Any study committee must have both sides, and the minority side always has the right to file a minority report.

Therefore, I called attention to you gentlemen that when we passed this resolution of the study committee last year, that we passed the resolution of an illegal committee.

This paper also reads, "on receiving the report of the study committee, and after quite prolonged debate," and as mentioned by Dr. Spalding in the committee meeting this afternoon, after prolonged debate and a great deal of effort put upon it. I call to your attention—and I have one if you haven't—the 1951 Handbook of Delegates in which it said this committee met twice. That was the prolonged study. It had two committee meetings, and I also have with me a copy of the minutes of one of those meetings.

The committee met at 12:30 and recessed at 2, so I cannot believe that the committee which we appointed last year could have spent a great deal of committee time. They had two meetings, one of them lasted an hour and a half, and therefore, Mr. President, I am not going to discuss basic science any. All I am discussing is the motion before the House.

I move that the report of the reference committee be amended to read "To study the Basic Science Law with particular reference to the effects of the recently enacted amendments."

THE SPEAKER: Is there a second to the amendment?

HAROLD J. MEIER, M.D. [Branch]: I support the motion.

THE SPEAKER: Is there any discussion on the amendment—the motion as amended?

All in favor of the amendment say "aye"; all in favor of the motion as amended say "aye"; opposed, "no." The motion as amended is carried, and the House is thus instructing the Council to appoint the committee as outlined in the motion.

XIII—g (3). SEMI-ANNUAL SESSION OF HOUSE OF DELEGATES

McGILLICUDDY, M.D., (Ingham)

"RESOLVED: That in the future the House convene for the consideration of such matters semi-annually and upon the occasion of the Scientific Meetings above mentioned," in other words, at the time of the postgraduate institute in the spring and also at the annual meeting.

The Committee on Resolutions does not favor the adoption of this resolution but offers in its stead the following:

XIII—h (3). AMENDMENT TO BY-LAWS CHAP. 8, SEC. 4 RE SPECIAL SESSIONS OF THE HOUSE OF DELEGATES

Chapter 8, Section 4 of the By-Laws of the Michigan State Medical Society be amended by adding the following:

"The House of Delegates may also be called into session at any time by the Speaker upon a two-thirds vote of The Council, or on petition of twenty-five per cent of the delegates. The purpose of such special sessions shall be stated in the notice to call."

I move that this report be approved.

JOHN H. SCHLEMER, M.D.: I support the motion.

THE SPEAKER: The Chair believes that the delegates should take some action on this recommendation. There is a motion before the House whether you wish to accept that motion, in which case it would have to be referred to a committee and left for further consideration tomorrow as an amendment to the by-laws.

Is there a second to Dr. Osius' motion?

R. WALLACE TEED, M.D. [Washtenaw]: I second the motion.

THE SPEAKER: Is there any discussion?

All in favor of considering that motion as an amendment to the by-laws? We are not considering the motion as passed. We are considering it as acceptable for amendment in that form and laid over until tomorrow.

EUGENE A. OSIUS, M.D.: I move, Mr. Speaker, the adoption of the report as a whole with the exception of what has been placed upon the table.

THE SPEAKER: You have heard the motion. Is there a second to that?

CLAUDE L. WESTON, M.D. [Shiawassee]: I support the motion.

THE SPEAKER: All in favor of the motion say "aye"; opposed, "no." The motion is carried.

We thank you, Dr. Osius, for a busy job. I sat in on part of the deliberations of that committee and know that it was handled well. I assure you he was very fair to all who wished to express an opinion.

XIII—f. REPORT OF THE REFERENCE COMMITTEE ON LEGISLATION AND PUBLIC RELATIONS

XIII—f (1). EXPERT TESTIMONY

DAVID I. SUGAR, M.D.: To amend Section 617.69 C.L. 1948, being Section 27.918 M.S.A., by adding a new section as follows:

Whenever, in a civil proceeding, a dispute arises between experts, the court on its own motion, or on the request of any party, may appoint one or more experts, not exceeding three on each issue, to investigate such issues and to testify at the trial. Such expert witness must be appointed from a panel designated by the Society, Association, Board or similar organization in his profession or field, and the compensation of such person or persons shall be fixed by the court at a reasonable amount, and paid as directed by the court. The fact that such witness or witnesses have been appointed by the court shall be made known to the jury. Any party to the proceeding may also call other expert witnesses.

Experts called by the court or by the parties in the

proceeding shall be permitted access to the persons, things or places under investigation for the purpose of inspection and examination.

An expert witness may be asked to state his inferences, and these may be stated as a fact, whether these inferences are based on the witness' personal observation, or on evidence introduced at the trial and seen or heard by the witness, or on his technical knowledge of the subject, without first specifying hypothetically in the question the data on which these inferences are based. An expert witness may be required, on direct or cross-examination, to specify the data on which his inferences are based.

DAVID I. SUGAR, M.D.: I move this resolution re Expert Testimony be accepted.

C. I. OWEN, M.D.: I second the motion.

HAROLD J. MEIER, M.D. [Branch]: The resolution states there will be not more than three expert witnesses on either side. Then in another part of the resolution it states anyone can call other expert witnesses.

I can imagine it could well get into a filibuster under such wording.

DAVID I. SUGAR, M.D.: No, either side may call any witnesses or as many as they wish, but in a conflict of testimony, the court may call from a panel one up to three to inform him with regard to the testimony which may be of a technical nature so that he may better understand the conflicting testimoney.

EDWARD D. SPALDING, M.D.: On any one point.

HAROLD J. MEIER, M.D.: So I take it there is a limit as to the number of expert witnesses that could be called so you wouldn't get into a filibuster procedure.

DAVID I. SUGAR, M.D.: Not exceeding three on each issue as appointed by the court.

THE VICE SPEAKER, M.D.: Are you ready for the question?

EDWARD D. SPALDING: May I say one word in explanation? As I said this morning, this is legal parlance. This proposed amendment or addition to the state law was drawn by a committee of the Detroit Bar, and after very careful consideration, not only this year but of all the years' work that had been done on this before. It was then considered by the joint committee, by men from the Detroit Bar and five men from Wayne County Medical Society, and had the unanimous approval of the five from Wayne County.

It was then submitted to the Council of the Wayne County Medical Society and has their unanimous backing.

This is a legal document drawn by lawyers, but with the advice of the medical profession.

THE VICE SPEAKER: I wonder if the Chair would ask Dr. Spalding a question that would clear up this issue. Do I understand the court is limited to three expert witnesses on any one issue in the panel, but obviously there is no limit to the amount of expert testimony which counsel may obtain.

EDWARD D. SPALDING, M.D.: That is correct, sir. It is important that the court cannot deprive either side of presenting their case in the best way possible. This in no way short-circuits the presentation of either side of the case by the two sides, but if the court is in doubt because of extremely conflicting testimony from the experts on the two sides, the court himself by his own motion, may select one, two or three experts from a previously appointed panel on any one issue to advise him on this conflict.

THE VICE SPEAKER: Does that clear up the point now? The court is limited but counsel is not.

Is there further discussion?

All those in favor of the motion will say "aye"; opposed, "no." The motion is carried.

* * *

THE VICE SPEAKER: This is the one about retirement, income deductions from doctors' income tax, that it be referred back to those who introduced the resolution to be rewritten and re-introduced if they so wish.

All those in favor say "aye"; opposed, "no." [Carried]

IX—k. RE "CITIZENSHIP"

THE VICE SPEAKER: Now we will consider the one on the citizenship requirements for license in the State of Michigan. Is there a second to the motion which the chairman made? Was there a second to that motion?

EDWARD D. KING, M.D. [Wayne]: I second the motion.

THE VICE SPEAKER: This is open for discussion.

RALPH A. JOHNSON, M.D.: I should like to ask the chairman of the reference committee what happened to the original requirement on citizenship as it was presented about a year ago here, and I ask that question because it seems to me that with this current recommendation from the reference committee, that interns and residents will not be permitted to come into Michigan for a two to three or four-year training period without a citizenship requirement. Am I correct on those points?

D. I. SUGAR, M.D.: We were informed by the man who introduced this resolution or sponsored it that this does not affect interns and residents, that at present they are taken care of by the State Board of Registration for Medicine and will not be affected by this.

JOHN H. SCHLEMER, M.D.: I would like to have the last part of the committee's substitute resolution read again.

D. I. SUGAR, M.D.: It was recommended to the sponsors of this resolution that they incorporate these three considerations into their bill.

1. Applicants to practice shall be graduates of a medical school approved by the AMA.
2. They must have filed papers applying for citizenship.
3. Temporary license covering the period required to become a citizen be granted and temporary license not renewable.

FRANK A. WEISER, M.D.: May I call the attention of the committee to the fact that at the present moment whatever leeway is given to residents is entirely a ruling of the Board of Registration. The Board of Registration for Medicine is only hoping that what they say is correct. Bill 301 definitely states that the qualifications for licensure is citizenship. It says nothing about temporary licensure at all so we are in danger that the residents, whenever anybody wishes to contest that law, will be barred from admission to hospitals exactly the same as graduates of any other accredited school.

I think the committee ignored that fact.

I would like to call your attention to this also that when the Board of Registration for Medicine made a ruling similar to this ruling that the Board has made at the present moment, only in the reverse direction, when they said that nurses may not practice nursing in the State of Michigan until they are citizens, the Attorney General reversed the rule on the basis it was contrary to the Fourteenth Amendment of the United States, and there is a Supreme Court decision on that basis.

I think we want to be just a little bit cautious on how we move on this thing.

The other thing is that Mr. Burns, our Executive Director, and Dr. Foster, the Secretary of our Society, have told us that since the McCarran Bill has gone in, which you remember was vetoed by the President and overridden by the Senate—since this McCarran Bill has come in, there is no such thing as first papers as declaration of intention for citizenship. If I am correct, that is the way I understood Mr. Burns, and that is the way I understood Dr. Foster, so the only thing that can happen is that a man that comes into this country has to wait five years before he can begin to practice medicine.

I think we want to consider rather seriously a man coming into this country, and don't misunderstand me. I am just as proud of being a doctor as any of you. If a cabinetmaker comes into this country, is it right for an

association or union or what-not to say, "You may not do this until you are a citizen."

I think there are some basic principles involved there. I think there is the danger we will lose our residencies in the first place because the committee is not willing to look carefully into this thing, so I would very strongly recommend that we proceed at least with caution. Go slowly.

EDWARD D. SPALDING, M.D.: In the light of Dr. Weiser's discussion, may I move that this be recommitted?

THE VICE SPEAKER: You may so move if you wish.

RUSSELL A. SPRINGER, M.D.: I second the motion.

THE VICE SPEAKER: The motion has been made and seconded by Dr. Springer that this matter be recommitted; in other words, referred back to the committee. Correct?

RUSSELL A. SPRINGER, M.D.: And that the committee consult with Dr. Weiser.

THE VICE SPEAKER: Is there discussion on Dr. Weiser's motion? The chairman wishes to discuss.

DAVID I. SUGAR, M.D.: Gentlemen, that is exactly what we wanted to do. That was all our intent was, to refer it back with these recommendations. I was given to understand, Dr. Weiser, by you this afternoon, and I ask you if this would apply to residents and interns, and your answer was that no, they were taken care of under the State Board of Registration.

FRANK A. WEISER, M.D.: If I may interrupt, I stated very clearly that the Board of Registration has made this ruling without benefit of anybody, and if anybody wished to contest it, that nobody knows how they would rule on this thing. It was purely a Board of Registration for Medicine ruling.

THE VICE SPEAKER: Dr. Troost, of Ingham.

FRANKLIN L. TROOST, M.D.: I would like to agree with Dr. Spalding that this be recommitted. [*Laughter*]

I may have a little information for you on this. As you know, I am a former member of the State Board of Registration. It seems the Governor and I are not of the same Party. When I was on the Board of Registration some years ago, I introduced a motion into that body that the citizenship clause as held in the rules and regulations at that time be eliminated.

This was passed by the Board of Registration, but at about the same time the Supreme Court of the State of Michigan held that the citizenship clause could not be put in there, that it was illegal.

Now, in regard to this bill which was passed last year as we sent it to the legislature, we said nothing about citizenship, but I understand that the legislature themselves put that in.

As far as I know, no one has challenged it. I agree that citizenship should not be a requirement.

THE VICE SPEAKER: Is there further discussion on the motion to refer back to committee?

[The question was called for.]

THE VICE SPEAKER: All those who wish to refer it back to the committee respond by saying "aye"; opposed, "no." It is referred back to committee.

XIII—i. REFERENCE COMMITTEE ON MEDICAL SERVICE AND PREPAYMENT INSURANCE

WARREN W. BABCOCK, M.D. [Wayne]:

XIII—i (1). SIMPLIFIED INSURANCE REPORTING FORMS

"RESOLVED: That the House of Delegates proceed in whatever fashion necessary to implement its action of 1950, and arrange for preparation and distribution to the members of MSMS of a Simplified Insurance Reporting Form which satisfies the intent of the resolution enacted in 1950."

The committee was in agreement with the resolution as submitted, save for a change in English in which the resolution was amended to read as follows: The committee approved the intent of the resolution, but felt that it could be implemented by changing the final resolution to the following:

"RESOLVED: That the House of Delegates instruct The Council of the MSMS to implement in whatever fashion necessary the action of 1950 House of Delegates and arrange for preparation and distribution to the members of MSMS of a Simplified Insurance Reporting Form which satisfies the intent of the resolution enacted in 1950."

I move the adoption of the amended resolution.

THE VICE SPEAKER: Is there a second to the motion?

ROBERT D. RISK, M.D. [Muskegon]: I second the motion.

All those in favor say "aye"; opposed, "no." The motion is carried.

XIII—i (2). FEES FOR SURGICAL ASSISTANTS (3 RESOLUTIONS)

WARREN W. BABCOCK, M.D.: Next considered by the committee were three resolutions that were considered together because the intent of each resolution was similar. These three resolutions were as follows: The first one again by Dr. Thorup.

"RESOLVED: That the Michigan State Medical Society, through its House of Delegates, convened September 22, 23, 1952, at Detroit, Michigan, request the various insurance companies, and Blue Cross in particular, operating in the State of Michigan, that some provision be made to compensate surgical assistants in hospitals where there is no intern or resident."

The other resolution was by Dr. Fenton of Wayne:

"RESOLVED: That the Michigan Blue Shield be requested to revise their fee schedule to provide for assistant's fees on major surgical procedures."

And the third resolution, also by Dr. Fenton:

"RESOLVED: That the uniform fee schedule for governmental agencies be amended to provide for an assistant's fee on major surgical procedures."

After active discussion by the committee it was felt that because of the extremely controversial nature of the problems involved, problems pertaining to basic medical ethics and governmental services, that it was impossible for the committee to reach a just and fair decision at this time. **It was therefore recommended that these three resolutions be referred to The Council with the recommendation that a study committee be formed by The Council to investigate the problems brought up by these three resolutions and report back at the next annual meeting of the House of Delegates.**

I submit this motion for your consideration.

THE VICE SPEAKER: Is there a second to the motion?

RALPH A. JOHNSON, M.D.: I second the motion.

THE VICE SPEAKER: The motion is now open for discussion.

WARREN W. BABCOCK, M.D.: I move that the report of the committee as a whole be adopted.

RUSSELL A. SPRINGER, M.D.: I second the motion.

THE VICE SPEAKER: All those in favor say "aye;" opposed, "no." (Carried)

The meeting was recessed at ten-fifteen o'clock.

TUESDAY MORNING SESSION

September 23, 1952

The meeting convened at ten-twenty o'clock with R. H. Baker, M.D., the Speaker, presiding.

The next item of business is unfinished business. Is there some unfinished business?

IX—p. MOTION: RE LEGISLATION CONCERNING RECALCITRANT TB PATIENTS

G. Thomas McKean, M.D.: As a member of the Tuberculosis Control Commission, I was remiss last night in not bringing up for further consideration the report of the reference committee in regard to the report of the Tuberculosis Control Commission.

This did cause some controversy in the committee hearing, and I spoke at some length at that time and thought some one else was going to speak last night who did not speak.

I would like to introduce a motion at this time in regard to the report of the Tuberculosis Control Committee, but as it differs from that report to some extent, perhaps it should be new or you can rule as you please, Mr. Speaker.

The motion is to the effect that the House of Delegates instruct the Legislative Committee to co-operate with the State Health Department in the promotion of legislation to improve disciplinary measures against recalcitrant tuberculosis patients.

The Speaker: I accept that as a motion. Is there a second?

Joseph G. Molner, M.D. (Wayne): I second the motion.

The Speaker: Is there any other discussion on this motion?

Joseph G. Molner, M.D.: I think probably I might speak to the background of this suggestion on the part of the State Department of Health and State Sanatorium Commission. As far as our tuberculosis rules and regulations are concerned which have been adopted by the State Advisory Council of Health—and I happen to be a member of that body—they are rather innocuous and certainly do not carry the teeth in them they should. When a recalcitrant patient leaves any tuberculosis sanatorium, we are faced with the great difficulty of getting the patients back. Actually, the thing the State Health Department is trying to do, and the State Sanatorium Commission, is to apply the same type of teeth in their tuberculosis rule and regulation as presently applies to communicable diseases.

I doubt if anybody in this House of Delegates would have any quarrel with that. I am sure you recognize the facts as far as tuberculosis is concerned. It is equally as much a problem as any other communicable disease.

May I, for your benefit, abuse your time for just a moment? This is reading from the Rules and Regulations of the Michigan State Department of Health.

Penalties for violation of State Health Department rules and regulations are provided for in Act 146, Public Acts of 1919, Section 12 as follows: "Any person violating any regulation, rule or order of the State Health Commissioner or that of the State Advisory Council of Health, shall be deemed to be guilty of a misdemeanor and on conviction thereof shall be subject to a fine of not more than two hundred dollars or to imprisonment in the county jail for not more than six months or both."

Actually, the thing the State Health Department is trying to do is to interpolate and include in their rules and regulations for the control of tuberculosis the same stipulation.

The precedent has been established, and I am sure the State Health Department wants your endorsement to include that in tuberculosis. The amateur "lawyers" tell us as far as these rules and regulations are concerned, which is the general communicable disease rule and regulation, it is applicable to the tuberculosis rule and regulation, and that is the interpretation we would put on it as amateurs, but the Attorney General's office tells us it does not, and when we go to court with these cases, we get sloughed off.

I trust that you will give favorable consideration to the resolution that was submitted by Dr. McKean.

The Speaker: All in favor of the question say "aye"; opposed, "no." It is carried.

IX—q. RE ENDORSING WORK OF WORLD MEDICAL ASSOCIATION

Eugene A. Osius, M.D.: Mr. Speaker and Gentlemen: I would like to present the following resolutions:

"WHEREAS, the World Medical Association is an association of the national Medical Associations of forty-three countries of the free world, and

"WHEREAS, this association is the only international association which can speak for the practicing physicians of the world, and

"WHEREAS, there are an increasing number of health problems being decided on an international basis, and

"WHEREAS, there is an increasing need for an association to represent the practicing profession, and

"WHEREAS, the American Medical Association is one of the founder members of the World Medical Association, and

"WHEREAS, the American Medical Association is also one of the founder corporate members of the United States Committee, Inc., of the World Medical Association and has urged physicians of the United States to become individual members of the United States Committee, Inc.; therefore, be it

"RESOLVED by the House of Delegates of the Michigan State Medical Society: That it endorses the work of the World Medical Association and of its supporting United States Committee, and be it

"FURTHER RESOLVED: That the House of Delegates of the Michigan State Medical Society urges the members of the Michigan State Medical Society to become individual members of the United States Committee, Inc., of the World Medical Association, and thereby aid in the elevation of standards in medical education and medical care throughout the world and ensure that the opinions of the practicing physicians of the world are adequately represented before various international bodies."

The Speaker: This resolution will be referred to the Reference Committee on Legislation and Public Relations.

XIII—e (4). ABOLISH COMMITTEE ON DISTRIBUTION OF MEDICAL CARE

The Committee on Constitution and By-Laws has something to report. Dr. Becker.

Myron G. Becker, M.D.: There was a resolution presented on the floor **to abolish the Committee on Distribution of Medical Care.** Your reference committee moved the acceptance of this resolution, and Mr. Speaker, I so move that this be adopted.

The Speaker: Is there a second to the motion?

Elbert S. Parmenter, M.D. (Alpena-Alcona-Presque Isle): I second the motion.

The Speaker: You have heard the motion. It is seconded. Is there any discussion? If not, all in favor say "aye"; opposed, "no." It is carried.

XIII—e (5). RE "SESSION" AND "MEETING"

Myron G. Becker, M.D.: There is another matter that was brought up last night about a change of wording in the By-Laws on page 154 and 155 in the Handbook. At the bottom of each page appears "Annual meeting." Now, it was thought at the time it should be changed to "Annual session" because our congregation here each year is called an "Annual session," but this annual meeting that it refers to here is the annual meeting of The Council only, so it should be left as it stands in the Handbook, but there was a resolution brought up to make that change yesterday. Mr. Speaker, I now move that resolution be not adopted.

The Speaker: You have heard the motion. Is there a second?

Warren W. Babcock, M.D.: I second the motion.

THE SPEAKER: All in favor of that motion say "aye;" opposed, "no." The motion is carried. There will be no change.

MYRON G. BECKER, M.D.: I move the adoption of the report as a whole.

WARREN W. BABCOCK, M.D.: I second the motion.

THE SPEAKER: You have heard the motion.

All in favor say "aye;" opposed, "no." The motion is carried.

WARREN W. BABCOCK, M.D.: I move that the House of Delegates convene at seven-thirty tonight.

MAX L. LICHTER, M.D.: I second the motion.

THE SPEAKER: It has been moved and seconded that the House of Delegates convene at seven-thirty tonight. Is there any discussion?

All in favor of the motion say "aye;" opposed, "no." The motion is carried.

XIII—h (3). RE SPECIAL SESSIONS OF HOUSE OF DELEGATES

EUGENE A. OSIUS, M.D.: Committee on Resolutions pertaining to a second meeting. Is that in order at this time?

THE SPEAKER: Yes, Doctor.

There is a supplemental report from the Resolutions Committee. Dr. Osius.

EUGENE A. OSIUS, M.D.: This is taking up the resolution No. 3 that was presented to the Committee on Resolutions yesterday and has to do with the resolution introduced by Dr. McGillicuddy of Ingham County.

"RESOLVED: That in the future the House convene for the consideration of such matters semiannually and upon the occasion of the Scientific Meetings above mentioned." This refers to the Michigan Clinical Institute.

The committee last night did not advise the adoption of that but substituted the following:

The Committee on Resolutions does not favor the adoption of this resolution but offers in its stead the following:

Chapter 8, Section 4 of the By-Laws of the Michigan State Medical Society be amended by adding the following:

"The House of Delegates may also be called into session at any time by the Speaker upon a two-thirds vote of The Council, or on petition of 25 per cent of the delegates. The purpose of such special sessions shall be stated in the notice to call."

I move that the amendment of the committee be adopted.

CLAUDE L. WESTON, M.D. (Shiawassee): I support the motion.

THE SPEAKER: Are you ready for the question? All in favor say "aye;" opposed, "no." It is carried. That will be an amendment to the by-laws.

EUGENE A. OSIUS, M.D.: I move the acceptance of the report of the committee in its entirety.

THE SPEAKER: Is there a second?

R. WALLACE TEED, M.D.: I second the motion.

THE SPEAKER: All in favor of that motion say "aye;" opposed, "no." It is carried.

SUGGESTIONS WELCOMED FOR IMPROVEMENT OF MEDICAL PUBLIC RELATIONS

ARCH WALLS, M.D. (Wayne): I would like to make a few comments regarding our public relations program.

We have one of the largest, most representative programs right in the State of Michigan on public relations. We are spending a great deal of the money that you men are paying in dues. Throughout the year, as chairman of this committee, I have had many criticisms offered by individuals, and at this time I would like—if there are any that have constructive criticisms—to have them offered to us. We would be very happy to have them.

If they have nothing constructive to offer in regard to our program, we have set up a large budget. The Council has favored that budget and we are in the process of carrying out that program.

I had the privilege of being in Chicago two weeks ago at the AMA Public Relations Convention, and at that time I realized how far ahead Michigan is in its public relations. Everyone was coming and asking Michigan men who were represented there in our executive staff what we were doing, and the entire program carried out in those two days was based upon the program which Michigan has been carrying out for the past three years. I would therefore like to take this opportunity to ask those men who have criticisms of our public relations program in the State of Michigan, to present them for our consideration. I don't like this gibing and criticizing without an opportunity to answer those criticisms. Thank you.

THE SPEAKER: It is an important thing for your consideration. There were no motions brought up at this session of the House of Delegates pertaining to this, but Dr. Walls, as the chairman, has given you an opportunity to express yourselves frankly and openly.

IX—r. MOTION: COMMITTEE TO REPORT ON PRESS RELEASES OF AMA PUBLIC RELATIONS

Secretary Foster reported on Press Releases re AMA Public Relations, and a thorough discussion followed.

THE SPEAKER: Is there any one who wishes to comment further? Is there any one who wishes to make a motion on this AMA thing?

EUGENE A. OSIUS, M.D.: I would suggest that you appoint a small committee to read the article and to report back to us and make a few recommendations and not go at this thing half cocked. I think there should be some answer to it, but I think you should be careful as to how you answer it.

I make a motion that you appoint a committee of not more than three to read the article and to report to us with some possible recommendations for our recommendation.

MILTON A. DARLING, M.D. (Wayne): I second the motion.

THE SPEAKER: You have heard the motion. All in favor, say "aye;" opposed, "no." The motion is carried.

The Chair appointed as the committee: E. F. Sladek, M.D., E. A. Osius, M.D., and Ralph Johnson, M.D.

XIII—f (2). ENDORSING WORK OF WORLD MEDICAL ASSOCIATION

The resolution on the World Medical Association was unanimously approved by the Reference Committee on Legislation and Public Relations. A motion was made for its adoption.

G. THOMAS MCKEAN, M.D.: I support the motion.

THE SPEAKER: You have heard the motion. It has been seconded.

All in favor say, "aye;" opposed, "no." The motion is carried.

XIII—f (3). SUPPORT OF KEOGH-REED BILLS IN CONGRESS

DAVID I. SUGAR, M.D.:

"WHEREAS, it has come to the attention of the members of this Society that legislation has been proposed to permit doctors to provide a retirement fund, and make deductions providing for retirement fund from income tax; therefore, be it

"RESOLVED: That the House of Delegates of the Michigan State Medical Society go on record as supporting such legislation, namely such as is embodied in the Keogh Bill, by whatever means it has at its disposal."

This was unanimously approved by the committee, and I move its adoption.

THE SPEAKER: You have heard the report.

EUGENE A. OSIUS, M.D.: I support the motion.

All in favor of the motion say "aye;" opposed, "no." The motion is carried.

XIII—f (4). REPEAL OF CITIZENSHIP IN MEDICAL PRACTICE ACT

DAVID I. SUGAR, M.D.: The amendment to Section 3, Act. No. 172, PA 1952 of the State of Michigan, as read last night and submitted by Dr. Krieg, has been unanimously disapproved by your committee.

Those who were interested in it met with us and gave us splendid co-operation, and the following substitute Resolution meets with their approval and unanimous approval of the committee.

I will read just two short paragraphs.

Amendment to Section 3, Act No. 172, Public Acts of the State of Michigan.

"WHEREAS, Section 3, Act. No. 172, Public Acts of the State of Michigan does not provide for licensing of noncitizen doctors of medicine in training in accredited hospitals; and

"WHEREAS, this creates a hardship in obtaining personnel for professional operation of the hospital in giving adequate care to the patient; be it

"RESOLVED: That the House of Delegates of the Michigan State Medical Society instruct The Council and legislative committee to obtain legislation which will permit temporary licensing of noncitizen doctors of medicine while in training in accredited hospitals; and be it

"FURTHER RESOLVED: That Act No. 172 be amended to permit temporary licensing of qualified doctors of medicine during their period of obtaining naturalization. Such temporary license be for a period not to exceed five years and not renewable."

I make a motion this be approved.

MILTON A. DARLING, M.D.: I second the motion.

CLARENCE I. OWEN, M.D.: Point of information! As part of the discussion of the committee, I would like to tell you something about the reasons I believe citizenship should have some bearing on licensure to practice medicine.

You may not know that an alien can come into this country and if he declares his intention of not becoming a citizen, he is excused from all military service. In other words, if we license doctors to practice medicine that were not citizens or who have not declared their intentions of becoming citizens, they may stay here and practice and have no obligation to serve in the armed forces.

At the present time, we have a doctor draft. All of you are familiar with that, and all of you who are under fifty are subject to that draft. Someone might come along from Canada or England or Australia, sit on the corner opposite you, and practice as long as he desires by not becoming a citizen, and you might have to go into the service.

THE SPEAKER: All in favor say "aye;" opposed, "no." The motion is carried.

DAVID I. SUGAR, M.D.: I would like to ask now for a resolution approving the entire action of this committee to make it official.

I make that as a motion.

MILTON A. DARLING: I second the motion.

THE SPEAKER: It has been moved and seconded to approve the report as presented.

All in favor say "aye;" opposed, "no." It is carried.

XIII—j. REPORT OF THE REFERENCE COMMITTEE ON SPECIAL MEMBERSHIPS

ELMER C. TEXTER, M.D.:

The Committee on Special Memberships had a full membership meeting yesterday, and the nominations were approved.

The committee wishes to recommend to the House of Delegates the following members to be elected *Emeritus Members.*

Barry—Edgar T. Morris, M.D., Nashville
Gratiot—Wilkie M. Drake, M.D., Breckenridge
Wayne—Mortimer E. Danforth, M.D., Detroit
William E. Keane, M.D., Detroit
Henry A. Luce, M.D., Detroit.

This last name was submitted for Emeritus Membership, and the committee feels that the House should go on record, in view of the fact that Dr. Luce has done so much as Speaker, President and Senior Delegate to AMA. I move that Dr. Henry Luce, M.D., be elected to Emeritus Membership.

OLIVER B. MCGILLICUDDY, M.D.: I support the motion.

THE SPEAKER: Is there any discussion?

All in favor of the motion say "aye;" opposed, "no." It is carried.

ELMER C. TEXTER, M.D.: Mecosta-Osceola-Lake, B. L. Franklin, M.D., Remus, was elected a Life Member in 1948. The committee recommends he be elected to *Emeritus Membership* now. I so move.

THE SPEAKER. Is there a second?

G. THOMAS MCKEAN, M.D.: I second the motion.

THE SPEAKER: Is there any discussion?

All in favor of the motion say "aye;" opposed, "no." It is carried.

ELMER C. TEXTER, M.D.: The committee wishes to recommend to the House of Delegates that the following members be elected to *Life Membership.*

Gratiot—William E. Barstow, M.D., St. Louis
Jackson—Clyde A. Leonard, M.D., Jackson
Kent—Edward C. Morey, M.D., Grand Rapids

(This nomination was approved by the Executive Committee, April 23, 1952, as part of this membership was served in the State of Ohio.)

Branch—B. W. Culver, M.D., of Coldwater
Calhoun—Willard M. Putnam, M.D., Battle Creek
Ingham—Earl H. Foust, M.D., Lansing
Monroe—John F. Hefferman, M.D., Carleton
Monroe—Olin E. Parmalee, M.D., Lambertville
Muskegon—Charles J. Bloom, M.D., Muskegon
Oakland—John S. Lambie, M.D., Birmingham
Oakland—Harry A. Sibley, M.D., Pontiac
Oakland—Charles A. Neafie, M.D., Pontiac
Oceana—Arthur R. Hayton, M.D., Shelby
Tuscola—Harry A. Barbour, M.D., Mayville
Washtenaw—Udo J. Wile, M.D., Ann Arbor
Wayne—Albert E. Bernstein, M.D., Detroit
Chester A. Doty, M.D., Detroit
Clayton J. Ettinger, M.D., Detroit
Nathaniel Gates, M.D., Detroit
Ledru O. Geib, M.D., Detroit
Thomas F. Keating, M.D., Detroit
Donald H. McRae, M.D., Detroit
Rudolph L. Pfeiffer, M.D., Detroit
Jean P. Pratt, M.D., Detroit
Frank J. Sladen, M.D., Grosse Point
Wm. P. Woodworth, M.D., Detroit

I move that these men be elected to Life Membership.

THE SPEAKER: Is there support to this motion?

MYRON G. BECKER, M.D., I support the motion.

THE SPEAKER: Is there any discussion?

ELMER C. TEXTER, M.D.: The committee wishes to recommend to the House of Delegates the following members be elected for *Honorary Membership.*

Ingham—LeRoy A. Potter, Lansing
Ottawa—Paul de Kruif, Ph.D., Holland
Ionia-Montcalm—D. Hale Brake, State Treasurer, Lansing

I move they be elected to Honorary Membership.

THE SPEAKER: Is there a second?

HAROLD W. WILEY, M.D. (Ingham): I second the motion.

THE SPEAKER: Is there any discussion?

All in favor say, "aye;" opposed, "no." The motion is carried.

ELMER C. TEXTER, M.D.: The committee wishes to recommend to the House of Delegates that the following members be elected for *Retired Membership.*

St. Clair—Frank V. Carney, St. Clair
Genesee—Clifford P. Clark, M.D., Lake Fenton
Wayne—C. Fremont Vale, M.D., Detroit
Dean R. Brengle, M.D., Wellington, Kansas
St. Clair—Charlton A. Macpherson, M.D., St. Clair

The men I am going to mention afterwards were in good standing at the time they were given Retired Memberships, and therefore, we ask that they be so accepted and elected by the MSMS House of Delegates without further payment of dues.

I would ask for an opinion from the Chair.

THE SPEAKER: Were they in good standing at the time they were retired?

ELMER C. TEXTER, M.D.: Yes, they were in good standing at the time they were retired. These are men from Wayne who have had 1951 dues paid.

Wayne—Walter A. Briegel, M.D., Detroit (1951 paid)
William A. Berkey, M.D., Detroit (1951 paid)
Guy Breon, M.D., Detroit (1951 paid)
James J. Drake, M.D., Ft. Lauderdale, Fla. (1951 paid)
Frank MacMullen, M.D., Boca Raton, Fla. (1951 paid)
Howard J. Porter, M.D., Romulus

I move that these men be elected to *Retired Membership.*

THE SPEAKER: Is there a second to that motion?

ROGER V. WALKER, M.D.: I second the motion.

THE SPEAKER: All in favor of the motion say "aye;" opposed, "no." It is carried.

IX—s. MOTION: COMMITTEE TO STUDY REQUIREMENTS FOR SPECIAL MEMBERSHIP

J. S. DETAR, M.D.: **I move that the Speaker of this House be instructed by this House of Delegates to appoint a committee of this House of Delegates to draft amendments to Chapter 5, Sections 4, 5, 6 and 7, page 146, regarding retired, emeritus, honorary, life memberships and associate memberships to clarify the requirements therefor, this committee to report during the 1953 session of the House.**

R. WALLACE TEED, M.D.: I second the motion.

THE SPEAKER: All in favor of that motion say "aye;" opposed, "no." The motion is carried. The committee: E. D. Spalding, M.D., R. W. Teed, M.D., R. A. Springer, M.D., D. W. Thorup, M.D.

ELMER C. TEXTER, M.D.: The committee wishes to recommend the following doctors who are temporarily out of practice due to illness or postgraduate medical studies for *Associate Membership.*

Wayne—Bernard W. Agranoff, M.D, Detroit
Russell M. Cashen, M.D., Detroit
James D. Collins, M.D., Detroit
William J. Dinnen, M.D., Military Service
E. N. Dolman, M.D., Detroit
Henry T. Holt, M.D., Grosse Point Farms
John K. Orwood, M.D., Detroit
Raymond J. Reichling, M.D., Detroit
J. J. Watts, M.D., Detroit
Delta-Schoolcraft—Morris W. Lambie, M.D., Powers (physically disabled)
Jackson—Samuel L. Miller, M.D., Jackson
Genesee—W. Claire Baird, M.D., Flint
Bay—William S. Reed, M.D., Ann Arbor

I so move.

THE SPEAKER: Is there support?

WARREN W. BABCOCK, M.D.: I support the motion.

THE SPEAKER: Is there any discussion?

All in favor say "aye;" opposed, "no." The motion is carried.

ELMER C. TEXTER, M.D.: RESOLVED: That the following members from Washtenaw County Medical Society be elected to *Associate Membership* in the MSMS.

William Arendshorst, Holland
Melvin H. Becker, Ann Arbor
Melvin D. Bivens, Ann Arbor
Wesley H. Bradley, Ann Arbor
Jerome F. Cordes, Ann Arbor
Owen W. Doyle, Ann Arbor
C. Thomas Flotte, Ann Arbor
Robert J. Gaukler, Pontiac
Richard D. Goldner, Ypsilanti
Theodore G. Kabza, Ann Arbor
Lloyd J. Lemmen, Holland
Robert B. McCloskey, Ann Arbor
W. Rutledge Miller, Ann Arbor
James C. Neering, Ann Arbor
Charles L. Nord, Ann Arbor
J. Stephen Phalen, Reno, Nevada
William Rottschafer, Ann Arbor
Norman L. Banghart, Ann Arbor
Ronald C. Bishop, Ann Arbor
George E. Block, Ann Arbor
Kenneth E. Burke, Ann Arbor
Hodge N. Crabtree, Ann Arbor
Robert M. Epstein, New York, N. Y.
Graydon R. Forrer, Ypsilanti
Raymond W. Goldblum, Pittsburgh, Pa.
Norman S. Hayner, Ann Arbor
George H. Koepke, Ann Arbor
Aaron B. Lerner, Ann Arbor
Russell F. Miller, Ann Arbor
Thomas P. Nash, III, Henning, Tenn.
Tom E. Nesbitt, Ann Arbor
John A. Pennington
Robert Rapp, Ann Arbor
Ralph W. Ryan, Ann Arbor
Edward B. Scott, Salt Lake City, Utah
Kathryn N. G. Scott, Salt Lake City, Utah
Holbrooke S. Seltzer, Ann Arbor
Herbert H. Spencer, Ann Arbor
William M. Tappan, Ann Arbor
David C. Valder, Ann Arbor
Gail H. William, Ann Arbor
Charles H. Willison, Midland
James A. Maher, Ann Arbor
Fred J. Hodges, III, Ann Arbor

I move they be elected as associates.

R. WALLACE TEED, M.D.: Support.

THE SPEAKER: Is there any discussion?

All in favor say "aye;" opposed, "no." The motion is carried.

ELMER C. TEXTER, M.D.: I move that all these be elected. Carried.

COMMITTEE REPORT ON PRESS RELEASES RE AMA PUBLIC RELATIONS. (See page 1609)

E. F. SLADEK, M.D.: This morning's *Detroit Free Press* had an article headlined, "Satisfied AMA Ends Fight on Health Plan."

I will read part of the article.

"The American Medical Association Monday ended its stormy, four-year fight against national compulsory health insurance, contending that it has been 'eminently successful.'

"Leaders of the AMA campaign resigned from their posts to form a committee in support of Dwight D. Eisenhower, the Republican candidate for president.

"Dr. Louis H. Bauer, AMA president, said the battle against what the medical group called 'socialized medicine' was terminated because it had served its purpose."

That is the thing we object to.

"A plan for compulsory national health insurance was advanced by President Truman, but never made any headway in Congress.

"Dr. Bauer also announced the resignation of Dr. Elmer L. Henderson, chairman of the AMA Co-ordinating Committee, and Clem Whitaker and Leone Baxter, directors of the AMA national education campaign.

"They resigned, Henderson said, to form a 'National Professional Committee for Eisenhower and Nixon,' which will seek to enlist the support of doctors, dentists, pharmacists, lawyers and other professional groups behind the Republican ticket.

Dr. Bauer made it clear that the three resigned to free themselves for political activity. He said the AMA 'is a nonpartisan, professional organization, and cannot participate in the presidential campaign.'

"Whitaker and Miss Baxter, a public relations team, along with Henderson directed the AMA's vigorous and often bitter battle against health insurance from the inception of the drive in January, 1949.

"To finance the fight, the AMA assessed each member $25 to raise a war chest of $3,000,000."

The first part is what we are concerned with. It implies that the fight against socialized medicine is over. We know that it isn't, and to that end, your committee has suggested the following resolution.

RESOLUTION ADOPTED BY MSMS HOUSE OF DELEGATES RE AMA PUBLIC RELATIONS

"WHEREAS, a press release this morning, September 23, 1952, implies that the AMA fight against socialized medicine is over, and

WHEREAS, it is our opinion this fight can never be concluded as long as present forces to provide compulsory health insurance are at work; therefore, be it

"RESOLVED, That the House of Delegates of the Michigan State Medical Society now in session is unalterably opposed to the federal control of medicine in any form now, or at any time, and be it further

"RESOLVED, that a copy of this resolution be sent to the AMA."

That is the resolution we propose and possibly a little explanation of what has actually occurred. We had just telephoned past President Henderson of the AMA to verify the facts that we knew.

Dr. Henderson has resigned from any active participation in the official family of the AMA and so has the public relations firm of Whitaker and Baxter. The Co-ordinating Committee of the AMA still exists, and I know that they will continue the fight against socialized medicine, but the Co-ordinating Committee, instead of being an independent public relations activity of the AMA, is now going to be an actual public relations activity of the AMA under their own direction without the public relations firm as a part of it.

There was a misinterpretation of this action and it was interpreted that the campaign against compulsory insurance has terminated.

We also have a press release being prepared by our Public Relations Committee of the MSMS.

THE SPEAKER: Is there a second to the motion?

EDWARD D. SPALDING, M.D.: I second the motion.

THE SPEAKER: All in favor of the motion and its resolution say "aye;" opposed, "no." It is carried.

The press release which was prepared by the Special Committee reads as follows:

The House of Delegates of the Michigan State Medical Society now in session wishes to correct the implication which the public might get from this morning's headlines that "The fight against socialized medicine is over."

This House of Delegates is unalterably opposed to socialized medicine now or at any time in the future as expressed in the following resolution:

"WHEREAS, a press release this morning, September 23, 1952, implies that the AMA fight against socialized medicine is over, and

"WHEREAS, it is our opinion this fight can never be concluded as long as present forces to provide compulsory health insurance are at work; therefore, be it

"RESOLVED: That the House of Delegates of the Michigan State Medical Society now in session is unalterably opposed to any federal control of medicine in any form now," and regrets that the action of officers of the American Medical Association should have been so interpreted.

* * *

The meeting recessed at twelve-thirty o'clock.

TUESDAY EVENING SESSION

September 23, 1952

The meeting of the House of Delegates reconvened at eight o'clock with R. H. Baker, the Speaker, presiding.

INTRODUCTION OF RUSSELL F. STAUDACHER OF AMEF

We have a distinguished friend and guest from the American Medical Association who is representing Dr. Elmer Henderson. His name is Russell F. Staudacher. Most of you know him. He has a message for us which will take a few minutes. We shall ask him to take the chair at this time.

R. F. STAUDACHER: Mr. Speaker, Members of the House of Delegates and Good Friends: I am awfully happy to be back in Michigan again because it is where I got my start in the work I am now doing and many of my good friendships are here and they always will be.

Tonight I am going to take a few moments to explain the American Medical Education Foundation and the role Michigan can play in it. Unfortunately, I am not in the position our good friend, Nixon, is in. I have no money to explain. On the contrary, we are trying to get the money, and afterwards, we will explain where it goes.

MICHIGAN AND THE AMERICAN MEDICAL EDUCATION FOUNDATION

By R. F. Staudacher

Years ago the noted philanthropist, Julius Rosenwald, declared that he found it "nearly always easier to make $1,000,000 honestly than to dispose of it wisely." Most of us have not been bothered by this first problem, but in connection with the second problem, The American Medical Education Foundation today is trying its level best to establish a welcome, wise and worthwhile program for financial aid to medical education.

America today is in a new era of giving. Our paternalistic Federal government has entered many areas which used to be a first charge upon the public purse. Income-tax rates, partly to meet the government's share in these new charges (social security, etc.), but in a greater measure because of the heavy costs of past, present and future national defense, have risen to heights undreamed of a decade ago.

This fact affects the stream of giving in diverse ways. It limits the large individual fortunes of the past which were the source of large gifts. On the other hand, the 15 per cent deductible provision on charitable gifts has helped to encourage contributions by making giving almost costless for persons in high-income brackets. The Collector of Internal Revenue has now taken over Viola's speech in Twelfth Night: "What is yours to bestow is not yours to reserve."

The past ten years has seen a sharp decline in income from most investments and from interest rates generally. A crystal ball shows little change for the future. The effects of this on giving are many. Welfare and educational institutions, who formerly derived much of their annual income from endowments, find themselves in desperate financial straits. Potential givers, whose income is derived chiefly from investments, have less from which to give, and finally, contributions to endowment funds, heretofore an effective means of keeping schools and institutions, are no longer very productive of annual income, and, therefore, have dwindled in number.

With particular reference to the medical schools of the United States, the end of World War II found them fighting a losing battle against the forces of inflation, rising costs and the decreased income from endowment previously mentioned. The problem was compounded by a call on the schools to expand their enrollments and to make provision in their teaching programs for the rapid advance of medical science and a broadened concept of medicine's role in the community. In recent years ample and unprecedented sums have been made available for research but support of basic teaching budgets has failed to keep pace with essential needs.

Convinced that an active program for additional financial support would have to be undertaken if the medical schools were to continue to provide the nation with an adequate number of well-trained physicians, several groups in 1948 began a serious study of methods of raising funds on a national scale for the support of medical education. These groups, which included leaders of the medical profession, medical educators, university presidents and outstanding public citizens, joined together in the spring of 1949 to sponsor the establishment of the National Fund for Medical Education. The objective of this organization is to raise substantial sums annually from the medical profession, industry, business, labor, agriculture and other groups, for the unrestricted use of the medical schools in support of their teaching programs.

By late 1950 the organization of the National Fund had advanced to the point where it became desirable to plan a definite program for securing contributions from the medical profession in support of the Fund. In December, 1950, the American Medical Association appropriated $500,000 as a nucleus for the sum to be raised by the medical profession in 1951. A few weeks later the Association sponsored the establishment of the American Medical Education Foundation, a not-for-profit corporation under the laws of the state of Illinois. The purpose of our Foundation is to provide an instrument through which individual physicians, state and county medical societies and other professional organizations can make their contributions in support of medical education.

The National Fund is designed to function on a wholesale basis and its objective is to raise funds from corporations and other organized groups. The AMEF on the other hand is conceived as a retail organization to raise funds from members and friends of the medical profession.

At this point I should like to explain the three classes of grants designated as Class "A," "B," and "C" grants.

Class "A" grants are to be a uniform annual sum given to every approved medical school in the United States.

Class "B" grants are to be a uniform annual sum per student to be given to every approved medical school in the United States.

Class "C" grants are to be awarded to individual medical schools on the basis of special needs and problems.

In any given year, the size of the Class "A" and "B" grants and the availability of Class "C" grants would be determined on the basis of the total sum raised for the year.

The thinking behind these formulae is obvious. Since the Foundation and the Fund are national efforts, all schools should benefit from their activities. This is provided for by the uniform Class "A" grants. At the same time some consideration must be given to the differences in the loads carried by the individual schools and this is provided by the Class "B" grants which are made on a per capita basis. Finally, the Foundation and the Fund should be able to give special help to schools with special problems. The Class "C" grants provide for such help.

Actually, during the first year, only sufficient funds were raised for Class "A" and Class "B" grants and these, totaling just over one and a half million dollars were only less than half the size that had been hoped for. Each of the four year schools received a Class "A" grant of $15,000 and a Class "B" grant of $17.00 per student, which averaged out at about $5,600 per school.

In future years the Fund hopes to be able to distribute at least four million dollars annually in "A" and "B" grants and to have further sums available for Class "C" grants.

In comparison with the overall operating budgets of the medical schools, these initial grants may seem small. Their importance and significance is increased, however, when it is realized that for many of the schools they constitute the largest amount of totally unrestricted money that the schools have had available in recent years. Those grants have thus had a useful value far in excess of the actual number of dollars involved. That this is so has been attested to by many schools that have reported that these grants have enabled them to meet urgent needs such as employing additional instructors, providing small but vitally important salary increases for underpaid teachers or securing badly needed equipment and teaching aids.

Ample evidence of the value of the grants already distributed comes in letters from the Deans of Michigan's two excellent medical schools.

Dean Furstenberg states that, and I quote, "this fund has been of immeasurable value to us. It has functioned as a contingency fund, which has made certain projects possible after the regular medical school budget for the year has been established. In this manner it functions admirably.

"To be more specific, we have received some $40,000, and it will be expended before the next six months have passed in the following manner:

"1. To enlarge our Clinical Microscopy laboratory and to furnish additional equipment for it, because we are taking entering classes of 200 students.

"2. To increase the seating capacity of one of our large lecture rooms in the University Hospital.

"3. To furnish new desks, kymographs, and other equipment for an additional fifty students in the Department of Physiology.

"4. To rehabilitate and refurbish the Department of Biochemistry; particularly additional equipment for the added number of students.

"5. New seats for our Pathology amphitheater.

"6. A much-needed new Projection Lantern and Screen for one of our ampitheaters in the Medical School."

Dean Gordon H. Scott amplifies Doctor Furstenberg's feeling and points to another use for the funds when he writes:

"The grant has for the most part been used to hire additional faculty. We have on our staff four persons now being paid, either entirely or partially by a portion of the grants. These are: A Professor of Radiology, an Associate Professor of Obstetrics and Gynecology, and Instructor in Microbiology and an Instructor in Physiological Chemistry. These funds have made it possible for us to supplement salaries to the extent that we were not only able to attract desirable individuals, but in two instances to retain them as well."

There, in the words of your own deans lies the value of unrestricted funds in the operating budgets of a medical school.

For a moment now I should like to discuss certain major policies of the Foundation which are helpful in understanding the mechanics of the contributing.

1. As I have already mentioned, the funds raised by the Foundation are for the unrestricted use of medical schools. The directors of the Foundation properly feel that we must bend over backwards to avoid even the appearance of tying strings to this support.

2. All the expenses of the Foundation are being met by the American Medical Association. This means that every dollar contributed to the Foundation is passed on without any deduction of any kind to the medical schools.

3. Physicians may earmark their contributions to the Foundation for a specific school. These contributions will go in full to the schools for which they are earmarked

and will be over and above the grants from the unearmarked funds raised by the Foundation and the National Fund. It is requested, however, that contributions from organizations be unearmarked, since they are given on behalf of physicians who have allegiances to and interests in many different schools.

4. The Foundation does not wish to impede or detract from the fund-raising activities of any individual schools. To avoid possible competition with the schools, the Directors of the Foundation therefore have voted that their annual reports should include the names of those physicians contributing to the Foundation, as well as those who the schools report as having made a direct contribution to the medical school.

The advantage of making contributions to a medical school through the Foundation are that the larger the sum raised by the Foundation, the more of a stimulus it will be to business, industry and other groups to contribute to the National Fund on the basis that those who help themselves are most deserving of help and secondly, swelling the total raised by the National Fund will make it possible to collect certain contributions that are contingent upon the National Fund's achieving certain goals.

By virtue of my position and my temperament, I cannot be a preacher, but through past experience as the first Executive Secretary of the Foundation, I can assume the role of a reporter.

In the twenty months since the American Medical Education Foundation came into being, 112 of Michigan's 6,000 doctors of medicine made contributions to the Foundation. Their total gifts amounted to $7,305.

In this same period, the University of Michigan and Wayne University medical schools have received grants totalling $75,011.00. This isn't a good report, and it doesn't sound like Michigan, a leader among all state medical societies. Let's look at Nebraska. With only 1,300 physicians this state under the spirited leadership of Dr. L. D. McGuire raised over $60,000 in sixty days. The good doctor hired a pilot and personally contacted every county society in Nebraska. As a result his state leads all others in per capita contributions. If Nebraska can do it, so can Michigan. From my experience working with you several years back, I know of many "McGuire's" to spur your campaign on. Your deans have indicated the Foundation is worthy of your support.

Four months remain in the '52 campaign. Write your check today and encourage others to write theirs. The Foundation isn't one of Michigan's firsts, but there's plenty of time left for Michigan to be first.

In closing, I should like to join Dr. Henderson and the Directors of the Foundation in expressing appreciation to all of you who have signified your willingness to work on behalf of the Foundation. We know it will involve sacrifice and hard work. We hope you will consider the satisfaction of having played a leading role in one of the most important and constructive programs ever undertaken by the medical profession a worthwhile reward for your efforts.

Upon the success of this entire program depends in a large measure the future success and freedom of medical education in this country.

XIV—PRESENTATION OF DEAN CORNWELL PAINTING (BEAUMONT & ST. MARTIN) TO MSMS BY WYETH, INC., PHILADELPHIA

PRESIDENT BECK: Mr. Speaker.

Members of the House of Delegates: It gives me great pleasure tonight to introduce Mr. Stuart V. Smith of the Wyeth Company who has come here from Philadelphia to make this presentation. Mr. Smith. (*Applause.*)

(Mr. Stuart V. Smith read his prepared paper, which appeared in the November issue of JMSMS.)

PRESIDENT BECK: Mr. Smith, in behalf of the Michigan State Medical Society, I am most happy to accept this fine painting about to be unveiled. We are deeply appreciative of the generosity shown by the Wyeth Company in making this gift. It will hang on the north wall of the principal room of the restored American Fur Company store on Mackinac Island. Here it will doubtless become the center of attraction to thousands of visitors who will view the memorial to a great medical scientist, William Beaumont.

Most fortunately, there is present this evening, the great grand niece of Dr. Beaumont, who has consented to take part in this ceremony. I will now ask Mrs. Eddy Beaumont Stokes to unveil the painting of her famous uncle. William Beaumont. Mrs. Stokes (*Applause.*)

(Mrs. Stokes unveiled the painting of Dr. Beaumont.) (*Applause.*)

PRESIDENT BECK: I would like to make a little announcement with reference to contributions to the Beaumont memorial. This evening we received a $100 contribution from Dr. Paul deKruif who will give the Biddle Lecture tomorrow night. Also, we received a $100 contribution from Mr. W. T. Coulter of the Bruce Publishing Company, the publishers of our JOURNAL. (*Applause.*)

IX—c. MOTION: PRESIDENT-FOR-A-DAY R. L. NOVY, M.D.

THE SPEAKER: Dr. Beck and Dr. Novy, will you come back to the platform? Some twenty-four hours having expired, we have an additional ceremony. President Novy, President-for-a-Day. (*Applause.*)

PRESIDENT NOVY: Twenty-four hours having expired, the clock has tolled, and I would like to return to Dr. Otto Beck the emblem that has so kindly been bestowed upon me.

In doing so I would like to place it on his neck as he placed it upon mine.

(Dr. Novy returned the symbol of the office of President to Dr. Beck.) (*Applause.*)

PRESIDENT BECK: Thank you, Dr. Novy. You wore it most graciously for twenty-four hours, and I now have possession for twenty-four more hours. Thank you. (*Applause.*)

XV. PRESENTATION OF HONORARY MEMBERSHIP SCROLL TO PAUL DE KRUIF, Ph.D., HOLLAND

THE SPEAKER: Special order of business. Presentation of honorary membership scroll to Paul De Kruif Ph.D.,

This gentleman to whom I present the scroll in your behalf is one I have known since my college days. In fact, we went swimming together.

The thing which I remember about it—Paul probably does not—is that along in the summer evenings that I spent in summer school, I had a bicycle and he would come around to the house about ten or eleven at night. He would leave the laboratory where he worked all day and night, and he would say, "Come on. Let's go for a swim." I would say, "Wait until I get my bike." He would run out. He would get there before I did, and he would meet me there, and then he would go back and work the rest of the night. That is the kind of worker that he has been.

I have always held Paul deKruif in a very friendly spot in my heart. I know there have been many times, and I know he is conscious of it, in which the various things that he has said about medicine have not always been accepted in the spirit in which they were intended.

I feel that Dr. deKruif has done a very great deal for the reading public in making them aware and acquainted with the progress of medical science, and because of that, we owe him a great distinction. It therefore becomes my pleasure and honor at this moment in accordance with your vote today in presenting to Dr. deKruif this scroll which reads as follows:

> "Honorary Membership award presented by the Michigan State Medical Society to Paul deKruif, elected by the House of Delegates in recognition of unusual service rendered to medicine and to the public."

It is my pleasure, Paul, to present you with this.

[The assembly arose and applauded.]

PAUL DEKRUIF, M.D.: Ladies and Gentlemen, Mr. Secretary: Where is Otto, the President? Mr. Speaker: I mustn't say much because tomorrow night I am going to really shoot my wad. Ernest Hemingway, who is a very dear friend of mine, says never tell your story before you write the story because you lose something. You lose the pressure, and so all I can say is just two sentences.

When the Ottawa County Medical Society made me an Honorary Member last December, I wrote them a little letter and said that next to Mrs. deKruif's consenting to be my wife, it was the greatest honor I had ever had. I am going now to 1531 where she is probably sleeping and wake her and show her this and tell her that this is an even greater honor than her consenting to be my wife. [*Laughter*] Thank you very much. [*Applause*]

THE SPEAKER: Thank you, Paul.

XVI. ELECTIONS

XVI—(a). COUNCILOR, SEVENTH DISTRICT

DANIEL J. O.'BRIEN, M.D. [Lapeer]: I wish to nominate Dr. Harry Zemmer, the incumbent in the Seventh District to succeed himself.

THE SPEAKER: The nomination of Harry Zemmer to succeed himself.

RALPH A. JOHNSON, M.D.: I second the nomination.

R. WALLACE TEED, M.D.: I move the nominations be closed and that the Secretary be instructed to cast the unanimous ballot.

ELMER C. TEXTER, M.D.: I second the motion.

THE SPEAKER: It has been moved and seconded that the nominations be closed and that the Secretary be instructed to cast the unanimous ballot for Dr. Zemmer to succeed himself as Councilor of the Seventh District. Is there any discussion?

All in favor say "aye"; opposed, "no." Dr. Zemmer is elected to succeed himself.

XVI—(b). COUNCILOR, EIGHTH DISTRICT

JOSEPH P. MARKEY, M.D. [Saginaw]: I would like to place in nomination the name of Dr. Lloyd C. Harvie who has served for four years the Eighth District, to succeed himself for Councilor from our district.

THE SPEAKER: Dr. Harvie has been placed in nomination. Do I hear a motion to close the nomination?

JOSEPH F. BEER, M.D.: I move that the nominations be closed and that the Secretary be instructed to cast the unanimous ballot.

FRANKLIN W. BASKE, M.D.: I second the motion.

THE SPEAKER: It has been moved and seconded.

All in favor of the motion say "aye"; opposed, "no." Dr. Harvie has been re-elected to succeed himself as Councilor of the Eighth District.

XVI—c. COUNCILOR, THE NINTH DISTRICT

ELLERY A. OAKES, M.D. [Manistee]: We have had an excellent Councilor serving the rest of my term up in my district, and I think he should have a chance to serve a full term of his own.

I would like to nominate G. B. Saltonstall of Charlevoix.

RUSSELL A. SPRINGER, M.D.: I second the nomination.

ROBERT V. DAUGHERTY, M.D. [Wexford-Missaukee]: I move that the nominations be closed and that the Secretary be instructed to cast the unanimous ballot.

EDWARD D. SPALDING, M.D. [Wayne]: I second the motion.

THE SPEAKER: It has been moved and seconded. Is there any discussion?

All in favor of the motion say "aye"; opposed, "no." Dr. Saltonstall is duly elected to succeed himself in the Ninth District.

XVI—d. COUNCILOR, TENTH DISTRICT

WALTER S. STINSON, M.D. [Bay-Arenac-Iosco]: I would like to place in nomination the name of a man who has served one and one-half terms as Councilor from the Tenth District and has been very satisfactory. The name of Dr. F. H. Drummond, of Kawkawlin.

STANLEY A. STEALY, M.D. [Medical Society of North Central Counties]: I second the motion.

ELBERT S. PARMENTER, M.D.: I move that the nominations be closed and that the Secretary be instructed to cast the unanimous ballot.

ELLERY A. OAKES, M.D.: I second the motion.

THE SPEAKER: It has been moved and seconded that the nominations be closed and that the Secretary cast the unanimous ballot.

All in favor of the motion say "aye"; opposed, "no." Dr. Drummond is re-elected to succeed himself.

XVI—e. DELEGATES TO THE AMERICAN MEDICAL ASSOCIATION

THE SPEAKER: According to the Handbook, there are three incumbents whose terms expire. According to the By-Laws, nominations may be made from the floor and elections made by ballot. Nominations are now in order.

RALPH A. JOHNSON, M.D.: It is my good fortune to have the opportunity to place before you for nomination to succeed himself an honored and respected name.

Six years ago he began representing the Michigan State Medical Society in the House of Delegates of the American Medical Association. At that time he was the youngest member of the Michigan delegation. Today he is the oldest.

He has been heard to say that he is too old. He isn't often wrong, but, Brother, is he wrong here and now, and do I delight in jumping on him for being wrong!

We have the chance to sing: "Doctor Michigan" is our delegate to the House of Delegates of the American Medical Association. Let us not fail.

Gentlemen, I nominate *W. D. Barrett, M.D.,* as delegate to the American Medical Association to succeed himself. [*Applause*]

[The motion was severally seconded.]

THE SPEAKER: It has been moved by Dr. Johnson and severally seconded. Are there any other nominations?

ROGER V. WALKER, M.D.: It gives me great pleasure, too, to place in nomination the name of a man whom we have seen fit to honor by electing him President-for-a-Day during this particular session. He is a man that you all know well. He is a man that has great stature in medical professional matters and has arisen to his height as a delegate to the American Medical Association.

I think along with the man who has been previously nominated, Dr. Barrett, he will give equally good service, so I nominate my friend, Bob Novy.

THE SPEAKER: Dr. R. L. Novy has been placed in nomination [*Applause*]

EDWARD D. SPALDING, M.D.: I would like to second the nomination of Dr. Novy.

LIONEL E. IRVINE, M.D. [Dickinson-Iron]: I wish to place in nomination for a delegate to the American Medical Association the name of *W. H. Huron, M.D.,* Iron Mountain. Dr. Huron has worked very faithfully for many years in our Society as Councilor for our district and is the present incumbent for the office. [*Applause*]

[The nomination was severally seconded.]

THE SPEAKER: The nomination was severally seconded.

JOHN S. DETAR, M.D.: As a new delegate to the AMA, as a one-year observer of the action of these three delegates, I should like to give the House of Delegates my impression, which is this: That the very strong position of Michigan in the House of Delegates is very largely attributable to the very strong position of the three men who have been renominated for another term, so I would like to move that the nominations be closed.

ROGER V. WALKER, M.D.: I second the motion.

THE SPEAKER: It has been moved that the nominations be closed. Is there any discussion?

All in favor of the motion say "aye"; opposed, "no." The motion is carried.

All in favor of the three candidates nominated, namely, Drs. Barrett, Huron and Novy—signify by saying "aye"; opposed, "no." They are unanimously elected. [*Applause*]

XVI—f. ALTERNATE DELEGATES TO THE AMERICAN MEDICAL ASSOCIATION

RALPH A. JOHNSON, M.D.: There is a queer parliamentary condition that has arisen because Michigan was permitted to have six delegates. As it now stands, you are electing in one year four alternate delegates and in another year such as this, two alternate delegates.

It seems to me with your permission, Mr. Speaker, perhaps it would be advisable for one of the alternate delegates to resign as of now and stand his chances for re-election to the two-year term, one of the four who now holds office as alternate delegate. If one of those would resign, it might clear up this little difficulty.

I offer that as a suggestion from the floor.

EDWARD D. SPALDING, M.D.: I would be very glad to resign under the circumstances to simplify the matter.

THE SPEAKER: Thank you, Dr. Spalding. You helped the maneuvering of this situation.

Do all you gentlemen understand what has been done? It throws the balance of nominations out because one year there have been two and another year four. We are trying to get it back in its three and three basis.

Dr. Spalding has offered to resign and take his chances at being re-elected, so there will be three men to be elected this year instead of two.

There are now three vacancies.

RALPH A. JOHNSON, M.D.: I think we will have to accept Dr. Spalding's resignation officially, and I move his resignation be accepted.

THE SPEAKER: It has been moved by Dr. Johnson that Dr. Spalding's resignation be accepted. Is there a second?

CHARLES W. OAKES, M.D.: I second the motion.

JOHN S. DETAR, M.D.: I would like to amend that motion by saying "with great regret."

THE SPEAKER: I believe the mover will accept the amendment.

THE SPEAKER: All in favor of the motion say "aye"; opposed, "no." The motion is carried and Dr. Spalding's resignation has been accepted with regret.

Nominations for alternate delegates are now in order.

MAX L. LICHTER, M.D.: I place in nomination the name of E. D. Spalding, M.D.

THE SPEAKER: E. D. Spalding, M.D., has been nominated.

JOHN S. DETAR, M.D.: On behalf of American medicine and just in case by any chance American medicine might be deprived of the very tacit and fast moving remarks of Dr. Spalding, I would like to second his nomination.

JOHN R. RODGER, M.D. [Northern Michigan Medical Society]: Since we all send our Alternate Delegate to the AMA along with the Delegates, it behooves us then to select our Alternate with as much care as we select our Delegates.

I would like to suggest to this group the name of a man who has been a member of this House, a man who is comparatively young in years but old in wisdom, a man who is now a member of The Council, a man who will work as hard at being an Alternate as he would being a Delegate if he were a Delegate. I would like to present the name of *George W. Slagle, M.D.,* of Battle Creek.

THE SPEAKER: Dr. Slagle has been nominated, and seconded by several.

[The nomination was severally seconded.]

WILLIAM L. BROSIUS, M.D. [Wayne]: I would like to place before you a man who has done a very great deal for medicine and whom you all know and who served faithfully—my colleague, *Clarence I. Owen, M.D.*

THE SPEAKER: Dr. Owen has been nominated. Are there other nominations?

LUTHER C. CARPENTER, M.D. [Kent]: I would like to nominate R. H. Denham, M.D., of Grand Rapids.

THE SPEAKER: Dr. Denham has been nominated.

[The nomination was duly seconded.]

THE SPEAKER: Are there other nominations?

CHARLES W. OAKES, JR., M.D.: I move that the nominations be closed.

R. WALLACE TEED, M.D.: I support the motion.

THE SPEAKER: It has been moved and seconded.

All in favor say "aye"; those opposed, "no." The motion is carried.

The Chair now instructs you to ballot on three of the four names. The names are Drs. Spalding, Slagle, Owen and Denham.

It is important to give them seniority. I think we will do what we attempted to do last year. If you will put the man you wish to give seniority in first position and mark it one, the man in second position of seniority and mark it two, the man you wish to give third place in seniority and mark it three, then the tellers can tabulate it.

I will appoint as Tellers: B. T. Montgomery, M.D., Leon Bogart, M.D., and Wm. Brosius, M.D.

[The ballots were cast for three of the candidates and the tellers collected the ballots.]

Subsequently the tellers reported as follows: Ed. D. Spalding, M.D., No. 1; C. I. Owen, M.D., No. 2; G. W. Slagle, M.D., No. 3.

THE SPEAKER: These three names are declared elected and in the order of seniority as recorded.

XVI—g. PRESIDENT-ELECT

FRANK A. WEISER, M.D.: I am not going to keep you in suspense. I am going to talk about Buddy Hull, known to you as *LeRoy W. Hull, M.D.* I am going to nominate him for President-Elect.

I am going to tell you very honestly it is a rather hard job to do for me because I am biased all to pieces. I have known this guy for pretty close to thirty-five years, and I know him as a person who has worked for organized medicine, who has been President of Wayne County Medical Society, who has been chairman of Public Relations Committee of the State Medical Society and did an awfully swell job, and he is Councilor at the present moment.

If I went any further, you would get confused because you would think I was talking about St. Augustine or St. Swithen or something like that. I am actually talking about Buddy Hull.

We want a proper person to represent us for President-Elect as we have in all these years of Michigan State Society.

I place in nomination my good friend, *LeRoy W. Hull, M.D.,* of Detroit for President-Elect. [*Applause*]

THE SPEAKER: Dr. Hull has been placed in nomination.

CHARLES W. OAKES, M.D.—DONALD W. THORUP, M.D.: [In unison]: We second the nomination.

THE SPEAKER: Seconded by the duet.

JOHN H. SCHLEMER, M.D.: I move that the nominations be closed and the Secretary be instructed to cast the unanimous ballot for Dr. Hull.

THE SPEAKER: It has been moved. Is there a second?

DONALD A. YOUNG, M.D. [Wayne]: I second the motion.

THE SPEAKER: It has been moved and seconded that nominations be closed and the Secretary will cast the unanimous ballot for Dr. Hull as President-Elect.

All in favor of the motion say "aye"; opposed, "no." The motion is carried.

Dr. Hull is duly elected. Will Dr. Umphrey escort Dr.

Hull to the platform please? Dr. Umphrey is our immediate Past President.

[Dr. Umphrey escorted Dr. Hull to the platform.]

THE SPEAKER: I wish all the former past Presidents who are in the hall would please come forward.

Ray S. Morrish, M.D., Wilfrid Haughey, M.D., R. L. Novy, M.D., and E. F. Sladek, M.D., are here.

I will give the microphone to Dr. Umphrey to introduce the new President-Elect.

C. E. UMPHREY, M.D.: I have known Bud Hull for a long time. In fact, I was one of the group who got him into all of this, and tonight I have the most pleasant job I have had in a long, long time.

Now I give you Bud Hull. [*Applause*]

PRESIDENT-ELECT L. W. HULL: Dr. Umphrey and my Friends: I certainly am tickled to death with the job, and I didn't have to be drafted. [*Laughter*]. That is about all I can say.

I will try to do what I can, with the help of The Council and the Executive Committee, and I know that I can expect a great deal of assistance from them and from the past presidents whom we necessarily have to call up once in awhile I am thinking of men like Otto Beck, M.D., and Clarence Umphrey, M.D., the Speaker, L. Fernald Foster, M.D., Bill Burns, and the rest of them.

Again I thank you so much for the rest of them. [*Applause*]

THE SPEAKER: Dr. Livesay will take the Chair.

[J. E. Livesay, M.D., the Vice Speaker, assumed The Chair.]

XVI—h. SPEAKER OF THE HOUSE OF DELEGATES

THE VICE SPEAKER: The floor is now open for nominations for Speaker of the House of Delegates.

HAROLD A. FURLONG, M.D. [Oakland]: I would like to place in nomination for the Speaker of the House of Delegates, Robert H. Baker, M.D., to serve another term.

ALEXANDER B. GWINN, M.D.: I second the motion.

RUSSELL A. SPRINGER, M.D.: I move that the nominations be closed, and the Secretary be instructed to cast the unanimous ballot.

R. WALLACE TEED, M.D.: I second the nomination.

THE VICE SPEAKER: You have heard the motion.

All in favor signify by saying "aye"; opposed, "no." Dr. Baker is declared elected. [*Applause*]

[R. H. Baker, M.D., the Speaker, resumed the Chair.]

THE SPEAKER: Thank you, gentlemen. I shall try again to serve you.

I appreciate the honor that you have bestowed upon me for the term. You have been very kind. This session has gone along pretty smoothly, and there hasn't been too much to do and too much controversy.

I hope we have conducted business with the Chair taking due consideration of your wishes. The Chairman is always ready to listen to suggestions.

I shall endeavor to carry on another year. I enjoy very much the associations that it has been my privilege to have as Speaker of the House, the connection it gives me with the Executive Committee and The Council.

It is a rare experience to be this closely allied with the affairs of this Society. I have a much deeper respect for the activities of the Michigan State Medical Society, for the needs of organized medicine, what it stands for, and I tried to give that to you in a very inadequate way yesterday.

I hope the new delegates, particularly, will go home with some kind of a stimulus to carry the message of our organization to the constituents at home, the membership at the grass roots, because I feel as I see it in my own Society, it must exist in others. There are too many men who do not take any part, who do not feel any great responsibility, other than their personal work in their home and in the office.

I believe it is increasing more all the time. The public is expecting more help and guidance from our profession. The only way we can do it is by organization and pooling of our ideas. So it has been a great pleasure and privilege to serve as your Speaker and to be part of such an organization.

I might have a little more to say before we close the meeting. There will be two more items of business.

XVI—i. VICE SPEAKER OF THE HOUSE OF DELEGATES

THE SPEAKER: Nominations are now in order for Vice Speaker.

FRANK D. JOHNSON, M.D. [Genesee]: I wish to place in nomination the name of Jackson E. Livesay, M.D., of Flint.

THE SPEAKER: Dr. Livesay is nominated.

FRANKLIN W. BASKE, M.D.: I second the nomination.

THE SPEAKER: It has been seconded.

RALPH A. JOHNSON, M.D.: I move that the nominations be closed and the Secretary be instructed to cast the unanimous ballot.

ELMER C. TEXTER, M.D.: I second the motion.

THE SPEAKER: It has been moved and seconded. Is there any discussion?

All in favor of that motion say "aye"; opposed, "no." The motion is carried.

Dr. Livesay is re-elected for which I am very grateful. Dr. Livesay, will you stand up and let them give you a hand? [*Applause*]

This is a great help. I don't know whether you have noticed, I suppose you did down there, but every time I got in a jam today, I just referred to Jack, and he was looking over the books, and he always had an answer which I didn't always have.

He has been an extremely great help. Jack, like some others under the age of fifty-one, is subject to call, although he has volunteered on two previous occasions and has been rejected.

Now that he is well established like many others, with a family, and has many things to leave, he doesn't know whether he is going to have to serve Uncle Sam, but he has consented to serve.

I am very pleased that he was nominated and re-elected. It is very helpful to me and to you.

XVI—j. COUNCILOR—FIRST DISTRICT

PRESIDENT-ELECT HULL: Much as I hate to do it, I request my resignation as Councilor from the First District.

THE SPEAKER: To make it official, Dr. Hull has requested resignation. Is there a motion to accept Dr. Hull's resignation?

DONALD A. YOUNG, M.D.: I move Dr. Hull's resignation be accepted.

ELMER C. TEXTER, M.D.: I second the motion.

THE SPEAKER: It has been moved and seconded that Dr. Hull's resignation be accepted which now leaves a vacancy for Councilor from the First District.

All in favor of the motion say "aye"; opposed, "no." The motion is carried.

Nominations are now in order for Councilor of the First District.

MAX L. LICHTER, M.D.: I would like to place in nomination the name of a man who has done a great deal for organized medicine. He is past president of the county medical society. He has been chairman of the Academy of General Practice, the national chairman of the board of directors of the National Academy and in addition is at present chairman of the very important MSMS Public Relations Committee.

I would like to place in nomination the name of Arch Walls, M.D.

THE SPEAKER: Dr. Walls is nominated. It has been seconded by several.

[The nomination was duly seconded.]

JOHN H. SCHLEMER, M.D.: I move the nominations

be closed and the Secretary instructed to cast the unanimous ballot.

FRANK D. JOHNSON, M.D.: I second the motion.

THE SPEAKER: You have heard the motion. Is there no discussion?

All in favor say "aye"; opposed, "no." The motion is carried, and Dr. Walls is elected as Councilor of the First District. [*Applause*]

INTRODUCTION OF PRESIDENTS OF SAMA, WAYNE AND UNIVERSITY OF MICHIGAN

THE SPEAKER: Norman Henderson, president of the Student AMA of Wayne University College of Medicine and Frank Shubeck president of the SAMA of University of Michigan were invited to come to our meeting. We hope to recognize them at this time. If they are here, I wish they would stand.

THE SPEAKER: I understand Mr. Shubeck is here. [*Applause*]. Would you like to say a word, Mr. Shubeck?

MR. SHUBECK: I thank all of you for inviting me here and thank all of you for all the support you have given to our local society in sending our delegates to the national convention last year. Thank you very much. [*Applause*]

THE SPEAKER: Thank you. We appreciate having you here.

Before we conclude the meeting and entertain a motion for adjournment, I want again to extend my thanks first of all to Dr. Livesay at my left, the Vice Speaker, who has been so extremely helpful, and to Dr. Foster, Secretary of the Society, who has one of those encyclopedic minds that carries so many facts without always having to look up the record, who has been very helpful to me, helpful with advice, helpful in supplying information called for on the floor, and who expresses himself so well in making many announcements.

I wish to thank Bill Burns who is always helpful, as every officer and Councilor and anyone having to deal with the state office will know. Bill Burns again should be recognized for his very great ability to get things done and for the very few mistakes which Bill ever makes; if any, he is the first to recognize them.

I would like to thank the staff, Mr. Brenneman, the rest in the central office staff. Everyone has been very helpful, and I trust that it has implemented the action of this body.

I hope that we can succeed another year in expediting matters as well as they have gone this year.

I would like to thank all of the reference committees, particularly their chairmen. They have done a magnificent job I didn't have business enough to give to all of the committees. Perhaps I overloaded some, but I think you can testify to the very capable, orderly reports with which they came back to you.

I thank all the members of the committees. The Speaker is supposed to nominate those committees. Many times I place men on committees whose names and faces are not familiar to me, but I try to distribute them throughout the state, and I try to put new men on, to give them the opportunity.

I am very jealous of the way reference committees work and the way this body works. I think that the bulk of the work is done in reference committees. As I have said before, I think the new men coming to the House feel very green and wonder what it is all about.

Dr. Livesay explained a little bit of that to you. He explained how the organization worked in these sessions, and I feel that it makes it a bit easier for the new men coming to the House of Delegates to go to reference committees when they feel they are among friends and speak when sometimes they are too embarrassed to get up on the floor and express their opinions.

I hope that that will continue and new men elected to the House of Delegates will feel very free to follow a motion to the reference committee and take part in discussion or listen as they see fit.

I am very thankful especially to the sergeant-at-arms. He has done a nice job. It was difficult the first morning to keep track of the men.

If there are no other matters to come before the meeting, we will now stand adjourned.

The meeting was adjourned at ten-twenty o'clock.

Postgraduate Medicine

University of Michigan Medical School

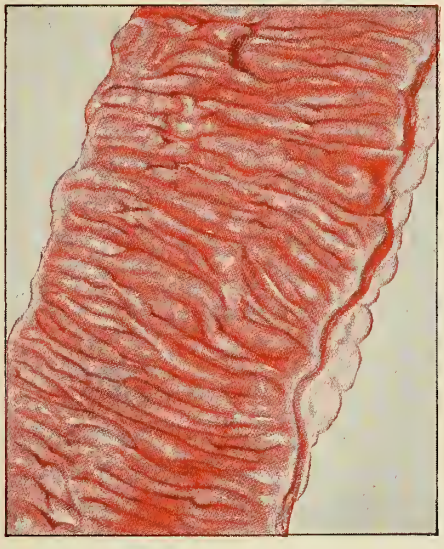
Brief Review Courses for Practicing Physicians

1953

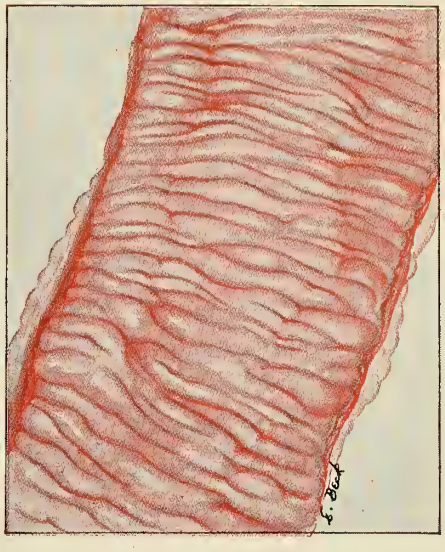
Anatomy (Thursdays)	February 2 and 3
Cancer	February 12-May 28
Internal Medicine	
Clinical Internal Medicine (Thursdays)	January 8-April 16
Diseases of the Heart	March 16-20
Electrocardiographic Diagnosis	March 23-28
Recent Advances in Therapeutics	March 30-April 2
Diseases of Blood and Blood-Forming Organs	April 6-10
Metabolism and Endocrinology	April 6-10
General Practice	April 13-24
Obstetrics and Gynecology, Obstetrics	January 21-24
Gynecology	February 25-28
Ophthalmology	April 20, 21 and 22
Roentgenology, Diagnostic	April 6-10

Further information may be obtained by writing to: H. H. Cummings, M.D., Chairman; Department of Postgraduate Medicine, University Hospital, Room 2040, Ann Arbor, Michigan.

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* Block, L. H.: Management of Constipation with a Refined Psyllium Mucilloid Combined with Dextrose, Am. J. Digest. Dis. *14*:64 (Feb.) 1947.

SEARLE RESEARCH IN THE SERVICE OF MEDICINE

Michigan's Department of Health

Albert E. Heustis, M.D., Commissioner

DEPARTMENT REEMPHASIZES POLICY ON DISTRIBUTION OF GAMMA GLOBULIN

The recent renewed public interest in the use of gamma globulin as a prophylaxis of paralytic poliomyelitis resulted in a re-statement by the Commissioner of the Department's policy in regard to its distribution of this product. The policy takes into consideration the role of gamma globulin in the prevention of measles and viral hepatitis and as a prophylaxis of paralytic poliomyelitis. The statement follows:

The preliminary scientific reports presented indicate that the administration of gamma globulin has limited prophylactic value from the end of the first week through the fifth week after it has been injected. It will be impossible to reach a final conclusion on the prophylactic value of gamma globulin in poliomyelitis until clinical and laboratory studies have been completed sometime during the fall of 1953.

The value of gamma globulin in the prevention and modification of measles and in the prevention of viral hepatitis has been clearly demonstrated.

The present rate of production of gamma globulin is but a small fraction of the minimal epidemic need for it in poliomyelitis alone.

Therefore, the supply of gamma globulin available from the Michigan Department of Health will be reserved for the control of measles and viral hepatitis until (a) the prophylactic value of gamma globulin against poliomyelitis has been clearly demonstrated; (b) adequate supplies of gamma globulin are available.

It is of interest to note that if the entire stock of gamma globulin now available to Michigan were used for the prevention or modification of polio and if we had the same success that the preliminary data from Texas would indicate, all of our material would result in the prevention or modification of but one case of the disease.

It is interesting, too, that the researchers themselves did not recommend the use of gamma globulin in the descending phase of an outbreak. Cases in Michigan are rapidly decreasing and have been since the second week in October. The peak of the disease was reached during the last week in August and the decline was gradual over the intervening six-week period.

SALMONELLA TYPHIMURIUM RESPONSIBLE FOR WIDESPREAD ILLNESS IN SOUTHERN MICHIGAN COMMUNITY

On a Sunday in early October a community group in a small town in southern Michigan served a turkey dinner. Attendance was excellent, with people coming from widely scattered areas. It was estimated that 250 people attended the dinner.

Within six to seventy-two hours after eating, a total of 161 persons were taken sick. Two people died, the first a man of seventy-seven.

Laboratory analysis of food samples showed the turkeys to be infected with Salmonella typhimurium—the most common of the salmonella organisms involved in food-borne infections.

Epidemiological investigation brought out the contributing circumstances. Nine turkeys were purchased by the women from a turkey grower on Thursday. On Friday the women gathered to make the dressing and to stuff the turkeys. They each took turkeys home with them. On Saturday they roasted the already-stuffed turkeys. On Sunday at 1:00 p.m. they served them at the dinner.

All of the people who worked on the turkeys ate the dinner, so it was impossible to identify the carrier of the infection.

As a result of the outbreak, the Department is considering ways of helping the local health departments to encourage their community groups to ask the health department sanitarian to work with them in planning and preparing for community dinners or suppers.

EDUCATIONAL PROGRAM ON GOITER PLANNED

At a joint meeting of the Commissioner's Advisory Committee on Nutrition and the Iodized Salt Committee of the Michigan State Medical Society in the Wayne County Medical Society Building on October 28, progress of the goiter prevention program was reviewed and plans were made for intensified educational measures promoting use of iodized salt.

The Commissioner's Advisory Committee on Nutrition is broadly representative of interested groups in the state—the State Medical Society, the medical schools of the University of Michigan and Wayne University, the School of Public Health of the University, the Research Laboratories of the Children's Fund, the Department of Foods and Nutrition of Michigan State College, the Michigan Nutrition Council and the Michigan Health Officers Association.

The lead article and the feature insert in the October issue of "Michigan's Health" are the beginning of the Department's part in the intensified educational program. A leaflet for general distribution and a poster are in preparation, both intended especially for use of local health departments. Radio scripts will be available for anyone wishing to adapt them for local use. Study group outlines will be prepared if they are needed. The active co-operation of interested agencies and organizations will be enlisted. Articles are planned for various state publications, professional and lay, giving the encouraging findings of the 1951 re-survey but emphasizing the necessity of continued use of iodized salt if the amazing gains are to be maintained.



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Correspondence

Wilfrid Haughey, M.D., Editor
610 Post Building,
Battle Creek, Mich.

Dear Wilfrid:

For the information and guidance of the Deans of the Medical School, junior and senior medical students, interns and resident physicians in training in approved teaching hospitals of Michigan, wish to advise you that the new dates of examination established by the Michigan State Board of Examiners in Basic Sciences are as follows, the second Fridays and Saturdays of February, May and October. All applications must be filed in the office of the Secretary of the Board, 423 W. Michigan Avenue, Lansing, Michigan, thirty days prior to date of examination.

Very sincerely yours,

J. Earl McIntyre, M.D., *Secretary*,
Michigan State Board of Registration in Medicine

Lansing, Michigan

Dr. R. J. Hubbell
President, Michigan State Medical Society
606 Townsend Street
Lansing 15, Michigan

Dear Dr. Hubbell:

It is with considerable pleasure and satisfaction that I read your report on the medical and hospital care program at the State Prison of Southern Michigan.

It is indeed gratifying to note the progress that has been made and to have the recognition of such outstanding groups as the Michigan State Medical Society and the Michigan Hospital Association.

Sincerely,
G. Mennen Williams
Governor

October 26, 1952

World Medical Association Att: Louis H. Bauer, M.D.,
Gentlemen: Secretary-Treasurer

The House of Delegates of the Michigan State Medical Society at its annual session in Detroit, September 22-23, 1952, adopted the following resolution:

"Whereas, the World Medical Association is an association of the National Medical Association of 43 countries of the free world, and

"Whereas, this association is the only international association which can speak for the practicing physicians of the world, and

"Whereas, there are an increasing number of health problems being decided on an international basis, and

"Whereas, there is an increasing need for an association to represent the practicing profession, and

"Whereas, the American Medical Association is one of the founder members of the World Medical Association, and

"WHEREAS, the American Medical Association is also one of the founder corporate members of the United States Committee, Inc., of the World Medical Association and has urged physicians of the United States to become individual members of the United States Committee, Inc., therefore, be it

"RESOLVED by the House of Delegates of the Michigan State Medical Society: That it endorses the work of the World Medical Association and of its supporting United States Committee, and be it

"FURTHER RESOLVED: That the House of Delegates of the Michigan State Medical Society urges the members of the Michigan State Medical Society to become individual members of the United States Committee, Inc., of the World Medical Association, and thereby aid in the elevation of standards in medical education and medical care throughout the world and ensure that the opinions of the practicing physicians of the world are adequately represented before various international bodies."

This resolution was adopted unanimously by the House of Delegates. The provisions in the final paragraph of the resolution are being put into operation in Michigan through use of the Journal of the Michigan State Medical Society and also through the Secretary's Letter to *all* MSMS members.

Sincerely,
L. FERNALD FOSTER, M.D.,
Secretary.

October 31, 1952

In Memoriam

JAMES A. FOOTE, M.D., of Lincoln Park, died October 27, 1952, at the age of fifty-six.

For the past twenty-eight years, Dr. Foote had practiced medicine in Lincoln Park. He was graduated from the Detroit College of Medicine in 1924.

Besides his wife, Hazel, he is survived by two sons and a daughter. They are Mrs. Henry Dalanger, James Foote, and Dr. John Foote.

THOMAS B. MARSDEN, M.D., died October 11, 1952, at the age of fifty-nine. Dr. Marsden was graduated from the Detroit College of Medicine in 1915.

He was a captain in the Medical Corps in World War II and was awarded the British Military Cross.

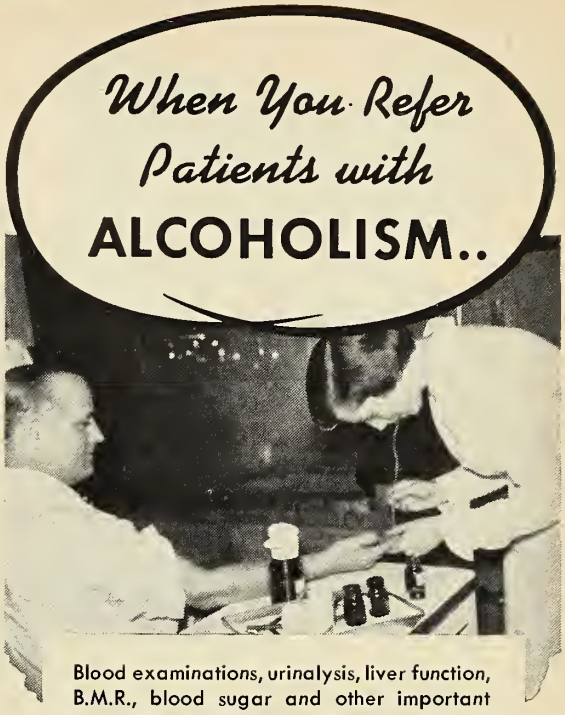
Dr. Marsden is survived by his wife Lillian; and two daughters, Eleanor and Mrs. John Bruny.

FREDERICK J. ROBERTS, M.D., formerly of Bay City, died October 4, 1952, at the age of sixty-five.

Dr. Roberts was graduated from the Detroit College of Medicine in 1910. He is survived by his wife, Helen; a daughter, Mary; a son, William, and a sister, Mrs. Fred C. Strickroot.

BERNARD ROSE, M.D., of Detroit, died October 27, 1952, at the age of fifty-two. Dr. Rose was graduated from the Detroit College of Medicine in 1922.

He is survived by his wife, June; a daughter, Mrs. Ludwig Strass; a son, Richard; two brothers; a sister and one grandchild.



Blood examinations, urinalysis, liver function, B.M.R., blood sugar and other important diagnostic tests are performed in a modern, well-equipped laboratory.

Years of experience in the specialized care of alcoholic addiction enable The Keeley Institute to embody the following phases of therapeutic approach—gradual withdrawal, physical rehabilitation, re-orientation an re-education.

Soon after admission the patient is given a thorough physical examination and laboratory studies. His nutritional status—highly important in alcoholism—is thoroughly investigated. Pertinent information regarding physical and psychosomatic disorders is obtained and related to each successive examination.

All patients receive the utmost consideration from our staff of full-time physicians. Restraining methods and avulsive reactors are not employed. The referring physician is constantly informed of the patient's progress.

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. NEWS MEDICAL

MICHIGAN AUTHORS

Elek Ludvigh, Ph.D., of Detroit, is the author of two articles, "Possible Role of Proprioception in the Extraocular Muscles," and "Control of Ocular Movements and Visual Interpretation of Environment," published in the *Archives of Ophthalmology,* October, 1952.

V. Everett Kinsey, Ph.D., of Detroit, is the author of an article, "Physiologic Chemistry of the Eye," published in the *Archives of Ophthalmology,* October, 1952.

J. Lewis Dill, M.D., of Detroit, is the author of an article, "Vertigo Diagnosis and Treatment," originally published in THE JOURNAL OF THE MICHIGAN STATE MEDICAL SOCIETY, June, 1952; published in the *Digest of Ophthalmology and Otolaryngology.*

W. H. Steffenson, M.D., of Grand Rapids, is the author of an article, "The Problem of the Burned Patient," published in *The Journal of the Indiana State Medical Association,* October, 1952.

Cleveland Denton, M.D., of Ann Arbor, is the author of an article, "Skin Protective Agents," published in the *University of Michigan Bulletin* and abstracted from an article originally published in the *Journal of the Michigan State Medical Society,* and republished in the *American Practitioner Digest of Treatment,* October, 1952.

Henry L. Williams, M.D., of Rochester, Minnesota, is the author of an article, "Ménière's Disease," abstracted from an article orginally published in the *Journal of the Michigan State Medical Society* and republished in the *American Practitioner Digest of Treatment,* October, 1952.

F. D. Dodrill, M.D.; E. Hill, M.D., and **R. A. Gerisch, M.D.,** of Detroit, are the authors of an article, "Temporary Mechanical Substitute For The Left Ventricle In Man," published in *The Journal of the American Medical Association,* October 18, 1952.

Raymond A Gagliardi, M.D., and **Philip D. Gelbach, M.D.,** of Detroit, are the authors of an article, "The Reformed Gallbladder: Clinical And Roentgen Aspects," published in the *American Journal of Digestive Diseases,* September, 1952.

Raymond A. Gagliardi, M.D., of Detroit, is the author of an article, "Upside Down Stomach: Rare Form of Diaphragmatic Hernia," published in *Gastroenterology,* June, 1952.

R. R. Margulis, M.D., and **B. E. Brush, M.D.,** of Detroit, are the authors of an article, "Use of Fibrinolysin in Surgical Complications," published in the *Archives of Surgery,* October, 1952.

Alfred Large, M.D., of Detroit, is the author of an article, "Effect of Direct Anastomosis of Common Bile Duct to Duodenum," published in the *Archives of Surgery,* October, 1952.

William C. Gardner, M.D., of Ann Arbor; **John B. Hartzell, M.D.,** and **William M. Tuttle, M.D.,** of Detroit, are the authors of an article, "Simplified Technique for Treatment of Esophageal Hiatus Hernia," published in the *Archives of Surgery,* October, 1952.

Wm. S. Reveno, M.D., Herbert Rosenbaum, M.D., and **John H. Buell, M.D., Detroit,** are authors of an original article "Short-Term Use of Corticotropin as Adjunctive Therapy," which appeared in JAMA of August 2, 1952.

A. C. Curtis, M.D., H. C. Blaylock, M.D., and **E. R. Harrell, Jr., M.D.,** of Ann Arbor, are authors of an original article "Malignant Lesions Associated with Dermatomyositis" which appeared in JAMA of November 1, 1952.

F. D. Dodrill, M.D., E. Hill, M.D., and R. A. Gerisch, M.D., Detroit, are the authors of an original article, "Temporary Mechanical Substitute for the Left Ventricle in Man" which appeared in JAMA of October 18, 1952.

* * *

The AMA Rural Health Conference will be held in Roanoke, Virginia, on February 27-28, 1953. For program, write Committee on Rural Medical Service, 535 N. Dearborn, Chicago 10, Illinois.

* * *

Cancer Incidence in Detroit area was up 59 per cent between 1937 and 1948. The greatest increase noted in the incidence of cancer in Detroit and Wayne County, Mich., was in cancer of the bronchus and lung (150 per cent). This is among the findings of U. S. Public Health Service report issued as the ninth in a series. The survey was conducted with co-operation of Wayne County Medical Society, the Hospital Council, the Michigan Association of Osteopathic Physicians and the Detroit, Wayne County and State health departments.

Dr. John R. Heller, director of the National Cancer Institute which supervised the survey, comments: "We believe that about half of these apparent increases were caused by the aging of the population. Better reporting by physicians and improved diagnostic methods may have contributed to the increases . . ."—*AMA Capitol Clinic,* Nov. 11, 1952.

* * *

Five physicians up for reelection or election to the House won their contests and the sixth race is so close a recount may be required. Dr. John T. Wood (R), seeking reelection in the first Idaho district, was trailing his Democratic opponent, Mrs. Grace Pfost, by a few

hundred votes on the complete but unofficial count. Reelected were Drs. Walter H. Judd (R) of Minnesota, A. L. Miller (R) of Nebraska and I. D. Fenton (R) and T. E. Morgan (D) of Pennsylvania. A physician newcomer to the House is Will E. Neal (R), elected in West Virgania. Dr. E. H. Hedrick of West Virginia (D) retired from the House to run unsuccessfully for governor.—*AMA Capitol Clinic,* Nov. 11, 1952.

* * *

AMA Secretary's Letter:

I'm back at my regular chores in headquarters after attending the meeting of the Council of the World Medical Association in Athens.

While abroad, I talked with physicians from many countries. The stories some of them told me made my heart ache. As I left for home, I couldn't help feeling proud of our American system of medical care. In many of the countries I visited, the long arm of socialism has reached into the profession to such an extent that the only thing the doctors can do is to bargain and make the best deal possible with their governments so as to save the remnants of what was once a free profession.

For years the planners in Washington took delight in heaping abuse upon the doctors and their profession. Anyone who had the temerity to strike back was smeared as an enemy of the public welfare. The health program, which they spent so much time in advocating, was pictured as having the support of all the people. But the voters spoke Tuesday, and by their ballots they decided they wanted no part of these crackpot schemes.

Doctors will no longer have to dance to the tune of the Ewing pipers, but can devote their full time and energy to a sound, constructive and unselfish program of better medical care for all the people—a program completely divorced from politics.

* * *

Richard J. Plunkett, M.D., 43, of 460 Hawthorne Lane, Winnetka, has been appointed secretary of the newly established Committee on Mental Health of the American Medical Association. The appointment was made by the association's Board of Trustees. Dr. Plunkett has been a member of the AMA's editorial staff for the last five years.

The committee, established in March, 1952, was formed primarily to consider problems that exist today in psychiatry and mental health.

Dr. Leo H. Bartemeier, Detroit, is chairman of the committee. Other members are Drs. Lauren H. Smith, Philadelphia, vice chairman; Walter H. Baer, Peoria, Ill.; Hugh T. Carmichael, Chicago; Francis M. Forster, Washington; M. Ralph Kaufman, New York, and Maurice Levine, Cincinnati.

* * *

A Detroit TV program entitled "The Health of People Who Work in Industry," with a sub-theme, "How the Automobile Industry Safeguards the Health of Its Workers" was given over station WJBK-TV, Detroit, August 10, 1952. This thirty-minute program was prepared under the guidance of the Institute of Industrial Health, and the four participants. The program was introduced by Dr. E. A. Irvin, President of the Industrial Medical Association, who outlined the scope of the Industrial Medical Association, and its



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interests in the health of the workers in America generally. Dr. Clifford H. Keene, Medical Director, Kaiser-Frazer Corporation, discussed the value of the physical examination, the preplacement examination, and the scope of the medical care provided by a medical service in industry. Mr. Ralph Smith, Chief Chemist, Bureau of Industrial Hygiene, Detroit Department of Health, reviewed the part played in environmental control by the industrial hygiene team. Illustrated were the uses of dust-sampling devices, sound-lever meter, and other detecting devices for common industrial hazards. The program was brought to a close by Dr. W. A. Dawson, in charge of the Medical Department of the Rouge Plant, Ford Motor Company, who discussed the plant medical services as they apply to accidents or sicknesses occurring to the employe while he is on the job. The program was given under the sponsorship of the Michigan Health Council, which has this half hour available to it each week. Further programs designed to acquaint the public with the activities and services of industrial medicine will be given. The Institute of Industrial Health will serve in a consulting capacity.—*Industrial Medicine and Surgery,* October, 1952.

* * *

Maxwell Reynolds, of Marquette, long-time member of the Michigan Crippled Children Commission, died at his home on November 2, 1952.

The State of Michigan has lost an able and tireless worker in behalf of crippled and afflicted children. Mr. Reynolds long will be remembered as the man who improvised dozens of "iron lungs" to save the lives of children and adults crippled in the great polio epidemic of 1940.

* * *

"A man in political life is more often aware of the enemies he makes rather than the friends he has."—Senator Homer Ferguson, Michigan.

* * *



Otto O. Beck, M.D., Birmingham, Immediate Past President of the Michigan State Medical Society, was signally honored by the Oakland County Medical Society, of which he is a Past President, on September 3. Chosen as the "outstanding member of the year" by his confreres, Dr. Beck was guest of honor at a banquet at the Knollwood Golf Club, attended by 176 doctors of medicine, including sixteen Officers and Councilors of the Michigan State Medical Society.

Congratulations, Dr. Beck, on this well-merited recognition!

* * *

W. C. Beets, M.D., Grand Rapids, President of the Kent County Medical Society for the ensuing year, has been appointed General Chairman of Arrangements for the MSMS Annual Session of 1953 (Grand Rapids, September 23-24-25).

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EXPECTORANT WITH CODEINE

A better tasting, more effective cough syrup

Each teaspoonful (5cc) contains:

Codeine Phosphate	10.9 mg.
Pyrilamine Maleate	13.5 mg.
Potassium Guaiacolsulfonate	169 mg.
Hyoscine Hydrobromide	0.005 mg.
Hyoscyamine Hydrobromide	0.025 mg.
Chloroform	0.333 min.
Alcohol	10%
Menthol	0.62 mg.

in a raspberry flavored syrup.

Exempt Narcotic
Supplied in Pint and Gallon bottles.

Histussin provides a powerful antihistamine combined with hyoscyamine and hyoscine to relieve respiratory congestion and alleviate bronchial irritation. Effective expectoration is accomplished by therapeutic dosage of potassium guaiacolsulfonate. The codeine reduces local irritability and inhibits the cough reflex.

Histussin is recommended for cough due to colds, allergic bronchitis, catarrhal bronchitis and other conditions that stimulate the cough reflex.

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ANNUAL COUNTY SECRETARIES CONFERENCE



JOHN A. WHITE, M.D.

Wednesday, February 25, 1953

Porter Hotel, Lansing

Chairman:
JOHN A. WHITE, M.D.,
Big Rapids

Morning Program—10:00 A.M.

The Ballot Battle to Save Bay City General Hospital—NEAL R. MOORE, M.D., Bay City
How to Report Cases to Michigan Medical Service—R. L. NOVY, M.D., Detroit and JOHN W. CASTELLUCCI, Detroit
Exchange of Scientific Programs between County Medical Societies—H. E. COPE, M.D., Lansing
Model Constitution and By-Laws for County Medical Societies—J. JOSEPH HERBERT, Manistique
What about Basic Science Act?—E. A. OSIUS, M.D., Detroit
What about Medical Practice Act?—E. C. SWANSON, M.D., Vassar
Techniques—New and Old—L. FERNALD FOSTER, M.D., Bay City

Afternoon Program—1:00 P.M.

Inspection of the new MSMS "home" at 606 Townsend Street, Lansing

Luncheon—1:30 p.m. Porter Hotel

Adjournment—3:00 p.m.

The Medical Society of the State of Wisconsin House of Delegates in October, 1952, voted the annual dues of the members of the Society to be $60.

* * *

The Academy of General Practice of Wayne County is sponsor of a postgraduate course in "Clinical Geriatrics," presented for four days in November, four in December, and continuing in January.

Clinic No. 1 was presented by A. D. Ruedemann, M.D., Detroit; Clinic No. 2 by Russell Costello, M.D., Detroit; Clinic No. 3 by E. D. Spalding, M.D. and J. G. Bielawski, M.D., both of Detroit; Clinic No. 4 by Drs. Spalding and Bielawski.

The January Clinics include: Clinic No. 5 on January 7-8, 1953 by Dan Myers, M.D., Detroit; Clinic No. 6 on January 14-15 by A. E. Schiller, M.D., Detroit; Clinic No. 7, January 21-22, by S. D. Jacobson, M.D., Detroit; Clinic No. 8, January 28-29, by Don McLean, M.D., and T. C. Arminski, M.D., Detroit.

Frank A. Weiser, M.D., Director of Education at Grace Hospital, Detroit, prepared the clinical program which was possible under an educational grant presented by Wyeth Incorporated, Philadelphia.

* * *

The Southwestern District Meeting on Improvement of Nursing Service in Michigan will be held in Kalamazoo, Thursday, January 29, 1953. This workshop meeting will start at 9:30 a.m. on the seventh floor of Bronson Memorial Hospital.

Counties included in the area for this workshop are: Allegan, Berrien, Branch, Calhoun, Cass, Eaton, Hillsdale, Ingham, Jackson, Kalamazoo, St. Joseph and Van Buren.

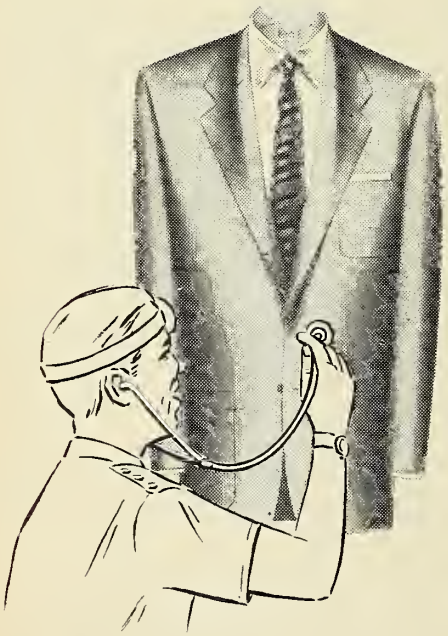
All members of the Michigan State Medical Society are invited and urged to attend this meeting, sponsored by the Michigan State Nurses Association.

Say you saw it in the Journal of the Michigan State Medical Society

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High Schools in Michigan.—A total of 568 public high schools are located in this State. In addition there are 160 Catholic, 5 Christian, 2 Lutheran, 5 Seventh Day Adventist high schools—a total of 740 high schools, with a student body of approximately 225,000.

* * *

The new dates of examination established by the Michigan State Board of Examiners in Basic Sciences are as follows: the second Fridays and Saturdays of February, May and October. All applications must be filed in the office of the Secretary of the Board, 423 W. Michigan Avenue, Lansing, Michigan, thirty days prior to date of examination.

* * *

John R. Rodger, M.D., Bellaire and **R. W. Teed, M.D.,** Ann Arbor, have been appointed as delegate and alternate delegate, respectively, representing the Michigan State Medical Society to the Michigan Health Council.

Congratulations, Drs. Rodger and Teed!

* * *

Harry M. Nelson, M.D., Detroit, was honored by being elected President of the American Cancer Society at its New York meeting in October.

Donald Johnson, Flint, was chosen as Director, representing Michigan.

E. I. Carr, M.D., Lansing, was Delegate representing the Michigan Cancer Society and **A. B. McGraw, M.D.,** Detroit, was Delegate representing the Southeastern Michigan Division of the American Cancer Society at the New York meeting.



L. Fernald Foster, M.D., Bay City, Secretary of the Michigan State Medical Society, was voted by the Michigan State Medical Assistants Society as Honorary Member for the year 1952. The selection was made at the September 22-23-24 Annual Session of the MSMAS and the award was made to Dr. Foster at the banquet of the organization.

* * *

The Nineteenth Annual Meeting of the American College of Chest Physicians will be held at the Hotel New Yorker, New York City, May 28-31, 1953.

Physicians who wish to present papers at the meeting should submit titles and abstracts to Dr. Arthur M. Olsen, Chairman, Committee on Scientific Program, American College of Chest Physicians, Mayo Clinic, Rochester, Minnesota.

* * *

Town Needs Doctor to Fill Vacancy in March.—The village of Ashley, Michigan, with its 446 inhabitants and surrounding fertile farming land of 300 square miles, urgently needs a doctor to fill the vacancy in March when its only M.D. is to be inducted into the Armed Forces. A large and very active general practice in southern Gratiot County with large adjoining areas in other counties of Clinton, Saginaw and Montcalm, is available. Adequate hospital facilities are in Alma, 22

ANNUAL CLINICAL CONFERENCE

CHICAGO MEDICAL SOCIETY

March 3, 4, 5, 6, 1953 • Palmer House, Chicago

THIRTY-FOUR HALF-HOUR LECTURES BY OUTSTANDING TEACHERS AND SPEAKERS on subjects of interest to both general practitioner and specialist.

FOUR PANELS ON TIMELY TOPICS.

DAILY TEACHING DEMONSTRATIONS.

SCIENTIFIC EXHIBITS worthy of real study and helpful and time-saving TECHNICAL EXHIBITS.

The CHICAGO MEDICAL SOCIETY ANNUAL CLINICAL CONFERENCE should be a MUST on the calendar of every physician. Plan now to attend and make your reservation at the Palmer House.

miles north, and in St. Johns, 18 miles south. If interested, immediately contact the village mayor, or V. L. Sheline, M.D., Ashley, Michigan.



Three of every four tuberculosis cases reported in Michigan are in advanced stages. In 1951 there were 3,287 new cases of active pulmonary tuberculosis reported in Michigan, of which 1,203 (36.6 per cent) were far advanced, 1,254 (38.1 per cent) moderately advanced, 506 (15.4 per cent) minimal and 324 (9.9 per cent) primary.

Routine chest x-rays by miniature film annually for all patients of practicing physicians would screen a large segment of the population not reached by routine admission x-ray in general hospitals and other mass screening efforts.

—MICHIGAN TUBERCULOSIS ASSOCIATION

"Seven Decades of Tuberculosis Control" is the title of an address by W. W. Bauer, M.D., Director of the Bureau of Health Education, American Medical Association and Editor of Today's Health, at the Annual Meeting of the Michigan T.B. Association in Ann Arbor on June 6, 1952. This address in booklet form is available by writing the M.T.A. at 403 Seymour Avenue, Lansing. Dr. Bauer's address is being used in the current campaign of the Christmas Seal sale and in the mobilization against tuberculosis which the seal has made possible.

* * *

Liebel-Flarsheim Company of Cincinnati opened its new plant at 111 E. Amity Road, Cincinnati, on October 4, 1952.

* * *

The National Foundation for Infantile Paralysis announces a limited number of post-doctoral clinical fellowships in physical medicine and rehabilitation to candidates who wish to become eligible for certification in that field. For complete information, write the Foundation at 120 Broadway, New York 5, N. Y.

* * *

The Pan American Medical Association announces its Eighth International Cruise-Congress to South America and the West Indies, January 7 to January 19, 1953, on the *S.S. Nieuw Amsterdam* from New York. For information, write Director General Joseph J. Eller, M.D., 745 Fifth Avenue, New York.

* * *

The Alexander Blain Hospital and Clinic celebrated its Twenty-eighth Annual Meeting and Dinner at the Detroit Club, Detroit, on November 10. Alton Ochsner, M.D., of New Orleans, was guest speaker, introduced by Fred A. Coller, M.D., Ann Arbor.

Say you saw it in the Journal of the Michigan State Medical Society



Gertrude Frances Mitchell, M.D., Detroit, has been named one of the "Women of Achievement" of Detroit by the Detroit Historical Society. As such, Dr. Mitchell will have her portrait hung in the Round Hall of the Detroit Historical Society from mid-January through February.

Dr. Mitchell is a practicing physician in Detroit; she was graduated from Wayne University and from the University of Michigan School of Medicine. She is a member of the Board of Directors, Detroit Tuberculosis and Health Society and has staff appointments to Woman's Hospital, Harper Hospital and the Detroit Tuberculosis Sanatorium.

Congratulations, Dr. Mitchell!

* * *

"ILO Spells Danger!" is the title of a most revealing brochure published by the Committee on Legislation of the American Medical Association—available to all members of the Michigan State Medical Society, upon request to C. Joseph Stetler, Secretary, 535 N. Dearborn Street, Chicago 10, Illinois.

The "dodger" accompanying the booklet states:

"Socialized medicine is again a very real threat in the the United States. Although Americans have repudiated compulsory health insurance through their Congress, a shift to international politicking may force socialized medicine upon the American people. The pamphlet "I.L.O. Spells Danger!" outlines the attempt to overrule the Congress and the people of the United States. Ratification of the International Labor Organization Convention on Minimum Standards of Social Security by a two-thirds majority of ONLY THE U.S. SENATE would effect socialized medicine, despite the objection of citizen voters."

Get your copy of "ILO Spells Danger!" and realize how socialized medicine might sneak through the back door of our legislative halls in Congress.

* * *

The Jackson County Medical Society, in cooperation with the Adult Education Department of the Jackson Public Schools, presented a Health Education Series, as a Public Health Service, during October and November. The October 29 subject was "Rheumatic Fever"; November 5, "Hypertension and Arterial Sclerosis"; November 12, "Coronary Occlusion and Angina Pectoris"; and November 19, "Heart Conditions in the Senior Age Group." Two doctors of medicine participated in each of these four presentations which were given the general subject of "How to Live With Your Heart."

On January 4 and February 11, 1953, the Health Education Series at Jackson will stress "Child Growth and Development." Five members of the Jackson County Medical Society will present these talks to the laity.

On April 15 and May 13, "Common Diseases of the Most Productive Years of Life" will be presented to the people by six members of the Jackson County Medical Society.

Congratulations, members of the Jackson County Medical Society, on this progressive activity which deserves emulation throughout the state and country!

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The University of Cincinnati's Institute on Industrial Health is accepting applications for a limited number of Fellowships offered to qualified candidates who wish to pursue a graduate course of instruction in preparation for the practice of industrial medicine. During the first two years, the stipends for the Fellowship are in accordance with the marital status of the individual and run from $2,100 to $3,000; in the third year the candidate will be compensated for his service by the industry in which he is completing his training. For full information, write the Institute at Eden and Bethesda, Cincinnati 19, Ohio.

* * *

Friends of Ralph C. Najarian, now of Chicgao but formerly of Detroit, will be glad to learn that he has been appointed Assistant Advertising Manager of Schering Corporation, Bloomfield, N. J. Mr. Najarian is a graduate of Wayne University College of Pharmacy and engaged in retail practice in Detroit for a number of years before he joined Schering in 1941.

* * *

Grants-in-aid for research into the cause and cure of arthritis were recently approved by the Board of Directors of the Michigan Chapter, Arthritis and Rheumatism Foundation. The grants were made to University of Michigan, $27,500; Harper Hospital, Detroit, $13,500; Henry Ford Hospital, Detroit, $10,000; Providence Hospital, Detroit, $7,000; Wayne University College of Medicine, $15,900; Wayne University Receiving Hospital, $2,000.

S. L. Loupee, M.D., of Dowagiac, "Michigan's Foremost Family Physician for 1952," was honored by his Rotary Club in Dowagiac on Thursday, October 23. Dr. Loupee was presented with the Rotary Red Rose citation indicating Rotary's appreciation for his public services. Judge Carl D. Mosier made the presentation, stating that Dr. Loupee qualified for the citation because of:

"1. Outstanding service to your community.
"2. Distinction for contributions in elevating the standards, scope and usefulness of your professional group.
"3. Recognition of your public service as a state and local office holder.
(Dr. Loupee was a long-time member of the Michigan Legislature.)
"4. A term as president of the Dowagiac Rotary Club. (Dr. Loupee was President of Dowagiac Rotary in 1936-37.)"

* * *

The American College of Surgeons announces its first Inter-American session will be held in Sao Paulo, Brazil, February 9-12, 1953.

* * *

The Wayne County Medical Society held its second indoctrination meeting for new members on October 29. These meetings, sponsored by the Membership Committee, acquaint the applicants for membership with some of the activities of the Society and point out to them the responsibilities and privileges of membership.

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$5,000 accidental death Quarterly $8.00 $25 weekly indemnity, accident and sickness	$15,000 accidental death Quarterly $24.00 $75 weekly indemnity, accident and sickness
$10,000 accidental death Quarterly $16.00 $50 weekly indemnity, accident and sickness	$20,000 accidental death Quarterly $32.00 $100 weekly indemnity, accident and sickness

COST HAS NEVER EXCEEDED AMOUNTS SHOWN

ALSO HOSPITAL INSURANCE

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60 days in Hospital	5.00 per day	10.00 per day	15.00 per day	20.00 per day
30 days of Nurse at Home	5.00 per day	10.00 per day	15.00 per day	20.00 per day
Laboratory Fees in Hospital	5.00	10.00	15.00	20.00
Operating Room in Hospital	10.00	20.00	30.00	40.00
Anesthetic in Hospital	10.00	20.00	30.00	40.00
X-Ray in Hospital	10.00	20.00	30.00	40.00
Medicines in Hospital	10.00	20.00	30.00	40.00
Ambulance to or from Hospital	10.00	20.00	30.00	40.00
COSTS (Quarterly)				
Adult	2.50	5.00	7.50	10.00
Child to age 19	1.50	3.00	4.50	6.00
Child over age 19	2.50	5.00	7.50	10.00

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$18,900,000.00
PAID FOR CLAIMS

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$200,000.00 deposited with State of Nebraska for protection of our members

The Joint Commission on Accreditation of Hospitals (see MSMS President's Message) was officially inaugurated on December 6 with ceremonies in the John B. Murphy Auditorium, Chicago. This marked the end of a thirty-five-year period in which the American College of Surgeons held sole responsibility for setting standards for the Nation's hospitals. From now on, the American College of Surgeons, the American Medical Association, the American College of Physicians, the American Hospital Association, and the Canadian Medical Association will share responsibilities of the program. Gunnar Gundersen, M.D., of La Crosse, Wisconsin, will be first Chairman of the Commission. Headquarters of the new Joint Commission are at 660 N. Rush Street, Chicago 11, Illinois. The new Executive Director of the Commission is Edwin L. Crosby, M.D., former Director of Johns Hopkins Hospital in Baltimore.

* * *

Ronald E. Clark, M.D., Detroit; **L. J. Gariepy, M.D.**, Detroit; **Dr. and Mrs. E. C. Texter**, Detroit; and **H. E. Woodford, M.D.**, Benton Harbor, attended the World Medical Association convention this autumn in Athens, Greece.

* * *

The International Academy of Proctology's 1952 Award contest for the best unpublished contribution on the subject of proctology or allied subjects has been announced. The top awardee will receive a Certificate of Merit and a check for $100. For information, write the Academy at 43-55 Kissena Blvd., Flushing 55, New York.



Presentation to Frank L. Rector, M.D. *(second from right),* Secretary of the Cancer Control Committee, Michigan State Medical Society, by Horace Wray Porter, M.D., of Jackson, energetic Chairman of the Committee for the past two years, at the final luncheon of the Annual Training program at Michigan State College Continuing Education Center, East Lansing, October 9. Freddy Homburger, M.D., of Boston, Massachusetts, guest speaker at the Conference *(left)* and R. J. Hubbell, M.D., of Kalamazoo, President of the Michigan State Medical Society, heartily second the presentation proceedings.

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Members of the Saginaw County Medical Society visited the plant of the eighty-six-year-old Parke, Davis & Co., Detroit, October 23-24. The visitors inspected the fifty-one-year-old research building, the first to be erected in America by any commercial institution solely for the purpose of scientific research. Parke, Davis, with home offices and laboratories in Detroit, has thirty branches and plants in the United States and Canada and nine overseas branches.

* * *

The Connecticut State Medical Society's news letter (called CoSMoS) "congratulates R. L. Novy, M.D., Detroit, and the Michigan State Medical Society on election of Dr. Novy as 'President of the Michigan Society for one day during the annual meeting in appreciation of his faithful and entirely uncompensated services rendered to the medical profession and the people of Michigan Medical Service for ten years.'"

* * *

"After Office Hours" is the title of an interesting column of "profiles" of Wayne County Medical Society members, published weekly in the *Detroit Medical News*.

* * *

Hill-Burton Hospital construction in Michigan, including a federal grant of $329,175 to supply forty-four additional beds to the Charlevoix Hospital at Charlevoix, Michigan (total cost being $612,500), is as follows:

Completed and in Operation: Twenty-two projects at a total cost of $19,187,485, including federal contribution of $6,935,312 and supplying 1,351 additional beds.

Under Construction: Sixteen projects at a total cost of $15,536,439, including federal contribution of $6,-244,073 and designed to supply 812 additional beds.

Approved But Not Yet Under Construction: Three projects at total cost of $2,692,500, including $1,213,325 federal contribution and designed to supply 153 additional beds.

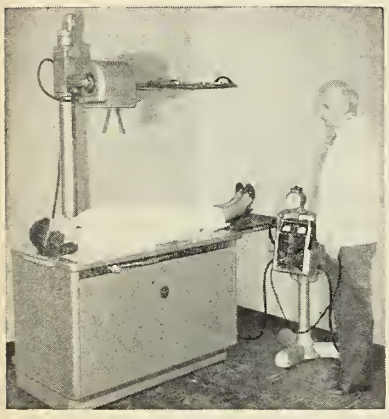
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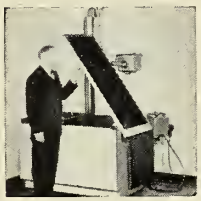
Scholarship Fund Announced.—To encourage young people who want to make health education or medical-social work their career, the Women's Committee of the tuberculosis and Health Society of Wayne County has established a scholarship fund named the Bruce H. Douglas Memorial Fund, in honor of the late Detroit Health Commissioner.

Qualified candidates may be awarded up to $2,000 for graduate study in health education or in medical-social work. Candidates must be qualified for admission to a recognized School of Public Health or Institute of Medical-Social Work.

The purpose of the fund is to relieve the critical shortage of professional personnel in these two fields. Persons desiring to inquire about or apply for a scholarship should write to the Tuberculosis and Health Society, 153 E. Elizabeth, Detroit 1, Michigan, or call WOodward 1-1697 in Detroit.

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"Spacesaver" 75 is a combination Radiographic-Fluoroscopic Unit and Examining Table with a capacity ranging from 75 MA at 75 KVP to 5 MA at 96 KVP.

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It provides radiography and fluoroscopy in both horizontal and vertical positions with easy change from horizontal fluoroscopy to horizontal radiography, or vice versa, without moving patient from table.

Milliampere preset device for both focal spots conserves tube life by providing means of duplicating various predetermined milliampere output settings without repeatedly energizing the x-ray tube.

Protective resistance on fine focal spot.

"Spacesaver" also furnished in 30, 50, 100, and 250 milliampere models.

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MOUNT CARMEL MERCY HOSPITAL—DETROIT

14th Annual Clinic Day Program
January 28, 1953

Morning Session—9:00 a.m.

"The Management of Patients with Renal Lithiasis"—Charles C. Higgins, M.D., Chief of Department of Urology, Cleveland Clinic, Cleveland, Ohio.

"Office Gynecology"—Walter T. Dannreuther, M.D., Professor of Obstetrics and Gynecology, Postgraduate Medical School, New York University, New York, N. Y.

"Present-Day Treatment of Chronic Arthritis"—Russell L. Cecil, M.D., Professor of Clinical Medicine, Cornell University, New York, N. Y.

"Carcinoma in Situ, Grades of Malignancy and Prognostic Significance"—A. C. Broders, Sr., M.D., Senior Consultant, Department of Surgical Pathology and Pathologic Anatomy, Scott and White Clinic; Professor of Surgical Pathology, University of Texas Postgraduate School of Medicine, Temple, Texas.

Luncheon—12:30 p.m.

Compliments of the Sisters of Mercy

"The Priest and the Doctor"—Rt. Rev. Msgr. M. S. Sheehy, LL.D., Washington, D. C.

Afternoon Session—2:00 p.m.

"Iatrogenic vs. Theogenic Disease"—James Means, M.D., Professor of Clinical Medicine, Harvard University, Boston, Mass.

"The Use of Surgical Methods in the Treatment of Acute and Recurrent Pancreatitis"—Robert Elman, M.D., Professor of Clinical Surgery, Washington University, St. Louis, Missouri.

"Tumors of the Neck"—Samuel F. Marshall, M.D., Surgeon, Lahey Clinic, Boston, Mass.

Banquet—6:30 p.m.

Main Ball Room—Statler Hotel, Detroit

Entertainment

All MSMS members are cordially invited to attend the scientific and the evening programs.

* * *

The American College of Surgeons Annual Symposium on "Trauma and Nutrition" will be held in Ann Arbor, May 21, 1953

According to C. H. Keene, M.D., of Ann Arbor, chairman of the Committee on Arrangements, papers are competitive for the F. A. Coller, M.D. Award which is open to all residents and interns. For further information, write Dr. C. H. Keene, 2120 Wallingford Road, Ann Arbor.

* * *

Harold B. Gardner, M.D., has been appointed Secretary-Treasurer of the Medical Society of the State of Pennsylvania, succeeding Walter F. Donaldson, who retired after thirty-five years of service as Secretary.

Dr. Gardner's address, after December 1, will be 230 State St., Harrisburg, Pa.



Cook County Graduate School of Medicine

POSTGRADUATE COURSES—Winter 1952-53

SURGERY—Intensive Course in Surgical Technic, two weeks, starting January 19, February 2, February 16
Surgical Technic, Surgical Anatomy and Clinical Surgery, four weeks, starting March 2
Surgical Anatomy and Clinical Surgery, two weeks, starting March 16
Basic Principles in General Surgery, two weeks, starting March 23
Gallbladder Surgery, ten hours, starting April 20
Surgery of Colon and Rectum, one week, starting March 2
General Surgery, one week, starting February 9
General Surgery, two weeks, starting April 20
Fractures and Traumatic Surgery, two weeks, starting March 2

GYNECOLOGY—Intensive Course, two weeks, starting February 16
Vaginal Approach to Pelvic Surgery, one week, starting March 2

OBSTETRICS—Intensive Course, two weeks, starting March 2

PEDIATRICS—Intensive Course, two weeks, starting April 6

MEDICINE—Intensive General Course, two weeks, starting May 4
Electrocardiography and Heart Disease, two weeks, starting March 16
Allergy, one month and six months, by appointment

UROLOGY—Intensive Course, two weeks, starting April 13
Ten-Day Practical Course in Cystoscopy starting every two weeks

DERMATOLOGY—Intensive Course, two weeks, starting May 4

TEACHING FACULTY—ATTENDING STAFF OF COOK COUNTY HOSPITAL

ADDRESS: REGISTRAR, 707 South Wood Street, Chicago 12, Illinois

PUBLIC RELATIONS CONFERENCE

Sheraton-Cadillac, Detroit, Michigan
February 1, 1953

Chairman: C. A. Payne, M.D., Grand Rapids
Chairman Public Relations Committee, MSMS

Morning Session—10:30 A.M.

A Clinic on Procedures and Techniques of Public Relations

Ralph A. Johnson, M.D., Detroit
Vice Chairman, Public Relations Committee

Panel: **"How to Make Meetings Produce Results"**

"Good Equipment Helps to Sell Ideas"
A demonstration of equipment for use in meetings
Manufacturer's representative

"Audiences Are Participants in Successful Meetings"
A demonstration of how to "run" a meeting
Dr. Howard Y. McCluskey, Ann Arbor
Professor of Educational Psychology, University of Michigan

"Getting Out a Crowd"
A demonstration of techniques used in calling a meeting
Eugene H. Wiard, Lansing
Exec. Secy., Michigan Health Council

Panel: **"How to Reach 'The People'"**

"Let Television and Radio Help Tell Your Story"
A demonstration of how to plan and produce television and radio programs
Charles Penman, Detroit
Program Director, WWJ & WWJ-TV

"Motion Pictures Sell"
A demonstration of how motion pictures sell ideas
Don Doane, Lansing
Doane Productions

"Newspapers Want News"
A demonstration of publicity—do's and dont's
Ernest T. Guy, Detroit, Michigan
Heart Association

Luncheon—Smörgasbord—12:00 M

Motion Picture: "Without Fear"
A motion picture that typifies the work of opponents of medicine

Afternoon Session—1:15 P.M.

Policies and Problems of Public Relations

Wallace Teed, M.D., Ann Arbor
Vice Chairman, Public Relations Committee

Panel: **"The People Make the Laws"**

"The Bay City Story"
A successful campaign against sub-standard healers
Orlen J. Johnson, M.D.
Chairman, Voters Hosp. Committee, Bay City

"Legislative Prophecies"
Presentation of pattern of legislation expected in 1953
L. A. Drolett, M.D.
Chairman, MSMS Legislative Committee, Lansing

Panel: **"You Make Your Own Public Relations"**

"Let's Get Together"
How we can gain better public relations by better relationship both within the medical profession and with other groups.
Warren B. Cooksey, M.D.
President United Health and Welfare Fund, Detroit

"Little Troubles Become Big Issues"
How to analyze local public relations problems—and a presentation of 1953 MSMS Public Relations program.
C. A. Payne, M.D.

Question and Answer Period.

Say you saw it in the Journal of the Michigan State Medical Society

The American Medical Education Foundation is now prepared to accept memorial gifts from individuals who wish to honor the deceased in some manner other than the conventional floral tribute. All such gifts received will be acknowledged to the donors and notice of receipt will also be sent to the survivors of the deceased.

The Council of the Michigan State Medical Society respectfully recommends that members of MSMS continue to remember in their generosity the American Medical Education Foundation—a strong bulwark against socialized medical education—and that annual and more frequent contributions be urged upon every member of MSMS and their friends who are interested in a maintenance of the present high unfettered standards in medical education.

* * *

O. D. Stryker, M.D., Mt. Clemens (formerly MSMS Councilor from the Eleventh District) is President of the Michigan Health Officers Association. Vice President is **Vergil N. Slee, M.D.** of Hastings, long-time Secretary of the Association. **C. E. Merrit, M.D.,** of Lake City, Michigan, is Secretary of the MHOA.

* * *

Half the hospitals in the United States look to the Red Cross for all or part of the blood needed to treat their patients. During the fiscal year ended June 30, 1952, the Red Cross collected 1,681,500 pints of blood for civilian, military, and veteran hospitals in this country. The Red Cross and co-operating blood banks collected an additional 2,439,700 pints for shipment to Korea and for dried plasma defense reserves.

THE DOCTOR'S LIBRARY

Acknowledgment of all books received will be made in this column, and this will be deemed by us as full compensation to those sending them. A selection will be made for review, as expedient.

SPATIAL VECTORCARDIOGRAPHY. By Arthur Grisham, M.D., Adjunct Physician for Cardiology, Mount Sinai Hospital, New York; Adjunct Physician in Medicine and Assistant Roentgenologist, Beth Israel Hospital, New York; Former Adjunct Attending Physician in Medicine and Assistant Roentgenologist, Montefiore Hospital, New York, and Leonard Scherll, M.D., Research Assistant in Cardiology, Mount Sinai Hospital, New York. Illustrated. Philadelphia: W. B. Saunders Co., 1952. Price $6.00.

This is the third of a series of Monographs intended to bring to the medical profession the practical results of research in special fields of medicine. These investigations in spatial vectorcardiography were started in 1948. In the vector concept of electrocardiography, electrocardiographic leads are treated as derivatives of a single unit, the spatial cardiac vector. All the information available concerning the electrical activity of the heart can be presented as a single curve, namely, the spatial vectorcardiograph.

This most excellent Monograph proves to be a very valuable adjuvant to clinical electrocardiography. Its form is concise but it has many explanations, occasionally repeated for the sake of clarity. There are twelve chapters, beginning with a general introduction and a

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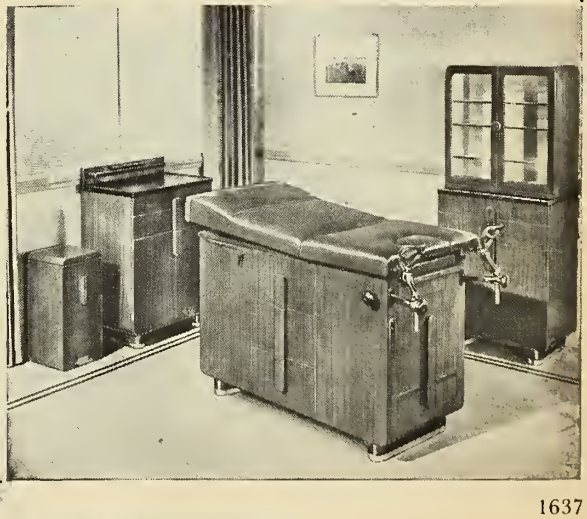
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description of the cardiac Vector concept, and ending with a discussion of aberrant artioventricular conduction and dextrocardia. Each chapter is greatly amplified with excellent diagrams and reproductions and this makes this text most worthwhile for the student of cardiology. The authors are to be complimented, for this is truly one of the best of the original works on this new and most interesting aspect of clinical medicine.

G.W.S.

SEX AFTER FORTY. By S. A. Lewin, M.D., and John Gilmore, Ph.D. Introduction by The Reverend Dr. Russell L. Dicks, Professor of Pastoral Care, Duke University. New York: Medical Research Press, 1952. Distributed by Grosset & Dunlap.

The authors supply a comprehensive explanatory discourse addressed to both men and women which, if digested thoroughly, should go far to promote an understanding of sex problems after forty. Anatomy and physiological mechanism of the menstrual cycle, the climacteric in both men and women are plainly described and are accompanied by excellent illustrations. Of necessity the explanation of the endocrine system is somewhat technical but is couched in terms the intelligent lay individual can understand.

The importance of love, thoughtfulness and understanding of the partner's problems, especially during the climacteric, are emphasized. The authors believe that bedroom technique, personal hygiene and outside interests all go to help each individual lead a full life. There are short explanatory chapters on Cancer and emotional problems which are adequate.

The book concludes with a number of case histories illustrating various problems.

BRAIN SURGEON, The Autobiography of William Sharpe. New York: The Viking Press, 1952. Price $3.75.

The "summing up" of the author's years is as interesting and absorbing as a novel. The author has been a fortunate man. He was born poor but was intelligent and physically strong. He had God fearing, idealistic parents. He received a superior education. In his early years he learned to study and think. His early boy-gang associates taught him to protect himself and be courageous. Lastly he was lucky in his adventures. It may be the spirit of his father walked with and protected him.

He did much pioneering work in neurosurgery. He became interested especially in cerebral palsy, i.e., the spastics. His theory is that the majority of cases of cerebral palsy are the result of birth injuries. He believes that much could be accomplished preventively by the avoidance of prolonged and difficult deliveries. If signs of birth injury present themselves then repeated spinal punctures should be done in order to drain the hemorrhage off the brain to prevent a spastic condition.

Besides the student and medical phases of his life, he discusses his romances, his recreational activities, his interests and friends. He describes his life in China and New York, and his travels through the Pan American



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countries. He recounts cases of both his successes and failures. He has had a full and successful life of seventy years, and is still actively engaged in his specialty. The recounting of his experiences is given in an intimate, friendly manner, and makes very enjoyable reading.

G.K.S.

CULDOSCOPY, A NEW TECHNIC IN GYNECOLOGIC AND OBSTETRIC DIAGNOSIS. By Albert Decker, M.D., D.O.G., F.A.C.S., Clinical Professor of Gynecology and Obstetrics, New York Polyclinic Medical School and Hospital, associate attending Physician in Gynecology and Obstetrics, New York Polyclinic Hospital, attending Gynecologist, Knickerbocker Hospital. With a Foreword by Richard W. TeLinde, M.D. Philadelphia: W. B. Saunders Co., 1952. Price $3.50.

This is an extremely interesting description of a new culdoscope perfected by the author with the help of a number of qualified technicians. It affords a direct method of visualization of the pelvis for diagnosis. The technique is well described and apparently it is a very safe and useful instrument. The foreword by Dr. Richard W. TeLinde speaks very highly for the use of this procedure and we feel that it will be more generally used in the very near future. The book is very readable and is short and to the point.

R.J.C.

CURRENT THERAPY 1952. Latest Approved Methods of Treatment for the Practicing Physician. Editor: Howard F. Conn, M.D. Consulting Editors: M. Edward Davis, Vincent J. Derbes, Garfield G. Duncan, Hugh J. Jewett, William J. Kerr, Perrin H. Long, H. Houston Merritt, Paul A. O'Leary, Walter L. Palmer, Hobart A. Reimann, Cyrus C. Sturgis and Robert H. Williams. Philadelphia: W. B. Saunders Co., 1952. Price $11.00.

This volume is an attempt to continue the fine work, as exemplified in previous issues, of presenting the latest of accurate, detailed and non-biased information on the treatment of disease. Diagnosis is not discussed, except rarely where it is an integral part of the therapy, as it is assumed that in all cases a diagnosis has been made prior to initiation of treatment.

Some valuable information from previous volumes is necessarily repeated with only slight modification but many important additions have been made. This present volume contains methods of 189 new contributors. In some instances one or more methods of therapy are given for the same disease, but no preference is indicated among such variant methods as each represents the opinion of a recognized authority and any state editorial preference would be illogical.

This text, as those before it, is extremely well done and achieves the goal that the editor, his consultants and contributors strove for, and as such, merit the repeated use of the doctor of Medicine.

G.W.S.

THE ESOPHAGUS AND ITS DISEASES. By Eddy D. Palmer, M.D., F.A.C.P., Lieutenant Colonel, Medical Corps, United States Army Chief, Gastrointestinal Section, Walter Reed Army Hospital Consultant in Gastroenterology to the Surgeon General. Illustra-

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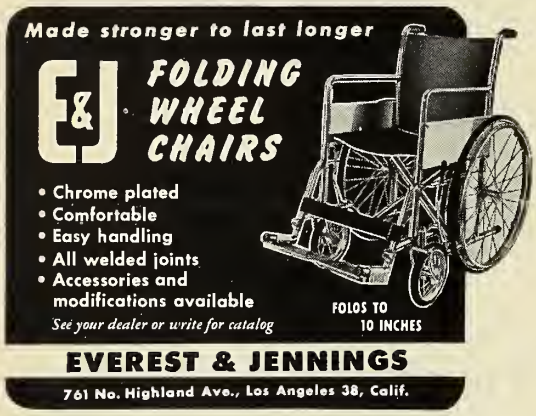
The pathologist in direction is recognized by the Council on Medical Education and Hospitals of the A. M. A.

tions by Phyllis Anderson. New York: Medical Book Dept. of Harper & Bros., Paul B. Hoeber, Ind., 1952. Price $15.00.

This is perhaps the most erudite and complete work yet to appear on the esophagus. Its review of the literature is complete. Of the first 146 pages, twenty are devoted to bibliography.

The first two chapters on Anatomy and Physiology are excellently organized and well-written. The remainder of the work, devoted to congenital abnormalities, neoplastic diseases, manifestations of infections, neurologic disorders, as well as intrinsic and extrinsic lesions, are well-outlined and treatment indicated. This will prove of most interest to the otolaryngologist, thoracic surgeon, and gastroenterologist.

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(Continued from Page 1562)

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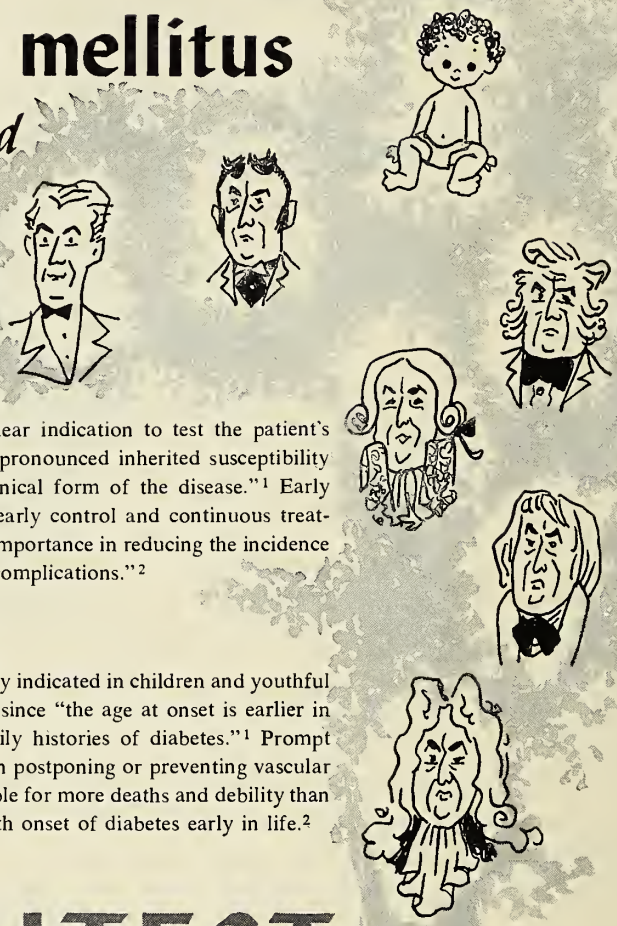
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2. Wilson, J. L.; Root, H. F., and Marble, A.: J.A.M.A. *147*:1526 (Dec. 15) 1951.

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